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Beyond the ACA: Moving Toward a Health Care System that Works for All of Us

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Executive Summary

The Affordable Care Act (ACA) is here to stay. Sixteen million uninsured Americans now have health coverage; 13,000 of them will live because of their new coverage. No more the terrifying insecurity of losing your job with no way to get health coverage, or of being turned away by a health insurance company because you had the audacity to get sick.

The passage of the ACA has fundamentally changed the political context for health care policy in the United States. Health care has now taken its place with other major advances in social policy – public education, Social Security, labor standards, equal rights under law, and more – as an established pillar of American life.

Today, peoples’ biggest worries are less about access to coverage and more about deductibles so high they can’t afford to go to the doctor, sky-high co-payments for prescription drugs, or getting a “surprise” bill after a hospital stay. For most people, health care has become like food, housing, transportation, retirement savings, higher education: one more costly, vital need to juggle in an era of stagnant wages and shaky job security.

But beneath the surface, the health care system is being transformed. The visible part of the transformation, the iceberg above the surface, is mega-health insurance and hospital mergers. Like other icebergs, they look scary: bigger corporations jacking up prices to increase profits, while consumers have fewer and fewer choices. People who need health care the most – those with chronic illness and disabilities, the elderly – are likely to be hurt the most.

The reason we have the highest health care costs in the world is that we have insisted on looking at health care as a commodity subject to the laws of supply and demand, rather than as a

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public good guaranteed by government. From the point of view of classical economics, all of this concentration is bad for consumers, as limited supply will mean higher prices. *Ironically, though, concentration could offer the opportunity for more effective regulation as well as to simplify that regulation. Concentration has the potential to facilitate the treatment of health care as the public good it truly is, rather than as a market good. Regulatory policies to control costs and increase quality should be easier to design and enforce if there are fewer entities to oversee and influence.*

The ACA is already illustrating how government payers can have a positive impact. It is accelerating the movement of the American health care system from a focus on providing more care – needed or not – to providing quality care. By using the purchasing power of Medicare, our national health insurance program for seniors and people with disabilities, the ACA has begun paying hospitals and doctors more when they reduce costs while increasing quality, and less when they provide poor quality care. In some states, Medicaid is beginning to drive the transformation, with a focus on primary care and community health.

Government payers are not alone. Major employers are demanding better value from the health care delivered to their employees. Private insurers are testing programs for the chronically ill that improve health while saving money. Hospital systems and large medical groups are organizing large integrated care networks to deliver better care at lower cost.

Which of these competing versions of the concentration in health care will prevail - concentration for larger profits or concentration for better, more cost-effective care and improved health?

It is up to those who champion health care as a human right and a public good to build from the foundation of the ACA toward a health care system focused on affordable high quality care, directed towards not just good health treatment, but good health.

Beyond the ACA: Moving Toward a Health Care System that Works for All of Us is offered as a roadmap. It paints a picture of the changing health care landscape, so that organizers and advocates can understand the shifting terrain. It proposes policies for a health care system that: covers every person living in our country; is affordable to the country; is affordable to individuals; is high-quality, including for people with chronic illnesses; promotes racial equity in access and quality; and is focused on population and community health. More than 20 specific policies are outlined to:

- Make sure that good insurance coverage is affordable and available to all of us.
- Make sure we can afford to go to the doctor when needed, by eliminating deductibles and lowering co-payments.
- Put an end to drug price gouging, requiring that prescription drugs prices be affordable.
- Insist on getting value for our health care dollar, with common sense measures that pay hospitals and doctors for the quality, rather than the amount of care provided. And by providing incentives to: coordinate our care; keep us healthy; help us take care of our own health; and improve the health of our communities.

- Assure that all of us, regardless of our gender, race or ethnicity, get access to quality care, investing in research and services that take account of our differences, our communities, and our cultures.

These proposals are bold – even audacious – but they are achievable over time because they meet an essential prerequisite for any health care reform in the United States: they build on the health care system we have today.

Given the complex pushes and pulls between controlling costs and increasing quality, advocates can expect a shifting set of allies and opponents when dealing with policy changes. Employers, various health providers, even insurers may support some of our proposals while opposing others.

There is much in the proposed policies to attract all the organizations and constituencies who were active supporters of what became the ACA. However, it will be difficult to achieve the same level of engagement experienced in the years leading up to, and the intense engagement during, the campaign to enact the ACA. The successes of the ACA and the incremental and technical nature of many of its policy changes are challenges to galvanizing broad, intense effort. Still, there will be a myriad of opportunities, particularly at the state level, to advance policy campaigns.

The path to organizing begins with a focus on people’s concern about out-of-pocket costs. Anger is a necessary ingredient for any push for political change. Advocates must convert people’s real concerns about high health care costs into anger at health insurers, drug companies, and hospital chains that put profit before our health.

The other necessary ingredient for successful organizing is hope. We must provide a vision for a health care system that offers affordable, good health coverage that is also affordable to use when we are sick; that allows us to get quality care from knowledgeable health professionals who know us and who can help us make good health choices, and who will work together in our communities to keep us healthy and treat us when we are sick.

Now our work is to move the health care system towards health justice. We will do that slowly, through policy debates and issue campaigns that reach milestones on our road. We may also have the opportunity do so more quickly, by linking with the emerging movements for economic, racial and climate justice. The challenge for health care advocates is to see themselves – and our vision of health care – as part of these young movements that are now building toward the next great progressive wave in American history.

