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Perspective

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The Future of Health Care Reform — A View from the States on Where We Go from Here

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The future of U.S. health care reform is muddier now than at any point in the past two decades. Health care was one of the most important issues for voters in the 2018 election, but there is little reason to believe that substantive national action is likely any time soon. The Trump administration is taking aggressive steps to undermine the Affordable Care Act (ACA) but is limited in what it can do on health policy absent legislation from Congress. States are poised to fill this vacuum. The risk of replicating the hyperpartisanship that has stalled Congress in recent years is real — 37 state governments will be controlled entirely by one party in 2019, and only Minnesota's legislature will have split control.[1] If the lessons of both the ACA's passage and the repeal-and-replace debate is that the durable reform must be bipartisan, what does a solutions-oriented conversation look like at the state level, how do we get there, and what does this shift mean for the future of health care reform?

There are many examples of states claiming an increasingly large role in health policy, to some degree spurred by the Trump administration's promise to allow greater flexibility. Kentucky, New Hampshire, and other states are introducing work requirements to their Medicaid programs. A larger number of states are moving toward Medicaid expansion than at any point since 2014, including Republican-run states such as Utah, Idaho, and Nebraska, where expansion was approved by ballot in November 2018. Maryland, Massachusetts, and others are experimenting with payment reform.

We reached out to state leaders to find out how they view this critical moment and to identify potential paths to consensus that would span the ideological spectrum. Our first step was a nationwide survey asking all state legislators serving on committees related to health to rank their policy priorities.[2] We then went to Colorado and Kansas to have conversations with legislators, executive-branch leaders, and key stakeholders about our survey results.[3] We chose Kansas to represent the 26 states led entirely by Republicans and Colorado to represent the 18 with split control. Both states had a high response rate on our survey and a health policy institute offering logistic support.

What we learned was provocative and illuminating, providing

a window into the challenges and opportunities that lie ahead. Four themes generated widespread agreement across ideologies, parties, branches of government, and stakeholder perspectives.

First, leaders expressed near-universal disdain for what was described as a dysfunctional and chaotic environment in Washington. It is difficult enough for state leaders to plan for the long term, given election cycles, short legislative sessions, and term limits. Strategic thinking is nearly impossible when Congress and the administration are unpredictable and volatile.

Second, access to health care — both to insurance and to providers — is a top priority for policymakers spanning the ideological spectrum. Leaders on all sides stressed the challenge of ensuring that there are enough providers in rural communities. Nearly enough Republicans in Kansas supported Medicaid expansion to override a veto from fellow Republican Governor Sam Brownback because they believed it would help their rural hospitals stay open. Leaders in Colorado were focused on how to increase the sustainability of their health insurance exchange in the context of decisions made by the Trump administration. But this conversation was not particularly ideological, in keeping with an overall theme in both states: although there may be quibbles about the ACA, there does not seem to be an appetite for a large-scale rewrite.

Third, our survey suggested that the greatest opportunity for bipartisanship on health care reform would be to focus on health care costs. However, though everyone we interviewed in Colorado and Kansas agreed that costs are a high priority, there was little agreement on the root of the problem or on whose costs should be prioritized. Costs to the government? Consumers? Hospitals? Providers? Are we actually talking about charges or prices instead of costs? This agreement on the importance of reducing costs but disagreement about pinpointing the problem was echoed in a recent survey of state legislators by Zhu et al.[4] Policymakers are likely to continue talking past each other until a common language is developed to differentiate various types of costs.

Fourth, and starkest, there was widespread agreement — both in our studies and in the survey by Zhu et al.[4] — that philosophical differences over the role of government pose the greatest threat to state health care reform. Leaders were frustrated about this reality and eager to find ways to bridge this divide. One way members of both parties try to do so is by framing health policy conversations to acknowledge that it will be impossible to eliminate the role of government and that the key question, therefore, is how the public sector can get the most value for what it spends. Similarly, people on all sides expressed a desire to expand the scope of the conversation beyond insurance and medical care to the social factors that shape health, such as housing and employment, and to look at the proper role of government in that context. Divisions softened — even among staunch conservatives in Kansas — as the focus shifted from health care to health more broadly.

