



Our Health Care System Has Lost Its Way: Why U.S. Health Care Is Unaffordable and Low Quality

June 2022

Every person in the United States should have high-quality, affordable health care that prevents illness, allows them to see a doctor when needed and helps to keep their families healthy. Americans should never have to choose between going to the doctor and putting food on the table for their family, regardless of their color, their gender or where they live. Yet, nearly half of all Americans have reported having to forgo medical care due to the cost, and a third have indicated that the cost of medical care interferes with their ability to secure basic needs like food and housing.¹ The rising cost of American health care has created an affordability crisis for our nation's families, workers and consumers. Simply put, our health care system has lost its way.

For far too long, high and rising health care costs have crippled the ability of working people to earn a living wage. Today's real wages — wages after accounting for inflation — are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.² At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.³

NEARLY
1/2 of all Americans have reported having to forgo medical care due to the cost.

1/3 of Americans say the cost of medical care interferes with their ability to get basic needs met like food and housing.

The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries.

While the availability of affordable health care has decreased, medical debt has increased for our nation’s families. Nearly 18% of people in the U.S. have medical debt that has been turned over to a collection agency, and for the first time, the amount of medical debt in collections surpassed that of nonmedical debt.⁴ Clearly, the United States is losing the battle on health care affordability.

Per capita health spending in the U.S. has increased more than sixfold over the last five decades, from \$1,875 per person in 1970 to \$12,531 per person (in 2020 inflation-adjusted terms). During that same time period, total national spending on health care as a percentage of gross domestic product (GDP) increased from 6.9% in 1970 to an astounding 19.7% in 2020.^{5,6} That means that health care accounts for about one-fifth of the nation’s economy.⁷ This excessive growth in costs is primarily driven by paying higher prices than anywhere else in the world for health care, including prescription drugs, hospital stays, specialty care, MRIs, CT scans, births and time in the intensive care unit.⁸

Notably, the high cost of health care generally does not buy Americans higher-quality care or even higher volumes of care. In fact, the opposite is true. The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries. One of the best indicators for health outcomes is amenable mortality — the measure of treatable and preventable deaths that could be avoided with timely and effective interventions. The U.S. has a score of 81, faring far worse than most other industrialized countries and tied with Estonia and Montenegro.⁹ In other words, despite the fact that the U.S. spends nearly one-fifth of its economy on health care, the system fails to provide timely and effective interventions to save Americans’ lives. Health care acquired infections (HCAIs) are another indicator of health outcomes and are one of the top 10 causes of death in the U.S., causing more

Health Spending Increases Over the Last 5 Decades

(In 2020 inflation-adjusted terms)

PER CAPITA HEALTH SPENDING IN THE U.S.



TOTAL NATIONAL SPENDING ON HEALTH CARE AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT



ABOUT **1/5** of the nation's economy is spent on health care, and yet the U.S. has some of the worst health outcomes.

72,000 every year in the U.S. from preventable health care acquired infections.
PATIENTS DIE

than 72,000 patients to die each year.¹⁰ Furthermore, the U.S. has the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.¹¹ These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.¹²

These abysmal health outcomes and extraordinarily high prices are the product of broken financial incentives within the U.S. health care system. The health care system siphons money out of workers' paychecks and into building C-suites of big health care corporations to then increase health care prices. The health care system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, well-being and financial security of the community. As a result, the economic freedom of Americans is being eroded. We cannot afford to retire when we want, live in the home of our choice, send our children to college or even meet basic needs, like paying for rent, heat or food.¹³⁻¹⁴

This economic waste resulting from excessive health care spending also has created an economic crisis for the federal government, state governments and taxpayers.¹⁵ Every day the waste in our health care system limits our ability as a nation to educate our children, protect our neighborhoods, care for our elderly and build critical infrastructure like bridges and roads.



