

**A Pro-Consumer
Policy Agenda to
Achieve Meaningful
Health System
Transformation**



Our collective organizations have come together to put a stake in the ground about what it means to center the needs and interests of consumers and patients in efforts to make meaningful progress toward reforming U.S. health care payment and delivery. The following is a blueprint to advance pro-consumer policies that shift U.S. health care payment and delivery away from the inefficiencies and fragmentation of fee-for-service (FFS) economics toward the adoption of population-based economics that hold the health care system accountable for improving health and delivering affordable, high-quality, and equitable health care.



Overview

To achieve an equitable and person-centered system of health care that is designed to achieve optimal health and well-being for all, policymakers must embrace and enact critical policy changes that address the inefficiencies, inequities, and market failures ingrained in the U.S. health care system that drive unaffordable, low-quality, inequitable care and abysmal health outcomes. Our collective organizations, representing our nation's families, consumers, and patients, join together to urge policymakers to enact health care payment and delivery policy reforms that will enhance the availability, accessibility, and affordability of high-quality health care, and the efficient delivery of health services that drive improvements in population health. To that end, we encourage policymakers to pursue policy solutions across the following six priority areas:

1. Improve health outcomes by changing payment incentives to improve health, reduce inequities, and prioritize the delivery of high-value care over volume of services.
2. Strengthen primary care, behavioral health, and long-term care systems by investing in services that keep people healthy, address chronic illness, and prevent the need to use more expensive care settings.
3. Ensure strong patient protections and guardrails in health care payment systems to ensure medically underserved patients, patients with chronic illness, and patients with disabilities have full and complete access to high-quality, culturally-congruent care and services.
4. Establish national data-sharing, interoperability, and quality measurement standards, to reduce waste, enable real-time coordination of services across health sectors, and drive meaningful improvements in health equity and health outcomes.
5. Promote healthy competition in U.S. health care markets to support meaningful access to affordable, high-quality, and culturally-congruent care and services.
6. Improve consumer and other stakeholder access to meaningful information about treatment options, quality of care, patient experience and cost to enable effective decision-making, and improve consumer and community input into the design, implementation and evaluation of policies and programs.

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The problem: bad care with high costs

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 who they are, where they are from, or where they live. Yet, nearly half of all Americans have reported having to forgo medical care due to the cost, a third have indicated that the cost of medical care interferes with their ability to secure basic needs like food and housing, and more than 100 million Americans are in medical debt.^{1,2} The rising cost of American health care has created an affordability crisis for our nation's families, workers, consumers, and taxpayers.

Per capita health spending in the United States has increased more than sixfold over the last five decades, from \$1,875 per person in 1970 to \$12,914 per person (in 2021 inflation-adjusted terms).³ During that same time period, total national spending on health care as a percentage of gross domestic product increased from 6.9% in 1970 to an astounding 19.7% in 2020.^{4,5} Importantly, 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 United States has some of the worst health outcomes, lowest levels of access to care, and greatest inequities compared with other industrialized countries.⁶ For example, 72,000 patients die each year from health care-acquired infections, which is one of the top 10 causes of death in the United States.⁷ Moreover, the United States has the lowest life expectancy, the highest rates of infant mortality, and among the highest rates of maternal mortality compared with other industrialized nations.⁸ 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 to their white counterparts.⁹



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Our nation's affordability and health care quality crisis is driven by broken economic incentives in the health care system that encourage monopolistic behaviors that lead to health care price increases and generate high volumes of high-priced services. The economic incentives of health care payment and delivery are not designed to reward success in promoting the health, well-being and financial security of our communities – especially those that face chronic, inequitable health challenges. The overreliance on FFS economics is a major obstacle in being able to achieve the affordable, high-quality health care and improved health our nation's families deserve.

