NATIONAL COMMISSION TO REDESIGN **HEALTHCARE**

Efforts to improve health care over the past decade, or since passage of the Affordable Care Act, have been largely consumed by expanding insurance coverage. More fundamental questions concerning access, what services get covered – including services that address the most basic needs of individuals – the quality and cost of health care, and what value is achieved for the dollar spent, remain sorely unanswered. We are calling for federal policymakers to create a commission composed of medical, social service and other cross sector professionals to recommend policies that will simultaneously improve health care service delivery, payment value and overall health and well-being for all citizens.

OUR PROPOSAL: A NATIONAL COMMISSION TO RECOMMEND POLICIES TO REDESIGN U.S. HEALTHCARE DELIVERY AND PAYMENT

With input from cross sectors, we are proposing a National Commission that will outline a healthcare delivery model to include, but not limited to:

- Identifying methods by which population health outcomes are improved in part by addressing the social determinants of health
- Identifying healthy aging and long-term care solutions
- Recognizing and addressing the needs of rural and frontier communities
- Developing payment models that both reward value or spending efficiency and are fiscally sustainable
- Addressing work force supply and training issues
- Emphasizing care value or outcomes achieved relative to spending

RECENT ATTEMPTS TO REFORM AND IMPROVE DELIVERY:

- 12.4% uninsured and 45% inadequately insured - the same as in 2010
- Uncovered services, e.g., Medicare does not cover LTSS, oral health, SDOHs; and FFS has no out of pocket cap
- Shortage of primary care and behavioral health providers
- Persistent and worsening drug shortage
- Health care disparities persist, e.g., in maternal and infant mortality
- Environmental harm: healthcare industry green house gas emissions account to upwards of 98,000 deaths
- Unintended negative consequences of employer healthcare tax exclusion
- Pay for Performance Models: No template for successful participation since there is no correlation between quality and spending
- Medicare Advantage is not designed to save money or reduce spending growth (Accounts for 34% of the Medicare population)
- Employer-based coverage covers nearly 160 million (approx. half the population), HDHPs w/HSAs grew by over 400% between 2007 and 2017

A SAMPLING OF HEALTHCARE'S IMPACT TO OVERALL HEALTH AND WELL-BEING

- Projected that healthcare will account for 20% GDP by 2026 – unsustainable model
- Healthcare spends $39 billion annually on regulatory requirements
- Individuals cannot afford basic care:
  - Cost of healthcare is the Number 1 cause of bankruptcy
  - One-third of people skip care and/or prescriptions due to cost
  - Bankruptcy for 65-year-olds is three times higher today than in 1991
- Inequities of Care:
  - 1 in 10 seniors in the U.S. live below the federal poverty level
  - 40% of American families struggled in the last 12 months to meet basic needs of food, healthcare, housing, or utilities
- Net Medicare Spending:
  - 2018: $583 Billion
  - 2028: $1.26 Trillion
- Total Medicaid Expenditure:
  - 2018: $632 Billion
  - 2025: $957 Billion
- For the 12 month period ending 12/18, drug overdoses (that includes opioids) were 67,700. Alcoholism deaths annually are nearly 90,000
- Per the Dartmouth Atlas, overtreatment alone accounts for approximately $250 billion annually

ON BACKGROUND

Health Status: A 2013 Institute of Medicine study titled *Shorter Lives, Poorer Health*, concluded Americans, throughout their life course, suffer comparatively higher disease prevalence and mortality rates compared to post-industrial Western countries. Even highly advantaged Americans, or white, college-educated and insured, are in worse health than their peers in comparative countries. The US "mortality gap" cannot be attributed to the adverse health status of the poor or racial or ethnic minorities. For the first time in over a century, US life expectancy has declined over the past three consecutive years.

Spending and Prices: Per recent research published by Johns Hopkins, US per capita health care spending at $9,892 in 2016 was 145% higher than the Organization for Economic and Development Cooperation median of $4,033 – despite comparatively similar utilization rates. US spending growth between 2000 and 2016 was comparatively 8% higher. Excessive US spending is largely a function of prices. For example, the price differential between private insurance and Medicare grew from approximately 10% to 50% between 2000 and 2016. The US spends more than twice the per capita OECD average for drugs and medical devices and because of highly fragmented care, US administrative costs are nearly eight times the OECD per capita average.

Solvency and Waste: The June 2019 Medicare Trustees report concluded the Medicare Part A trust fund will be bankrupt in 2026. This is largely due to the combination of an aging population and wasteful spending. The Medicare program is estimated to grow from currently $60 million to $86 million beneficiaries by 2040 and by 2050 the number of Americans in their 80s and 90s and beyond are estimated to triple and quadruple, respectively. The National Academies and others estimate one-third or more of health care spending, or well in excess of $1 trillion annually, or 6% of the GDP, is wasteful or does not improve our health status.

DESPITE RECENT REFORMS, SIGNIFICANT DELIVERY AND PAYMENT CHALLENGES PERSIST. THESE INCLUDE:

1. **Insurance Coverage:** Despite substantial gains in insured lives this decade, more people who have coverage are underinsured today, nearly 30%, than in 2010 with the greatest increase in underinsurance occurring among those covered by employer plans.
2. **Prescription Drug Pricing:** The US suffers both excessive pricing for branded drugs and the underpricing of generics that is causing increases in the frequency and duration of shortages and to wide-spread quality problems in the generic drug industry.
3. **Long-Term Care:** The US has no non-catastrophic long-term care policy. Nearly 15 million Americans need long term care, only 60% are seniors. Medicaid coverage is means tested and private insurance funds only 8% of total long-term care spending.
4. **Fragmented Care:** Fragmented care drives administrative costs that represent upwards of 31% of total US health care spending. Approximately two-thirds of administrative costs are attributed to billing. Compared to other industries it takes eight times the number of full-time workers to collect $1 billion in health care bills.
5. **Health Equity and Disparities:** Over the past 25 years, the US has made no progress on improving health equity, and disparities in life expectancies have increased since 1980.
6. **Pay for Value:** CMS' four hospital incentive programs, the agency's Quality Payment Program (MIPS and Alternative Payment Models/APMs) neither measure for value, or outcomes achieved relative to spending, nor reward for it. There is no real health care quality and price competition.
7. **Price Transparency:** Evidence published in JAMA, NEJM and other scholarly publications show price transparency is not associated with lower spending.
8. **Medical Harm:** A DHHS Office of the Inspector General study found one in seven Medicare beneficiaries experienced at least one hospital adverse event, 13% of these experienced serious harm and 1.5% experienced an event that contributed to their death.
9. **The Employer Tax Exclusion:** As the government's third largest expenditure on health care at $260 billion, it is extremely costly and disproportionately favors higher income employees, incents overly generous coverage and distorts job and retirement decisions.

NATIONAL COMMISSION
TO REDESIGN **HEALTHCARE**