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The problem: Broken financial incentives

There are two principal financial drivers of unaffordable, inequitable health care and poor health for the American people:

1. **High health care prices driven by big health care corporations and medical monopolies.**
2. **Fee-for-service economics as the predominant payment model in the U.S. health care system.**

High health care prices

There is long-standing evidence that the excessive cost of health care in the United States relative to peer countries is driven by paying much higher prices than in any other country, rather than receiving better health care. These high prices have gotten worse in recent years because of health care industry consolidation that has eliminated competition and led to monopolistic pricing. This consolidation has taken place without meaningful regulatory oversight or intervention.¹⁶ These higher prices result in \$240 billion annually coming out of workers' paychecks and becoming profits for large health care corporations.^{17,18,19}

These unjustified prices in America occur across health care goods and services, including prescription drugs, hospital stays, MRIs and CT scans. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in the U.S. as in the United Kingdom and almost twice as expensive as in Germany.²⁰ The average price of a hospital-based MRI in the U.S. is \$1,475.²¹ That same scan costs \$503 in Switzerland and \$215 in Australia.²² These higher prices for an identical service are the main driver of the dramatic increase in per capita health care spending in the U.S., where health care accounted for nearly 20% of the nation's GDP in 2020, far exceeding health care spending by any other industrialized country.²³

Health Care Industry Consolidation Has Led to Uncontrolled Price Hikes That Families Are Left to Bear



Hospital Costs Are:

NEARLY **1/3** of national health care spending.

Growing **MORE THAN 4X** FASTER than workers' paychecks.

Hospital costs, in particular, have increased dramatically in the last decade and make up a large portion of increasing health care costs.^{24,25} These overall cost increases have occurred despite lower hospital utilization and are largely due to higher prices, which are the result of hospitals buying other hospitals and community doctors to eliminate competition and form big health care corporations and medical monopolies.^{26,27} Americans in many communities have watched as hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and policymaking community have not realized is how much this has destroyed any real competition in our health care sector; and even fewer realize that hospitals are dramatically increasing their prices every year.^{28,29} Since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.^{30,31,32} Importantly, these higher prices have not improved our nation's health.³³

Despite its flaws, the only real effort to establish a fair price for health care in this country is through the Medicare program.^{34,35} In most instances, the prices established for Medicare services become the basis for the prices paid by Medicaid and commercial insurers, expressed as a percentage of the Medicare price (for example, 100%, 150%, etc. of the Medicare established rate).^{36,37}

Most people in our nation of working age receive health care through their employers and private insurance.³⁸ Unfortunately, private health insurance companies have done a terrible job

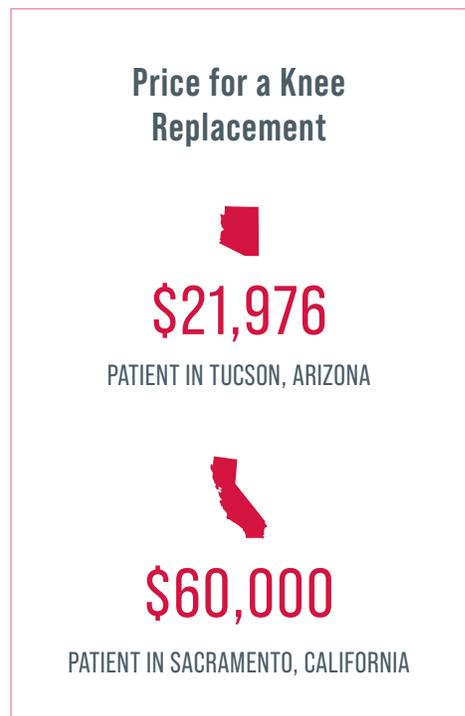
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negotiating a fair price for health care services, and these health plans often have their own conflict of interest because their long-term margins or profits are directly proportionate to the total amount of money collected for health care services.³⁹

As a result, study after study shows that commercial health care prices that drive up premium costs for most working-age people and families are growing much faster than Medicare payments. In 2020, privately insured consumers and employers paid on average nearly two and a half times what Medicare would have paid for the same hospital and outpatient services.^{40,41,42} In some states, employers and private health plans paid on average nearly three and a half times what Medicare pays for hospital inpatient and outpatient services.⁴³

Even among private insurers, health care prices vary widely without justification. For example, commercial insurance prices for the exact same hospital or physician services in monopolistic markets like Florida, South Carolina, Tennessee and West Virginia can be almost twice as much as the exact same services in Arkansas, Michigan and Rhode Island.⁴⁴ The average price for a knee replacement for a patient in Tucson, Arizona, is \$21,976, while the same procedure would cost about \$60,000 in Sacramento, California.⁴⁵ Even prices in a single hospital system vary significantly across payers. For example, the price of an MRI at Massachusetts General Hospital in Boston, Massachusetts, ranged from \$839 to \$4,200 depending on the insurance carrier.⁴⁶

This unchecked increase in what health care corporations charge insurance plans results in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance through their employer or directly from a health plan.^{47,48} The irrationality and out-of-control growth in commercial health care prices also underscore the broken economic incentives within the health care system that allow plans, providers and drug companies to amass unchecked market power and unscrupulously increase prices to generate profit or margin without any link to improving the health of the people and communities they serve.