Americans are proud of the best of our health care. It’s time we worked together to make the best of American health care work for all of us. We can insist that our elected officials stand up to the insurance companies and drug companies and hospital chains and write the rules so that they put our families’ and our communities’ health before their profits. We can demand that everyday people have a voice in the health care system.

There will be setbacks. But we will advance over time, because a government guarantee of health coverage is now one of the pillars of American life.

Introduction

The passage of the Affordable Care Act (ACA) was the culmination of a century of efforts in the United States to enact a government guarantee of health coverage for all its citizens. Millions of Americans now have health coverage for the first time, with the biggest gains among people with low-and-moderate incomes, African-Americans and Hispanics. The ACA assures that insurance coverage is much more likely to cover medically-needed health treatment than was required previously in many states. The ACA is also accelerating the nascent trend toward a health care delivery system with financial incentives geared toward quality of care, rather than the amount of care provided.

For all its accomplishments, the ACA, in both design and execution, still falls well short of creating a health care system that provides quality, affordable, accessible health coverage to all U.S. residents and promotes health. Millions remain without coverage, and will even if the ACA's design is fully executed. High and increasing out-of-pocket costs are a growing impediment to accessing quality care. Many Americans still receive care that is not needed and may in fact be harmful, while many others do not get the care they need. The system is still burdened by administrative cost and complexity. The prices for health services in the United States remain far too high. The rapid shifts in health care delivery and financing precipitated by the passage of the ACA have created new challenges as the form and function of insurers and hospitals systems are realigned. Finally, the system is still fundamentally focused almost entirely on the treatment of disease rather than the promotion of good health.

Despite the relentless right-wing political opposition to the ACA the American public now firmly rejects calls for the ACA to be repealed. Most Americans take the common sense point of view that the law should be built upon, rather than torn down. In a sign of grudging acceptance that the ACA is here to stay, a growing number of Republican governors are pushing their states to implement the ACA's Medicaid expansion. If a Democrat is elected President in 2016, the fight to repeal will finally be over. If a Republican prevails, we will have to endure more political theater and even some weakening of the law's provisions. But, as we saw when Republicans realized the chaos that would have erupted if the Supreme Court had ruled in favor of ending health insurance premium subsidies for people in most states¹, the political reality of millions of newly covered people and a health care industry profiting from that coverage, means that the ACA is here to stay.

How do we move from the new policy and political reality created by the Affordable Care Act, towards a health care system that more fully delivers on the goal of quality, affordable health coverage for all? Further, can we raise our aspirations from a focus on health coverage and treatment to the goal of promoting good health? This paper is a beginning attempt to answer these questions.

¹ In June 2015 the Supreme Court ruled in *King vs. Burwell* that subsidies for the purchase of health coverage were allowed in health insurance exchanges established by the federal government.

The paper contains the following sections:

- What has the ACA achieved and what major challenges remain?
- What can we learn from the campaign to enact the ACA about how health system change is achieved?
- What is the outline of a health care system that would, building on where we are now, advance the policy goals of access to quality, affordable care and better health for all?
- How we can organize to advance beyond the ACA to a health care system that works for all of us.

I address these questions deeply aware that we have entered a new era in both the politics and policy of health care in the United States, and that we are just beginning to understand the new terrain, test what is possible, and learn from our experimentation. My hope is that this paper will help advocates and organizers take those first steps together.

What has the ACA achieved and what are the remaining major challenges?

The enactment of the Patient Protection and Affordable Care Act in March of 2010 was the culmination of a more than a century of struggle to have the United States provide a government guarantee of health care coverage to all its residents. It was enacted over the same strenuous ideological opposition that defeated every past effort. Like all major advances in social policy in U.S. history, it was a political compromise, achieving much but falling well short of its most lofty goals.

ACA achievements

By the middle of 2015, the percentage of residents of the United States without health insurance had fallen to 9 percent from more than 16 percent just before the ACA was enacted. Some 16 million Americans who had been uninsured now had health insurance coverage².

The newly insured are using their coverage: 60 percent have gone to the doctor or hospital or filled a prescription. Of those, 62 percent would not have been able to afford to do so without their new coverage. Two-thirds said they were able to get a doctor's appointment within two weeks³.

Accessing the health care system saves lives. Based on the actual experience in Massachusetts, 13,000 Americans will not die in 2015 because of lacking health insurance⁴.

The increase in coverage has, as *The New York Times* wrote, "done something rather unusual in the American economy this century: It has pushed back against inequality, essentially redistributing

² *Number of Uninsured Has Declined by 15 Million Since 2013, Administration Says*, Robert Pear, New York Times, August 12, 2015

³ *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, Sara R. Collins, Petra W. Rasmussen and Michelle M. Doty, The Commonwealth Fund, July 2014.