The role of fee-for-service economics

The FFS payment model has long been the predominant model for how health care in the United States is reimbursed. In this model, health care providers are paid for each individual service or health care product they provide with no regard to the outcome of that care. 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.¹⁰

FFS payment incentivizes providers to make money by doing more, particularly performing high-profit or high-margin procedures, rather than encouraging providers to generate a profit or margin based on keeping people healthy and reducing disparities.¹¹ Patients can be billed for each additional service, driving up the cost of their care.¹² As a result, 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, while fees for many other integral services, like patient navigation supports, care coordination or taking the time to discuss your care needs with your doctor, are priced too low or at zero.¹³ 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.¹⁴

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 United States offers no payment for addressing the social determinants of health.¹⁵ By definition, FFS payment provides a very narrow view of health and health care by only reimbursing the clinical care – which drives 10% to 20% of health.¹⁶ Fees are generated for hospital admissions, procedures, office visits, and tests, but little to no reimbursement is provided for answering patient questions or sending a health worker to the patient's home.¹⁷ 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 and 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.¹⁸ 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 — which often means providing low-value care — to drive up profit or margins. Meaningful value-based care should hold providers accountable for improving population health outcomes and addressing health inequities at a price people can afford, rather than promote high volumes of high-priced services with little accountability for the quality of care provided.

As a result, it is critical for policymakers to closely examine claims of value-based care, including supposed value-based care contracts, to understand if they fundamentally shift away from FFS economics or if those payers have simply built new service delivery on top of broken FFS incentives that only serve to drive unaffordable, low-quality care. Moreover, all value-based care should be evaluated not just on how much money is saved, but also on how quality, outcomes and equity have been improved.

The solution: pro-consumer policy principles

To address the U.S. health care affordability and quality crisis, and meaningfully transform health care payment and delivery to drive improvements in health equity and health outcomes, it is essential to reorient economic incentives to hold the health care system accountable for the health and financial security of our nation's families. We believe the following policy principles represent important pro-consumer reforms that tackle many of the underlying incentives in the health care system to help make progress towards this goal. To that end, we urge policymakers to consider reforms that adhere to the following policy principles to begin to drive meaningful value into U.S. health care payment and delivery:



Improve health outcomes by changing payment incentives to improve health, reduce inequities, and prioritize the delivery of high-value care over volume of services. The Institute for Healthcare Improvement set the gold standard for improved health care in the Triple Aim framework, which called for improving population health, care quality, and patient experience, and lowering health care costs simultaneously.¹⁹ When done right, health care payment and delivery reform can help achieve the Triple Aim. Yet, the FFS financial incentives, which make up the majority of U.S. health care payments, directly impede these goals by driving increases in the volume of services provided, which in turn drives up health care spending without any corresponding increases in the quality of care. In fact, FFS payment

is a significant driver of poor health outcomes and billions of dollars of health care waste in our system.^{20,21} The health care system has an essential role and responsibility to reduce disparities and advance health equity. Yet FFS payment fails to support care coordination services that address the social drivers of health and instead incentivizes fragmented care delivery that fails to provide the full spectrum of services required to meet the health needs of our nation's families.

It is critical to redesign the economic incentives and organizational structure of the U.S. health care system to align with the health, well-being, and financial security of consumers and families. We encourage policymakers to consider policy solutions that shift away from FFS economics and move toward advanced alternative payment models with population-based payment that holds the health care system accountable for improved health, health equity and affordable health care. We also encourage policymakers to promote multi-payer alignment by identifying and adopting a common set of payment programs and economic incentives, such as alternative payment models with population-based payment, that show great promise in achieving these goals and can be applied to all payers across the health care system. There are a number of promising models policymakers should look to: the Medicare Shared Savings Program, the Accountable Care Organization (ACO) Realizing Equity, Access and Community Health (REACH) model, Making Care Primary, States Advancing All Payer Equity Approaches and Development (AHEAD), bundled payment models, Vermont's All Payer ACO model and Oregon's Coordinated Care Organizations. In addition, we encourage policymakers to consider policy options that prepare and incentivize health care providers to move away from FFS payments toward population-based payment models, such as extending and expanding the Advanced Alternative Payment Model bonus payments under the Centers for Medicare and Medicaid Services Quality Payment Program.