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Fee-for-service economics

The fee-for-service (FFS) payment model has long been the predominant model for how health care in the U.S. is reimbursed and is used to pay doctors, hospitals, nursing homes and other health care providers. In this model, health care providers are paid for each service or health care product they provide. The health care industry often argues that FFS payments allow providers to do what they think is best for patients — that FFS does not create any conflict of interest between providers and patients. However, this simply is not true. FFS economics are a major driver of unaffordable, inequitable and low-quality care, and they are at odds with the interests of families and consumers.⁴⁹

FFS payment incentivizes providers to make money by doing more, particularly high-profit or high-margin procedures, rather than allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.⁵⁰ For

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WHAT FEE-FOR-SERVICE LOOKS LIKE IN PRACTICE

Payment for Physician-Administered Prescription Drugs

Medicare payments for physician-administered drugs, like those that can treat cancer or serious autoimmune problems, demonstrate the distortions created by FFS economics. Under this model, Medicare bases payment for physician-administered drugs on the prices charged for products grouped into a single billing code. Then an additional 6% of the average sales price of the drug is added to the price for that billing code. This means that if a patient goes to the doctor's office to receive a drug, the doctor makes more money when the doctor chooses the more expensive drug⁵¹ — and these drugs can be very expensive.

For example, Ipilimumab — a drug that treats melanoma — costs \$120,000 for four doses.⁵² The result is that physicians with unilateral control over which medicines they use are paid more when they choose a drug and billing code with a higher price. Providers are incentivized to make decisions about which drugs to administer to their patients based on the ability to generate higher reimbursement rather than the clinical effectiveness and value of that drug to the consumer. **Research indicates that doctors, and oncologists in particular, chose the drugs that give them the most money.**⁵³⁻⁵⁴⁻⁵⁵

A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.

example, the U.S. health care system incentivizes more surgeries, hospital admissions and tests, without any real link to the quality of care. Fees for hospital admissions, procedures, office visits and tests are priced too high, and fees for answering patient questions or sending a health worker to the home are priced too low or at zero.⁵⁶ Patients can be billed for each additional service, driving up the cost of their care.⁵⁷ A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.⁵⁸

It is well established that 80% to 90% of what drives variations in peoples' health is determined by the health-related socioeconomic and environmental factors in their lives, yet the predominant model for how health care is paid for in the U.S. offers no payment for addressing the social determinants of health.⁵⁹ By definition, FFS payment provides a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives

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Choosing Wisely to Avoid Expensive and Useless Care

The Choosing Wisely initiative — created by the American Board of Internal Medicine's ABIM Foundation — highlights how FFS payment encourages health care providers to prescribe unnecessary health care services. The goal of the effort is to identify and reduce overused tests and treatments to improve the quality of health care. Through the initiative, more than 600 recommendations of overused tests and treatments were identified by more than 80 medical specialty societies in an effort to reduce the prevalence of low-value health care. For example, the effort resulted in reducing the use of low-value imaging for lower back pain by up to 60% in some medical centers and clinics.^{60,61}

Almost all the providers reimbursed by Medicaid managed care or Medicare Advantage are still faced with the same perverse incentives to do more — often low-value care — to drive up profit or margin.

10% to 20% of health.⁶² By offering no payment for services that address the social determinants of health and paying so much for hospital admissions and procedures, the economic incentives of FFS actually work against the professional responsibilities and desires of providers to improve health or reduce disparities.

Despite these flawed incentives, FFS continues to be the predominant payment model for health care services across payers. Importantly, even those health insurers that purport to use value-based contracts, such as Medicaid managed care plans and Medicare Advantage, are still using FFS as the underlying reimbursement system for the vast majority of care delivery.⁶³ This means that almost all the providers reimbursed by Medicaid managed care or Medicare Advantage are still faced with the same perverse incentives to do more — often low-value care — to drive up profit or margin.

It is critical for policymakers to closely examine supposed value-based care contracts to understand if they fundamentally shift away from FFS economics or if those payers actually have built new service delivery on top of broken FFS incentives that only serve to drive unaffordable, low-quality care that fails to meet health needs and increases economic instability for our nation's families.

