Editor's Note

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The Limits and Possibilities of Health Policy Innovation

As I write this note in July 2017, the future of the Affordable Care Act remains unclear. Republicans have not abandoned their aim to "repeal and replace" the ACA, yet they have so far been unable to coalesce around a feasible alternative. Whatever the outcome of the current legislative struggle, ideologically charged debates over how best to improve the affordability, efficiency, equity, and political acceptability and sustainability of governmental interventions in the health care sector will continue, both in the United States and in other advanced democracies. The fundamental challenges of health care reform won't go away.

Given the hard realities of politics and economics, is there room for innovation in health policy? Can policy reformers alter long-standing patterns of resource allocation, market design, and political engagement, or are these patterns largely immune to change? Under what circumstances can health policy making be reconfigured to open up space for new modes of governance—and when do existing constraints leave policy makers with little or no room for creative thinking? The three research articles in this issue assess both the possibilities and limits of change in health care reform. Taken together, they provide a reminder that analysts and advocates need to avoid both excessive pessimism (the capacity of policy makers to bring about change is often greater than surface appearances suggest), and utopian thinking (political, economic, and legal barriers to reform cannot be simply wished away).

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The first article in this issue, by Rachel Sachs, Nicholas Bagley, and Darius N. Lakdawalla, examines novel pricing models (such as indication-based pricing, drug licenses, and drug mortgages) that would more closely link a drug price to its value. Liberals, conservatives, and diverse stakeholder groups agree on the need to move beyond the traditional model of paying strictly for volume in order to curb wasteful utilization and spending. However, there are practical barriers to the adoption of these models, including the lack of solid data on the performance of drugs in subpopulations. In their article, the authors focus on one alleged legal barrier to change: the requirement that drug manufacturers cannot charge state Medicaid programs more than the "best price" they offer for the drug in the private market. The legal concern is that, under innovative models of pharmaceutical contracting that link price to value, manufacturers may charge less when their drugs perform poorly. Doing this, however, would imply that the drug's "best price" is quite low. Drug manufacturers are reluctant to offer performance-based rebates that would cut deeply into their Medicaid payments. Sachs, Bagley, and Lakdawalla carefully examine this legal concern. While the law here is devilishly complex, the authors conclude that the best-price rule is not nearly as serious a barrier as it is made out to be and that, even where it is an obstacle, drug manufacturers and the Centers for Medicare and Medicaid Services should be able to find ways to avoid or mitigate the rule's impact. Overall, the authors believe that the United States could be on the cusp of a new era of paying for value in prescription drugs.

A key political goal of many US health care reformers is to incorporate not only the poor but also the middle class in government health insurance programs, not only to protect benefits from erosion but also to overcome the bifurcation of the US welfare state and create a new, more inclusive health politics going forward. In the second article in this issue, Jacqueline Chattopadhyay looks at the degree to which the ACA has been achieving this goal by examining whether middle-income earners believe they have personally benefited from the ACA so far and whether they think they will gain in the future. Based on an analysis of pooled data from nine nationally representative surveys from 2012 to 2015, Chattopadhyay finds that middle-income earners are less likely than lower-earning people to feel that the ACA has been helpful to them so far. One reason for middle-class ambivalence about the ACA is that many of the benefits that middle-class people receive under the ACA (such as consumer protections) are "submerged" and less visible. The study also uncovers key partisan effects. While middle-income Republicans are less likely than

low-income Republicans to think that the ACA will be helpful in the long run, Democrats of all income levels are equally likely to believe that the ACA will be personally helpful someday. The bottom line is that the ACA (at least as of 2015) has not generated a large, bipartisan cross-class constituency.

In the third research article, Martin Gorsky and Gareth Millward assess a novel policy intended to promote equity of access to services within Britain's National Health Service (NHS). They provide a detailed case study of the Resource Allocation Working Party (RAWP), established in 1975 to ensure that NHS resources were allocated in a fair and transparent manner to populations based upon their determined need for medical care. To explain the inception and persistence of the RAWP mechanism despite shifts in the United Kingdom's broader political climate, the authors emphasize the importance of policy learning, the role of midlevel civil servants in implementation, and the framing of the RAWP debate as essentially technocratic, even though it touched on core political values. At a time when there is renewed interest in the "Beveridge" model of universal coverage, the article offers broad lessons into the possibilities and limits of policy innovation within the health care arena.

In our special section on the "Politics and Policy of Health Reform," Adam S. Wilk, Leigh C. Evans, and David K. Jones investigate a puzzle: Why have six states that rejected the ACA's Medicaid expansion nonetheless taken a step to expand Medicaid access at state expense by adopting a provision of the ACA (the primary care "fee bump") that incentivizes primary care physicians to accept Medicaid patients? Based on interviews with leaders in five of these states, the authors find that the fee-bump extensions tended to move forward when they were cordoned off from national health reform debates and when they were aligned with preexisting policy-making structures and decision trends at the state level.

Overall, the articles in this issue paint a complex picture of the possibilities and limits of innovation in health policy making. There is clearly no "secret sauce" to innovation, no single factor that explains why novel ideas to reconfigure governance in the health arena are developed, rejected, or sustained. Yet the articles also suggest that health policy analysts are wise to focus on the role of ideas, interests, institutions, and policy legacies in shaping the political context in which innovation unfolds.