⁴ *Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study*, Benjamin D. Sommers, Sharon K. Long and Katherine Baicker, *Annals of Internal Medicine*, May, 6, 1024. The study found 830 fewer deaths in Massachusetts for every one million people covered.

income — in the form of health insurance or insurance subsidies — to many of the groups that have fared poorly over the last few decades. The biggest winners from the law include people between the ages of 18 and 34; blacks; Hispanics; and people who live in rural areas.⁵

The ACA has been one contributor to the lowest health care cost inflation in the United States since the government began tracking health care spending in the 1960s. As the Kaiser Family Foundation reports, that trend has held down costs for employers. Premiums for employer-sponsored health plans “increased more slowly over the past five years than the preceding five years (26 percent vs. 34 percent) and well below the annual double-digit increases recorded in the late 1990s and early 2000s⁶”

In the individual market, coverage also improved and was likely to be as or more affordable than before the ACA. The law brought national standards to what had been a loosely regulated market in most states, characterized by skimpy coverage and sales largely to healthy individuals without pre-existing conditions. The ACA requires: good benefit packages; prohibits the denial of coverage because of health conditions; stops insurers from charging higher premiums due to health history or gender; and eliminates annual and lifetime caps on coverage.

The ACA has played a significant role in accelerating major changes in delivery system structures and payment models. New delivery models are focused on enhancing primary care as well as integrating mental health care into primary care and improving care coordination for patients with complex medical problems. Alternative payment models are focused on supporting these delivery changes, and shifting the emphasis from paying for volume to paying for quality and outcomes. The changes are being driven by Medicare, which historically has been the main mechanism through which the government has pioneered changes in health care financing.

One ACA provision reduces payments to hospitals when they readmit a Medicare patient within 30 days after discharge. The provision is aimed at discouraging hospitals from discharging patients too early and has achieved cost savings⁷. However, a frequent criticism, backed by a recent study of the readmission provision, is that this policy penalizes hospitals that serve low-income patients, who have less support when they are discharged⁸.

Medicare is testing a variety of approaches for new payment systems, varying from bundled payments for certain surgical procedures to Accountable Care Organizations (ACOs) that encompass all the care received by a Medicare patient. There were 401 ACOs at the beginning of 2015, including various combinations of hospitals, hospitals and physician groups, and just physician groups; engaging in five different variations of risk-sharing arrangements with Medicare. In some, the ACOs are rewarded only for saving money while meeting quality

⁵ *Obama's Health Law: Who Was Helped Most*, Kevin Quealy and Margot Sanger-Katz, New York Times, October 29, 2014.

⁶ *Employer-Sponsored Family Health Premiums Rise 3 Percent in 2014*, Kaiser Family Foundation, September 10, 2014.

⁷ *Assessing Medicare's Hospital Pay-For-Performance Programs And Whether They Are Achieving Their Goals*, Charles Kahn III et. al, Health Affairs, Vol. 34, No. 11, November 2015

⁸ *Adding Socioeconomic Data To Hospital Readmissions Calculations May Produce More Useful Results*, Elna Nagasako et.al., Health Affairs, Vol. 34, No. 11, November 2015

standards. In others – and this is the policy Medicare intends to institute more widely – they are also penalized for failing to meet spending targets and quality measures.

An early evaluation of the first 114 ACOs found that 54 of the ACOs saved money, with 29 saving enough to receive bonus payments. The 54 ACOs that saved money produced shared net savings for the networks of \$126 million; Medicare saved an additional \$128 million.

Medicare is intent on expanding the reach of these new value based payment (VBP) arrangements. CMS, the arm of the federal government that administers Medicare and Medicaid, announced in 2015 a goal of incorporating 85 percent of Medicare fee-for-service payments in VBP models based on quality and shared savings by 2016, and 90 percent by 2018.

The growth of ACOs reaches well beyond Medicare, with one estimate that there are 744 ACOs in 2015, including those paid by Medicaid, private insurers and self-uninsured businesses. By this count, 23.5 million people were covered by ACOs at the end of 2014. Of these, only 7.8 million are part of the Medicare ACO programs, meaning that the majority of ACO volume is coming from the commercial and Medicaid sectors.

Where the ACA falls short

For all its accomplishment in a short time, the ACA falls well short of the purpose of national health care plans in developed countries around the world: to provide quality, affordable coverage to every resident. It barely aspires to a broader goal of maintaining health and preventing disease.

Not for all. A major reason that the ACA is falling short of its coverage goals is the Supreme Court decision to allow states to opt out of Medicaid expansion; these opt-outs reduced eligibility by an estimated 5.5 million people. States controlled by conservative lawmakers have also dragged their feet on outreach and enrollment. Still, the political resistance is slowly melting. A growing number of Republican governors are pushing for expansion of Medicaid, a harbinger that over time, more states will approve the expansion⁹.

In addition, undocumented immigrants are not eligible for coverage, and low-income immigrants who are lawfully present in the United States are not allowed to enroll into Medicaid until they have been in the country for five years. As a result, more than 12 million people are excluded from the program – more than one-third of those who remain uninsured.

The complex structure of the law's coverage provisions are another major barrier. Changes in income, work status or family size all can trigger different coverage sources and people can fall through the cracks or fail to apply in the confusion.

In many cases, premiums – even with income-based subsidies – are simply not affordable; the subsidies are not big enough and leave out people who still need them.

⁹ *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update*, Rachel Garfield and Anthony Damico, Kaiser Family Foundation, October 23, 2015

Still, what we have learned from Massachusetts, which has had Medicaid expansion and pursued aggressive enrollment strategies in its exchange for seven years, is that the incentives and coverage mechanisms of the ACA, when implemented well, can lead to near universal enrollment; 96 percent of the state's residents had health coverage in 2014¹⁰.