CASE STUDY

The Impact of COVID-19 on the Health Care System

During the pandemic, health care providers and organizations worked to respond quickly to provide an effective COVID-19 response. Health care providers who are reliant on fee-for-service payment experienced dramatic and persistent revenue shortfalls as a result of the severe disruption of face-to-face visits caused by the pandemic. These revenue shortfalls threatened the collapse of entire sectors of our health care system, primary care being the most notable example. Primary care practices experienced declines of up to 50% in service volume, putting nearly 30% of these practices at risk of going out of business,⁶⁴ thereby jeopardizing access to primary care at a critical time.

Throughout the pandemic, FFS payment — payments based on the number of services or tests ordered — offered no protection to health care providers when the number of in-person visits dropped, putting access to health care at risk at a time when people needed it most.

Providers and health systems participating in efforts to transform their compensation structure to what is referred to as value-based payment have been more financially stable during the pandemic, particularly those that use alternative payment models, which allow providers to receive upfront, ongoing payments not tied to FFS. Practices receiving these alternative payments were able not only to have a more effective pandemic response but also to build a wide range of capabilities critical to effective prevention of COVID-19 hospitalizations and deaths that are not well supported under the current volume-based payment structure of FFS. These preventive measures included paying for care coordination staff; addressing the social determinants of health; spending more time with patients to discuss pandemic risks and vaccines; creating patient engagement tools, including mobile phone apps and 24/7 help lines; performing robust data analysis; and building infrastructures to support telehealth, remote monitoring and home-based care.⁶⁵

Providers who are reliant on the existing FFS payment system have had to rely on Congress and the federal government to make policy changes to have an effective COVID-19 response and to move forward with such innovations.⁶⁶ COVID-19 has been a stark reminder that we need to transform the way we pay for health care to better support the delivery of high-quality, affordable health care to improve the health of our nation's families.



Policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

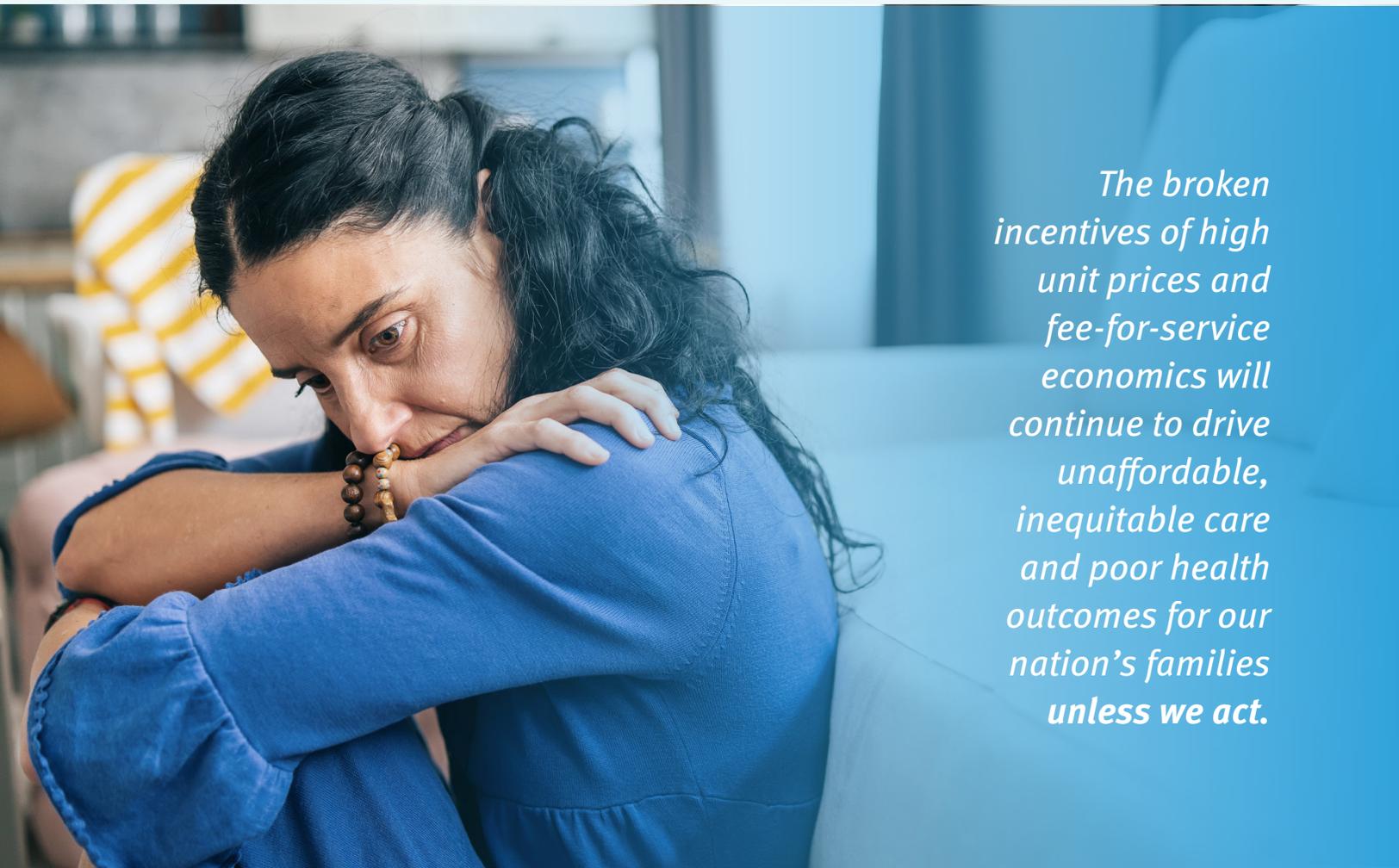
The need for policy solutions

As described above, health care payments are largely driven by Medicare and other payment policy. It is past time to implement policy changes that will make health care affordable and allow our nation's families to get the health and health care they deserve. These new policy efforts need to happen in the U.S. Congress and the federal administration as well as in state capitols and by governors. There are both short- and long-term policy solutions that will begin to fix the broken incentives in the health care system that are driving the nation's health care affordability and quality crises.

In the short term, policymakers should focus on ending the health care sector's pricing abuses and introducing real competition by reining in monopolistic behavior in the health care industry, a result of industry consolidation. Policymakers should also ensure there is a great deal more transparency around both the cost of care and health care outcomes, including for vulnerable populations living in rural America, people of color, etc. **In the intermediate to long term,** policymakers should focus on redesigning the economic incentives of the health care sector to be aligned with consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

Policy Solutions Already Underway

- » Passage of the No Surprises Act and current implementation efforts.
- » Authority for Medicare to negotiate prescription drug prices.
- » Development of all-payer claims databases and other efforts to ensure data are available to understand health care costs and outcomes.
- » Implementation of the Hospital Price Transparency and the Transparency in Coverage Regulations.
- » Prohibition of anti-competitive behaviors like “gag” clauses through passage of the Consolidated Appropriations Act of 2021, and efforts to ban other anti-competitive behavior like “all-or-nothing” clauses and “anti-steering” or “anti-tiering” clauses.
- » Proliferation of state affordability and cost boards and all-payer claims databases.
- » State efforts to codify hospital price transparency regulations into law.
- » Implementation of new payment and delivery reform models, such as Primary Care First; the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model; and the oncology bundled payment model.
- » Global hospital budgets and all-payer rate setting models in Maryland, Pennsylvania and Vermont.
- » Increased oversight and enforcement over mergers and acquisitions by the Federal Trade Commission and the U.S. Department of Justice.
- » Development of new community-based entities, like coordinated care organizations in Oregon, to establish health care targets and redistribute health care dollars into community-identified needs, with cost and quality targets.



The broken incentives of high unit prices and fee-for-service economics will continue to drive unaffordable, inequitable care and poor health outcomes for our nation's families unless we act.

Conclusion

There are so many talented women and men who work in the U.S. health care system. But, because of the underlying financial incentives, we continue to spend much more on health care than other nations and have poorer outcomes, and our nation's and families' economic security is threatened. It is clear our health care system has lost its way. The broken incentives of high unit prices and fee-for-service economics will continue to drive unaffordable, inequitable care and poor health outcomes for our nation's families unless we act. Given the entrenched interests of health care corporations in maintaining the status quo, it will require a national consumer-driven movement to make needed policy change. Almost every year, the percentage of our national spending that flows into the health care sector grows and makes it politically harder for policymakers to change the status quo. We must act now if we are going to redesign our health care system to ensure it serves the needs our nation's families.

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Our health care system has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills.

People First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low-quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high-quality care for all.

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