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Strengthen primary care, behavioral health, and long-term care systems by investing in services that keep people healthy, address chronic illness, and prevent the need to use more expensive care settings.

Central to improving the health and health care of our nation's families is ensuring that primary care, behavioral health, and long-term care providers are valued and empowered in our health care delivery system.²² Historically low reimbursement for primary care and behavioral health is an important driver of the inadequate supply of primary care and behavioral health care patient experience across our nation, resulting in reduced access to essential health care and services for many families.^{23,24} Moreover, the primary care setting is an integral point of entry into the health care system for identifying and treating mental health problems.²⁵ Integrating primary care and mental health services is an essential step toward creating a health care system designed to meet the needs of all people living in our country. Yet, the longstanding under-reimbursement of primary care and mental health in primary care settings remains a significant barrier to achieving that goal. Furthermore, long-term care services that are used to help individuals with chronic illnesses or disabilities live safely and meet their health needs also face notably low reimbursement rates and inadequate coverage, creating barriers to needed care and contributing to worsened health outcomes for those in need of support services.^{26,27} Our collective organizations recognize the critical role that Long-Term Services and Supports and Long-Term Care facilities play in patient-centered care and the importance of developing policies that improve access, quality and affordability of long-term care.

Specifically, office/outpatient evaluation and management (E/M) services – a category of Current Procedural Terminology (CPT) codes most commonly used by family physicians and other primary care providers, including behavioral health and long term care providers – encompass activities that require significant clinician time, such as taking patient histories, engaging in medical decision-making, or conducting home visits – services that cannot be easily replaced or optimized by advances in technique or technology. We encourage policymakers to pursue policy options that would rebalance the payment rates between primary care and specialty care, including by increasing the E/M values for the services that primary care, behavioral health, and long-term care providers most commonly bill.



Ensure strong patient protections and guardrails in health care payment systems to ensure medically underserved patients, patients with chronic illness, and patients with disabilities have full and complete access to high-quality, culturally-congruent care and services.

Risk adjustment, for instance, is a critical patient safeguard which comes in the form of a payment adjustment (for example, increased payment for providers who treat sicker patients) to ensure providers do not participate in “adverse selection” or exclusively treat healthier patients while avoiding sicker patients who are associated with higher treatment costs. However, current risk adjustment methods have significant flaws, which are actively harming patients and helping drive low-quality care and health disparities.²⁸ They underestimate the health care needs of many patients, particularly those with serious illnesses and social needs, too often not accounting for the full range of factors that affect an individual patient’s expected health care costs (for example, socioeconomic variables, housing, food insecurity).²⁹ As a result, providers are disincentivized to treat the most marginalized and medically complex patients.

There is also substantial evidence that current risk adjustment methodologies are susceptible to industry gaming and upcoding, due to relying on variables and data, such as health diagnoses, that can be easily manipulated and over-reported to inflate risk adjustment payments.³⁰ Not only has this led to billions of dollars in wasteful spending, it also hurts patients, as providers can manipulate the system to increase payments without providing commensurate increases in care to their patients.³¹

As the health care system adopts alternative-based payment models, such as population-based models, it is critical that the risk adjustment methodologies used to set payment benchmarks and payment adjustments are redesigned to prevent industry gaming and encourage the treatment of all types of patients, including high- and low-cost patients alike. Payment systems employing risk adjustment methodologies should also fully account for and encourage the treatment of patients with social risk factors and health related social needs.



Establish national data-sharing, interoperability, and quality measurement standards to reduce waste, enable real-time coordination of services across health sectors, and drive meaningful improvements in health equity and health outcomes.