Not affordable. One reason that health care costs overall and insurance premiums specifically are now under control is that the ACA has accelerated a long-term trend toward massive cost shifting to consumers. For several decades, the right-wing prescription for health coverage in the United States has been to dramatically increase out-of-pocket costs to consumers, moving towards a system where people pay for all but catastrophic care. But while high deductibles and co-payments have always been very unpopular, they are becoming the norm, largely because increasing these payments is the easiest way to keep premiums lower.

In the employer sponsored market, deductibles have increased by 47 percent since 2009, to an average of \$1,217 for a single worker. The family-plan deductible averaged \$4,522 in 2014. And while high-deductible plans are more prevalent among smaller employers, the trend is accelerating among large employers as well¹¹.

High deductibles are even more prevalent within the ACA exchanges, in order to keep premiums low; eight out of ten consumers are able to find premiums under \$100 per month after their income-based subsidy¹². The benchmark ACA plans are designed to pay for an average of 70 percent of medical expenses – leaving 30 percent to consumers. They had an average deductible of \$2,927 for individuals and \$6,010 for families for 2015¹³.

High deductibles result in less access to care. *The Wall Street Journal* reports that, “One in three Americans said they or a family member delayed medical care because of costs in 2014, according to a report last month by survey company Gallup. That is the highest percentage since Gallup began asking the question in 2001¹⁴.”

Doctors and hospitals are finding more inventive ways to shift even more costs to consumers. Surprise bills from out-of-network doctors, such as anesthesiologists, are charging thousands of dollars to insurers and patients for care that patients thought they obtained in-network. Doctors and other providers create new charges by unbundling treatments that are required to go together.

¹⁰ *Health Insurance Coverage of the Total Population*; 2014 data, Kaiser Family Foundation, <http://kff.org/other/state-indicator/total-population/>. Note also that 2.4% of Massachusetts residents are immigrants who are not authorized to be in the U.S. and so not eligible for ACA coverage. http://www.slate.com/articles/news_and_politics/map_of_the_week/2013/02/map_illegal_immigrant_population_by_state.html. which means that only 1% to 2% of eligible Massachusetts residents are not covered.

¹¹ *Employer-Sponsored Family Health Premiums Rise 3 Percent in 2014*, Kaiser Family Foundation, September 10, 2014

¹² *Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 In 37 States Using The Healthcare.Gov Platform*, Dept. of Health and Human Services, February 1;7, 2015
37 States Using The Healthcare.Gov Platform, Dept. of Health

¹³ <https://www.healthpocket.com/individual-health-insurance/silver-health-plans#.VkpQR4QxFMo>

¹⁴ *More Cost of Health Care Shifts to Consumers - High-Deductible Insurance Plans Prompt Some to Delay Treatment*, Stephanie Armour, Wall Street Journal, December 3, 2014.

High system costs. While no one can claim to fully understand why health care expenditures are not rising as fast as they have, the two most commonly cited factors are: 1) low economic growth since 2008 which suppresses demand; and 2) the surge in out-of-pocket costs, also lowering demand.

But the ACA did little to tackle directly the biggest single factor in why health care costs are higher in the United States than other countries: the price of health services is much higher. As Community Catalyst summarizes: “Health care prices are the primary contributor to higher health spending in the U.S. Comparative studies show that prices for many health services in the U.S. are significantly higher than in 12 other OECD study countries.”¹⁵

Today, huge hikes in the prices of many drugs used to treat cancer and many chronic illnesses is the most visible manifestation of these higher costs. Medicare reports that one-quarter of drug spending is due to only 400 (11 percent) of the mostly expensive drugs it pays for. The result is huge costs to public and private insurers and often enormous co-payments for patients¹⁶.

Administrative costs are another major factor. While the ACA limited the share of costs insurers can charge for administration and profit, this measure only scratches the surface of the expenses caused by our hugely complex health care system. One estimate by the Institute of Medicine counted \$190 billion a year in administrative inefficiencies from the myriad of health insurance plans alone¹⁷.

Challenges to quality. One other way that insurers have held down premiums in the exchanges is by establishing what are being called “narrow networks,” in which a limited choice of hospitals and providers is available. According to McKinsey, 70 percent of the lowest-cost plans in the exchanges were built on narrow networks¹⁸.

While building a closed network that includes the full range of health care providers is certainly possible, the use of narrow networks raises a number of potential quality problems, including access to specialists for people with chronic illnesses.

As discussed earlier, new payment and delivery models promoted by the ACA, such as ACOs, are focused on moving the system to one that rewards quality over volume. But much work remains to agree on quality measures and align incentives across multiple payers.

Long way to go on racial equity. African Americans and Hispanics in the U.S. have higher infant mortality and proceed to poorer health status than White Americans throughout life.

The expansion of coverage under the ACA is a major step toward greater racial equity in health care. But access to coverage alone will not close the gap.

¹⁵ *The Path to a People-Centered Health System*, Community Catalyst, 2014, p. 12.

¹⁶ *Small Number of Drugs Drives Big Medicare Bill, Spending Data Show*, Joseph Walker and Anna Wilde Mathews, April 30, 2015

¹⁷ *To Err Is Human: Building a Safer Health System*, Institute of Medicine, 1999

¹⁸ *Health Insurance Shoppers Look to Limited Networks to Save Money*, Reed Abelson, New York Times, April 13, 2015.