What more is needed to build on these pillars of health policy consensus and facilitate productive solutions-oriented conversations at the state level? Though policymaking at the state level has the advantage of more closely reflecting local politics, in many cases the most consequential schisms occur within a party. Bipartisan agreement remains necessary for durable legislation and is more likely to happen with leadership that is less ideologically driven. Election results this November in Kansas suggest that there are states where the moderates are ascending within the Republican party. We will find out in 2019 how true this is elsewhere and whether this shift opens up a bit more room to move toward the middle. It is up to political leaders to frame issues in a way that creates space for productive conversations.

Finally, it is critical that policymakers, stakeholders, and academics learn from what is happening in states around the country. This period of state-level experimentation is an opportunity to develop evidence about the effects of everything from Medicaid work requirements to housing vouchers. Increased variation at the state level brings with it a risk that inequities will be exacerbated as states choose radically different paths. It will be important to develop reliable data about the effects of state decisions. National and state-level organizations have a crucial role in facilitating cross-state learning. Legislators and executive branch officials representing all points on the ideological spectrum stressed the importance of local nonpartisan organizations that adopt a mission of convening leaders and providing objective information. There

is a great need and opportunity for credible state-level policy think tanks and foundations to step up and play this role.

Conversations in Colorado and Kansas suggest that the new ground to be broken in health policy involves a focus on the social determinants of health and developing a common language for discussing health care costs. Shared understanding of the problems and goals may create opportunities for bipartisan collaboration, policy innovation, and difficult conversations about the role of government — if state officials are willing to take risks. Then, if history repeats itself, their efforts will show the way for that lagging legislature in the District of Columbia.

An audio interview with Dr. Jones is available at NEJM.org

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Politics and Pandemics

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This year marks the 100th anniversary of the deadliest event in U.S. history: the Spanish influenza epidemic of 1918, which killed more Americans than World Wars I and II combined. Although science and technology have advanced tremendously over the past century, the pandemic peril remains: a recent exercise at the Johns Hopkins Center for Health Security showed that an epidemic of an influenza-like virus could kill 15 million Americans in a single year.

The medical community's response to this danger is, understandably, focused on research and response — discovering new vaccines, therapeutics, and diagnostics and fighting ongoing epidemics, such as the current Ebola outbreak in the Democratic Republic of Congo (DRC). But these urgent undertakings are not sufficient. If the world is to tackle many factors that raise our risk of a devastating pandemic, the medical community may have to enter theatres of operation beyond the laboratory bench and the treatment unit and publicly engage with controversial issues that some observers would consider nonmedical. Indeed, I believe that only such efforts can save us from the social trends, political movements, and policy failures that are elevating our risk of a pandemic.

Of course, the social trend that has most increased that risk is also the most beneficial: the vast increase in global connectedness attributable to improvements in transportation and infrastructure. Today, it would take less than 24 hours for a virus like the 1918 influenza to move from almost any point on the planet to Paris or Washington, Beijing or Riyadh. Yet the benefits of global connectedness are too important, and the transportation revolution would be impossible to reverse even if we wanted to.

But what about less beneficial changes and trends that are making us less safe? There are three in particular in which the medical community's intervention is sorely needed.

First is the rising tide of isolationism and xenophobia — a turn inward — in many high-income nations, particularly the United States and European countries. A nationalistic mindset — with leaders telling us that global engagement is not our responsibility and proposing the retrenchment of our commitment to global health security — makes all countries less safe with regard to pandemic prevention and response. The belief that isolating ourselves from the world can prevent the spread of diseases is foolhardy: we can build no wall high enough to keep out infectious diseases and disease-bearing