NATIONAL COMMISSION TO REDESIGN **HEALTHCARE**

National policy making efforts to improve healthcare over approximately the past decade have largely been consumed by expanding insurance coverage moreover via passage of the Affordable Care Act. While coverage remains a significant concern particularly because of the pandemic's effect on the economy, several other substantive healthcare policy issues continue to need national attention including healthcare costs or spending, care quality, long term care, and the social determinants of health. For these reasons and others we are calling for federal policymakers to create a National Commission composed of industry leaders to recommend policy reforms that will, in sum, improve service delivery, quality, payment value and population health.

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

BACKGROUND: THE HEALTHCARE PARADOX

As has been well documented, healthcare outcomes do not reflect the significant investment made in healthcare delivery.

Concerning healthcare outcomes, compared to other rich countries, Americans throughout their life course suffer higher disease prevalence and mortality rates. The COVID-19 pandemic has cast these facts into stark relief. Even highly advantaged Americans, or moreover those white, college-educated and insured, are in worse health than their peers in comparative countries. Our comparative health disadvantage or mortality gap cannot be attributed to the adverse health status of the poor or racial or ethnic minorities - though health inequities for these populations continue unabated - and our mortality gap has been widening for several decades.

Total healthcare spending, per capita spending and spending growth are all multiples of comparable countries. US per capita spending is twice the average of 11 other like countries and 2.5 times the per capita OECD average - despite the fact Americans do not, comparatively, consume more healthcare services. US healthcare spending also suffers wide price heterogeneity or significant price discrepancy. The finest healthcare in the world, Uwe Rinehardt explained, costs twice as much as the finest healthcare in the world. As for spending growth, between 2000 and 2016 overall US spending increased at an average annual rate of eight percent higher than the median OECD annual increase and comparatively 29 percent higher for pharmaceutical spending. While there has been and will remain debate regarding how to best calculate prices or interpret price signals, there is consensus US healthcare suffers a significant pricing problem. For example, we spend more than twice the per capita OECD average on drugs and medical devices. As a widely referenced 2003 health economics article concluded, "it's the prices stupid."

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SIGNIFICANT DELIVERY AND SPENDING CHALLENGES PERSIST. THESE INCLUDE:

1. **Insurance Coverage:** Despite substantial gains in insured lives this decade, well over ten percent of Americans remain uninsured and approximately the same percent of Americans are under-insured today, at over 40 percent, as pre-ACA.

2. **Pay for Value:** Medicare's Part A hospital quality programs, Medicare Part B's MIPS and APM quality payment programs, the Medicare Shared Savings Program or ACOs, and Medicare Advantage's Quality Bonus Payment program neither measure for value, or outcomes achieved relative to spending, nor reward for it.

3. **Long-Term Care:** The US has no non-catastrophic long-term care policy. Nearly 15 million Americans, 40 percent of whom are non-elderly, need long term care. Medicaid coverage for long term care is means tested and of generally poor quality. Private insurance funds only eight percent of total long-term care spending.

4. **Prescription Drug Pricing:** We suffer from both excessive pricing for branded drugs and the underpricing of generics that has caused increases in the frequency and duration of drug shortages and to wide-spread quality problems in the generic drug industry.

5. **Fragmented Care:** Fragmented coverage drives administrative costs that represent upwards of 31 percent of total US healthcare spending. Two-thirds of administrative costs are attributed to billing. Compared to other large industries, US healthcare requires eight times the number of full-time workers to collect $1 billion in healthcare charges.

6. **Health Equity and Disparities:** Over the past 25 years, the US has made no progress in improving health equity. As a result, disparities in life expectancy have increased since 1980.

7. **Medical Harm:** Among numerous other like studies, a DHHS Office of the Inspector General study found one in seven Medicare beneficiaries experienced at least one hospital adverse event, 13 percent of these experienced serious harm and 1.5 percent experienced an event that contributed to their death.

8. **Medicare Solvency:** A recent Congressional Budget Office report projected the Part A hospital trust fund will be bankrupt as soon as 2024. This is due in part to the combination of a rapidly aging population, the program is estimated to grow from 61 to 80 million beneficiaries by 2030 and a worker-to-beneficiary ratio that has steadily decreased from 4:1 in 1980 to a projected 2:1 by 2040.

9. **Price Transparency:** Despite the enthusiasm for price transparency, the research literature published to date does not demonstrate price transparency is associated with lower costs or spending or improved quality.

10. **The Employer Tax Exclusion:** The employer tax exclusion is the federal government's third largest healthcare expenditure at roughly $260 billion annually. Among several other problems the policy, an accident of history, disproportionately favors higher income employees, incents overly generous coverage and compromises job and retirement decision-making.

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A NATIONAL COMMISSION WILL PROPOSE TO THE CONGRESS POLICY REFORMS THAT INCLUDE BUT ARE NOT LIMITED TO:

- Identifying policies that improve primary care access and delivery.
- Furthering the development of payment models that measurably bend the cost curve or are fiscally sustainable. Specifically, payment models that that reward value or spending efficiency measured as outcomes achieved relative to spending.
- Identifying healthy aging policies that include universal long-term care coverage.
- Recognize and address the needs of rural and frontier communities.
- Identifying reforms that address the social determinants or integrate clinical care and social service supports.
- Address work force supply and training issues.