The law also contains a number of specific measures aimed at reducing racial disparities, including: data collection; research on disparities and on differential outcomes from treatments; increasing recruitment of racially diverse health professionals; training for health professionals on cultural competence; and raising the level of bureaucratic importance of the offices within Health and Human Services responsible for addressing “minority health.” The ACA also included significant investment in and reforms of the Indian Health Service.

Even these added measures are not likely to be sufficient to address deep, persistent racial and ethnic health disparities.

To take one particularly trenchant example: elderly African American patients in the U.S. have higher 30-day hospital readmission rates than white patients for heart attacks, congestive heart failure and pneumonia¹⁹. This is not because the hospitals that serve these patients are discharging them prematurely in relation to their medical care. Rather, it is because the elderly Black patients are likely to be in poorer health and less likely to have the supports needed to continue their recovery after discharge. But accounting for patients’ race or ethnicity more fully in reimbursement formulas is not sufficient; it might be fairer to the hospital but still no help to the patient (and still costly to the system). Instead there is a need to provide resources to ensure the availability of community supports to keep patients healthy and out of the hospital.

What about health, not just health care? While the cost of health care makes up one-sixth of the economy, health care services are not the biggest determinants of our health. Data from a comparison of people in U.S. counties show that clinical care accounts for only 20 percent of health outcomes, as measured by length and quality of life. The largest influence (40 percent) is due to socioeconomic factors (education; employment; income; family and social support; community safety). Health behaviors (tobacco use; drug and alcohol consumption; diet and exercise; sexual activity) make up another 30 percent. The physical environment (air and water quality; housing and transit) makes up the final 10 percent²⁰. While the ACA supports preventive care and provided some funding for public health interventions, much of that funding has been cut. Overall, the law does little to address the many social and economic factors that have a huge impact on health.

Rapidly increasing concentration. All of these challenges must be considered in the wake of the cascade of consolidations occurring in both the insurance and hospital industries.

From 1994 through 2012 there were more than 1,000 hospital mergers²¹, with 86 completed in 2011, the highest in a decade²². Data from 2006 reported that 75 percent of hospital markets were non-competitive by Department of Justice (DOJ) standards, a number certainly exceeded now given the

¹⁹ Joynt, K. E., E. J. Orav, and A. K. Jha. “Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care.” *JAMA: The Journal of the American Medical Association* 305.7 (2011): 675-81.

²⁰ Data from UWPHI County Health Ranking as reported in *The Path to a People-Centered Health System*, Community Catalyst, 2014.

²¹ *More Than 1k Mergers Recorded in U.S. Hospital Sector Since 1994*, Becker’s Hospital Review, Bob Herman, March 4, 2013

²² *5 FTC Challenges to Hospital Mergers: Key Concepts for Today’s Antitrust Environment*, Becker’s Hospital Review, Molly Gamble, April 1, 2013

accelerating trend²³.

Hospitals are also buying physician practices, allowing hospitals to capture market share and also to charge higher prices when the same level of care is provided in an out-patient setting that is part of a hospital network, rather than an independent physician's office. One survey found 67,700 physicians participating in hospital networks, a 39 percent increase in just one year²⁴.

The health insurance industry decries hospital consolidation as a driver of higher health care costs, as insurers have little choice but to include hospital networks that supply much of a region's health care services in their provider networks and pay whatever prices they demand. However, the health insurance industry is even more concentrated than the hospital industry; in 2008 an American Medical Association study found that 94 percent of health insurance markets were highly-concentrated by DOJ standards²⁵. Since 2008, health insurance concentration has continued apace, culminating in 2015 with two proposed mega health insurance mergers: Humana (#3) with Aetna (#5) and Anthem (#1) with Cigna (#6).

Hospitals and insurers are also consolidating in a new way: hospitals are becoming insurers or partnering with insurers. From a hospital's point of view, these consolidations make perfect sense. As hospitals become the center of huge provider networks, capable of delivering comprehensive health services to a large population, why not assume the insurance function? This joint function was pioneered by Kaiser Permanente decades ago, and Kaiser remains the dominant insurer in California. To compete with Kaiser, in 2014 seven Los Angeles area hospitals formed a joint venture with Anthem Blue Cross Blue Shield to offer health coverage to employers. In Pittsburgh, the dominant health insurer set up its own health care network to compete with the dominant hospital network, which started offering insurance.

Much of this consolidation is being done in the name of the ACA. Insurers and providers cite the need to operate more efficiently, and to have the resources to implement new payment and delivery models. But with consolidation comes the threat of monopoly pricing and even higher health care expenditures.

Clearly while the ACA is a breakthrough accomplishment, there is much work left to be done to increase access, lower costs, improve quality and enhance health. But before this paper outlines a series of new policy proposals, it's important to understand what can be learned from the battle to enact the ACA about what it takes to change U.S. health policy.

What can be learned from the history of health reform in the United States about how health system change can be achieved?

The final Congressional passage of the Patient Protection and Affordable Care Act on March 21st, 2010 ended more than a century of failure by advocates in the United States to get their government to enact some sort of comprehensive guarantee of health coverage for its citizens.

²³ *Is Hospital Consolidation Exacerbating Higher Healthcare Prices?*, Molly Gamble, November 14, 2012

²⁴ *Consolidation creating giant hospital systems*, *Modern Healthcare*, Melanie Evans, June 21, 2014

²⁵ American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2008 update."

Why did this fight have a different outcome than every other?