National data-sharing and interoperability standards are essential for reducing waste and inefficiencies in the health care system. They enable real-time coordination of health care services across health care providers and organizations. This allows providers to better identify and bridge potential gaps in care and drive needed improvements in the quality, equity, and value of health care services. We encourage policymakers to consider a variety of policy solutions that would ensure all payers and providers are sharing a comprehensive set of health care data, interoperable across the following categories of data: medical and clinical data, prescription drug data, dental and behavioral health, and available social needs data. Alongside policies to advance data sharing and interoperability, policy makers must prioritize the privacy of patient health data to protect consumers from the risks of re-identification or data misuse. These are critical steps to enable the exchange of data across all providers, health systems, payers, public health, and social service agencies.

In addition, establishing a comprehensive set of quality, equity, and outcomes measures is essential to a high-value health care system. Health care providers should be held accountable for ensuring patient safety and delivering high-quality, person-centered care through a meaningful set of clinical process and outcomes measures, as well as patient-reported quality measures, such as patient-reported outcomes and experience measures. Policymakers should consider policy options that work to harmonize quality measures across payers and providers and ensure that all measures are disaggregated and stratified by a comprehensive set of sociodemographic factors, including race and ethnicity, sexual orientation, gender identity, disability and primary language.



Promote healthy competition in U.S. health care markets to support meaningful access to high quality care and services.

High and rising health care prices are the leading cause of unaffordable health care for our nation's families and patients. Health care prices vary significantly among providers and these differences are unrelated to the quality of care or health outcomes.³² For example, the price of an MRI at a single health system in Massachusetts ranges between \$839 and \$4,200 depending on the insurance carrier.³³ This large variation in price does not account for the quality of the test and is part of a nationwide trend where hospitals' prices, in particular, range from 150% to more than 400% of what Medicare pays for those same services.³⁴

These high and variable health care prices are often the result of growing consolidation across and within health care markets among hospitals, insurers, and other health care organizations that battle for relative market power and control to set prices or prevent health care data from being shared.³⁵ Consolidation undermines healthy competition in these health care markets, removing incentives for health care organizations to compete on the basis of providing affordable, equitable, or high-quality care. While we cannot turn back the clock on the high degree of consolidation that has already occurred, policymakers can pursue a variety of policy options that work to rein in anticompetitive behavior and restore competition in U.S. health care markets, such as: restricting the use of anticompetitive contracting terms that limit access to higher quality, lower cost care; enacting fair payment policies to ensure patients pay congruent prices for the same service; and increasing the authority of the Federal Trade Commission to scrutinize anticompetitive behavior across the health care system.

Unveiling health care prices and quality data would ensure that health care providers and insurers compete on fair prices and high-quality care rather than consolidating market power to increase prices and generate high volumes of high-priced services.



Improve consumer and other stakeholder access to meaningful information about treatment options, quality of care, patient experience and cost to enable effective decision-making, and improve consumer and community input into the design, implementation and evaluation of policies and programs.

Unveiling health care prices and quality data would ensure that health care providers and insurers compete on fair prices and high-quality care rather than consolidating market power to increase prices and generate high volumes of high-priced services. It would also enable policymakers, researchers, and purchasers of health care to accurately assess and improve the quality and value of health care services. Such data needed to lower the cost of care and drive improvements in health outcomes include: health care prices (i.e., the negotiated rates between insurers and providers), health care costs (for example, provider operating costs associated with care delivery), health care quality and health outcomes, medical and clinical data, prescription drug data, as well as dental, behavioral health and available social needs data. These data should be disaggregated and stratified by a comprehensive list of sociodemographic factors, such as race, ethnicity and primary language to ensure the health care system is delivering equitable care for everyone, and must be made available in a manner to protect confidentiality and privacy. Furthermore, policy development and decision-making must be shaped by the priorities and expertise of individuals and communities.

By enacting these policy recommendations, policymakers have the opportunity to realign the economic incentives and design of health care payment and delivery to ensure the system delivers the health and high-value care that all people across the nation need and deserve. Our collective organizations stand ready to work with policymakers to achieve that goal.

Endnotes

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