Early efforts culminating in the passage of Medicare and Medicaid

For the first half of the 20th century, medicine had not advanced to the point where it could effectively treat most diseases, cure the ailments that often killed people, and regularly prolong life past what we now consider middle age. The costs of the treatments that people did seek did not amount to a large share of family income. Compared to other unmet needs, like retirement security or compensation while out of work, health care was not as vital an issue in people's lives. The result is that there was not the broad movement for basic income security, as there was in the Townsend movement for retirement or the labor movement. Without those movements, politicians did not feel compelled to act in the face of organized opposition to what we know as "compulsory health insurance." This was the story from the Progressive era through the New Deal and the Truman administration.

The extraordinary advances in medical care post World War II and the increases in family income, including access to good food and housing – building on the public health infrastructure of the first part of the 20th century – meant that people lived longer. Access to those medical advances through good health insurance coverage became vital. After the defeat of President Harry Truman's proposal for national health insurance, the labor movement led the way toward establishing health coverage as a benefit at work. That initiative left out retirees and people with low-wage, no-benefit jobs, or those who were out of work. Both of these gaps were addressed in 1965. Medicare passed because seniors formed a big enough and powerful enough share of the electorate to defeat the same kind of American Medical Association opposition that had killed Truman's plan. President Lyndon Johnson was able to couple Medicaid to Medicare, as he advanced the Great Society, aimed at improving the lot of low income Americans.

Late 20th century: Coverage gets more costly and less secure

The slow and mounting attack on American workers, which began in the mid-1970s, was the genesis of the political forces that propelled passage of the ACA forty years later. Wages for most people have been stagnant for decades while the growing service sector of the economy has created millions of unstable, low-wage jobs with unpredictable schedules, little-to-no health care or pension benefits, and little-to-no ability for workers to have a voice at work.

Throughout this period, the share of workers with employer-sponsored health coverage slowly declined. Workers who still had health coverage paid a higher share of premiums for policies with higher out-of-pocket costs. By 2007, one in five adults under 65 were without health coverage.²⁶ The combination of more people without health insurance and higher out-of-pocket costs placed a financial burden on many families, so that health care costs were a factor in more than 60 percent of personal bankruptcies²⁷. The fear of losing health coverage created uncertainty, keeping people from changing jobs, taking entrepreneurial risks, or retiring early. Medicare's high out of pocket costs and the need to purchase supplemental coverage meant that even America's seniors were

²⁶ *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey*, Robin A. Cohen et. al, National Health Statistics Report, U.S. Dept of Health and Human Services, No. 17, July 1, 2009

²⁷ *Study Links Medical Costs and Personal Bankruptcy*, *Bloomberg Business*, Catherine Arnst, June 04, 2009

concerned about health care costs. All of these factors created the political conditions for broad and deep enough demand for change to potentially confront the opposition forces that had defeated earlier efforts.

Lessons from passage of the ACA

Still, the objective conditions described above were also in place in 1993 (although not as extreme), which is why the famous sign in Bill Clinton's Little Rock election campaign war room actually read, "It's the economy stupid, and don't forget health care." Yet the Clinton plan was defeated. The lessons learned in the failure of the Clinton plan were key to the ultimately successful strategy devised by reform champions in 2008. For the purposes of this paper, the most important lessons were:

- Understanding that dramatic change is not possible on an issue as personal as health care, where for all people's desires for relief, opponents can easily inflame the fear that change will mean loss of what you have. Reforms must be built on what is familiar.
- Reforms must be at least minimally acceptable to significant forces in the health care industry, because of the financial resources these forces can bring to both stoking public fears of change, and to directly influencing the political system through lobbying and campaign contributions.
- As with any movement for political change, organizing must be based on a combination of anger and hope. In the ACA's case, the anger was directed at the insurance industry for denying people care. The hope was for a system that provided the security of not losing or being denied health coverage.
- Reform must be powered by advocates who effectively organize grassroots support, personified by people directly affected by the system's failures.
- Reformers must build a broad coalition, beyond the confines of health care organizations, with shared principles that translate into specific policies.
- Reformers must have sufficient resources to execute their strategy, with the amount needed directly related to the ambition of political (for example changes at the federal vs. state level) and policy goals.

If this analysis above has merit, it suggests that developing a strategy to meet the goals laid out in the paper's introduction will mean tackling the following challenges:

1. What level of public support for change is possible post-ACA, when: nine out of ten Americans have health coverage; there are safeguards to provide coverage to people who are out of work or self-employed; and national consumer protections on insurance company practices are in place? What issues can generate sufficient public concern to drive political change? Who are the villains in the story, which can be used to drive public anger and organizing? How much can we look for change inside the health system, rather than through public policy?

2. Can we construct a policy vision that:
 - a. Addresses people's pressing concerns;
 - b. Realizes policy goals related to affordability, access, quality, equity and health;
 - c. Attracts a broad enough coalition to support a shared agenda;
 - d. Accommodates enough key players in the health care system to win their support, or at least their acquiescence?

The next section outlines what such a policy framework could look like.

What is the outline of a health care system that would advance our policy goals by building on where we are now?

If health care is valued as a human right – a public good in economic and political terms – then our government is responsible for enforcing and maintaining that right.

One characteristic of a public good is that conventional market economics do not work to control prices, access and quality. In health care, providers drive both the demand for the goods and the services they supply. That is because doctors (and other practitioners) largely determine the health care treatments that patients receive, including the services doctors provide directly, and the tests and procedures they order. Patients lack information about the quality and cost of services to help them make smart purchasing decisions. And much of health care is not “shoppable” – a person having a heart attack is in no shape to tell the ambulance which hospital to go to. Competition among insurers or among hospitals does not exist in many “markets” even as a possible mechanism to control prices. Even when there are competing health plans or facilities, people often lack information or understanding to make informed choices. These are just a few examples of why competition or the laws of supply and demand often don't work in health care.

Understanding this reality, the governments in other countries where health care is seen as a public good, set prices for medical services and establish means of enforcing national global budgets for health care expenditures. The budgets drive goals for quality and public health, not just spending targets.

Concentration as an opportunity for progress

Today, there is a huge shift underway in the United States, toward the concentration of providers into fewer and larger health care delivery systems and fewer and larger insurance companies. Government's role in paying for care through Medicare, Medicaid and subsidies in the ACA insurance marketplaces has also grown under the ACA. This concentration in the financing and delivery of health care can be a disaster or an opportunity.

We could end up with a health care system where ever larger and more powerful health insurance and hospital system monopolies drive up costs, while access to health is reduced because of higher and higher out-of-pocket costs.

Or this concentration could make it easier to implement policies and regulatory controls that hold providers and insurers accountable for providing comprehensive, high quality care at a reasonable cost. It also could open the door to a focus on population health and health equity.

Where the health care system goes in the coming years depends on whether we can build the public and political will to shape an emerging system that will provide quality, affordable treatment and promote the health of individuals, families, and communities.

Below I propose reforms that leverage public spending and the growing concentration of health care financing and delivery systems to: 1) control global health care spending in the United States; 2) make health care affordable to individuals; 3) improve the quality of care; 4) improve health care equity and population health.

Policy proposal: All payer rate setting for affordable, comprehensive health and wellness through capitated health systems with quality standards

This wonky title describes how we can transition toward a health system that results in quality, affordable health care for all.

The core of my proposal is that, over the next two decades, the United States would implement a system to deliver comprehensive, coordinated health care services through networks of health care providers. Each network would serve a defined population and receive a set amount of money per-person (capitation) for providing a full range of health services to the people they serve. The capitation amount would vary by patient characteristics; payments would be higher for people who are older, sicker and poorer.

Payment amounts would also be set to ensure health spending supports public good. Each health care system would be accountable for meeting robust quality standards and population health goals. Reimbursement would be adjusted higher or lower based on exceeding or failing to meet those standards.

Learning from current innovations

Existing model delivery systems. For many years, we have had models of integrated delivery systems in the United States, including Kaiser Permanente, which originated the health maintenance organization (HMO) concept in 1945, and now operates in nine states and the District of Columbia. Others include: Geisinger Health System in Pennsylvania; Group Health Cooperative in Washington State (as of December, 2015, acquisition of Group Health by Kaiser Permanente was pending); and Intermountain Healthcare in Utah²⁸. These systems are structured to provide primary, specialty hospital and post-acute care and to coordinate that care across settings. Some, like Kaiser and Group Health are insurers; others contract with multiple insurers.

In 2008, the Commonwealth Foundation identified best practices through a case study of 15 such systems. While all the systems do not operate under capitation, the Commonwealth authors advised that that “Full population prepayment – a single payment for the full continuum of services for a given patient population and period of time – should be encouraged. Such payments

²⁸ *Organizing the U.S. Health Care Delivery System For High Performance*, Anthony Shih et. al, The Commonwealth Fund, August 2008

should be adequately risk-adjusted to avoid adverse patient selection.²⁹

In the past few years, we have begun to move beyond a handful of integrated systems to widespread reorganization of health delivery through ACOs and other delivery models. At the same time, public payers (Medicare and in some cases, Medicaid) and many large corporations are increasingly using capitation and other forms of payment that reward outcomes and performance rather than the volume of procedures. Together, these new delivery and payment approaches aim to encourage greater value – better quality for the money spent.

Medicare and Medicaid driven initiatives. The biggest lever that the public has in driving changes is the substantial public financing of health care now, led by Medicare and Medicaid. The federal government accounted for 26 percent of health care spending in 2013 and also drove a substantial portion of health care spending by state governments, which made up another 17 percent of total spending³⁰. Total public spending on health care, including accounting for deductibility of health insurance by employers, was 58 percent of total spending in 2010, even before the advent of the Affordable Care Act³¹. With the ACA, that figure is now considerably larger.

The implementation of Medicare ACOs is described earlier in the paper. An example from Medicaid can be found in Oregon, which now assigns all of its Medicaid patients to coordinated care organizations (CCOs), capitated health systems responsible for delivering all Medicaid services to a defined population.

Over the next five years, New York aims to have 80 to 90 percent of Medicaid payments made through alternative payment models that entail shared risk, tied to cost savings and quality measures. Each delivery system will be funded for five years to build an integrated approach to care, reduce preventable hospital admissions and emergency department use by 25 percent, expand access to primary care and behavioral health services, and manage population health³².

One state, Maryland, has taken an all-payer approach that includes Medicare, Medicaid and private payers. Since 1977, Maryland has had an all-payer rate system, which set reimbursement rates for almost all hospital admissions. In 2014, Maryland proposed and the federal government approved, movement toward a global-budgeting system. The state will permanently shift all its hospital revenue into a model based on per capita total hospital cost growth, incentivizing hospitals to work in partnership with other providers to achieve a number of quality targets designed to promote better care, better health and lower costs to Medicare.

²⁹ *ibid*

³⁰ *National Health Expenditures 2013 Highlights*, CMS, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

³¹ *In Health Care Spending, Americans Who Make the Least Contribute the Greatest Share of Income, Changes in Health Care Financing & Organization*, Robert Wood Johnson Foundation, Vol. XV, No. 7 October 2012

³² *NY Medicaid Program Pushes Value-Based Purchasing Trend*, Law360, New York, July 7, 2015, http://www.bsk.com/site/rte_uploads/files/Tracy%20Miller%2007-07-15%20NYLJ%20article.pdf

Community health centered delivery. Vermont's Blueprint for Health focuses on teams of community health professionals who work with primary care providers to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care. These teams provide individual care coordination, health and wellness coaching, and behavioral health counseling. They also connect patients to social and economic support services. In addition, the teams perform community outreach to support public health initiatives. The program is open to all Vermonters, with a focus on people with chronic health conditions. An evaluation by CMS, focused on Medicare patients, found significant savings: \$1,756 less per member per year than Vermont Medicare recipients who were not part of the program³³.

The Vermont model is an example of how a focus on community health can result in savings on treatment, in addition to improved health. Vermont is doing this using care teams. Another approach is the community health center model, particularly as they were originally conceived. As Jack Geiger describes³⁴:

The early waves of health centers, in particular, went far beyond the provision of personal one-by-one medical care to address root causes of poverty and disease, the social and environmental determinants of health. They repaired old housing, built clean water and sanitary systems, organized food cooperatives, cleaned up environmental threats, created local transportation systems, developed potent community organizations, and – most important – trained and hired local residents as health workers at multiple levels, and opened pathways to professional education.

An analysis for The Robert Wood Johnson Foundation of six community health centers who do exemplary work in tackling racial inequities in health care found that³⁵:

All of the studied initiatives saw the health of their clients as extending beyond the one or two diseases they were trying to prevent, detect or manage. They were very sophisticated in understanding the multiple factors that can determine health, and the many ways that an individual and his environment must change to restore health. In Sacramento, it takes the form of inquiring about family activity levels and television-viewing habits to gauge diabetes risk during a mental health assessment. In Nogales, promotoras begin the initial home visit by assessing water supply, sewage systems and general housing conditions. In Contra Costa, it takes the form of sensitivity to environmental toxins in an area with a history of industrial pollution. Making multiple services available to clients was a common feature of the programs we studied, and represents an important, broad-based approach to health.

³³ *Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost*, Christina Bielaszka-DuVernay, Health Affairs, 30, no.3 (2011)

³⁴ *The origins of Community Health Centers*, H. Jack Geiger, MD, United Health Foundation, undated <http://www.unitedhealthfoundation.org/~media/UHF/PDF/2009/geiger.ashx>

³⁵ *Addressing Health Disparities In Community Settings: An Analysis of Best Practices in Community-Based Approaches to Ending Disparities in Health Care*, Bruce Seigel et. al, Robert Wood Johnson Foundation, October 2003

Private insurance and employer - led initiatives. Private insurers are helping to drive transformation too, encouraged by public policy. In 2008, Massachusetts enacted legislation to limit the overall growth of health care spending in the state. To meet those goals, Blue Cross Blue Shield of Massachusetts (BCBSMA) implemented a global budget program in which 11 health care provider organizations were given a budget to care for patients who use BCBSMA insurance³⁶. Researchers at Harvard found that on average, participating provider groups achieved spending reductions of from 6.3 percent in the first year to 9.9 percent in year two. The researchers also found that improvements in quality of chronic care management, adult preventive care, and pediatric care increased in the second year. An example of how practice changed is that a health system began to pay for high-filter vacuum cleaners for asthma patient³⁷.

Large employers are also driving new delivery and payment arrangements. A recent study reviewed private systems covering 12 million patients, which typically took on more risk than in the Medicare ACO models. One common feature used by private payers is to lower the out-of-pocket for services that the payer considers to be of high value – better quality for the money spent – and increase out-of-pocket costs to care considered lower value³⁸. In a New Yorker article, Atul Gwande describes how Wal-Mart used such value payments to lead an employee to travel half-way across the country to seek treatment in a hospital specializing in the care he needed. As a result, instead of getting the unnecessary and costly back surgery recommended by his local surgeon, he received proper rehabilitative care.³⁹

Reimagined government regulation. Implementing these changes will require reimagining the way that government regulates health care delivery and financing. Government will need to move away from a regulatory scheme that separates insurance regulation, regulation of public coverage programs, public health and delivery of social services. This does not imply that all of these functions must be brought into one agency. It does mean that government will need to see them as all integrally related. And government will have to play a more direct role in controlling health care costs and prices.

Some states are starting on this path, with a focus on delivery system and payment reforms and in some cases limiting health care cost growth. These public bodies include: the Massachusetts Health Policy Commission; Vermont's Green Mountain Care Board; the Oregon Health Policy Board; and the Maryland Health Services Cost Commission. Innovative state exchanges, like Massachusetts and California, which are setting rules on cost and quality for insurance companies, are also modeling a new regulatory role. Medicare's increased role in driving delivery system reform is another example of how the government's role is evolving.

³⁶ *The New Era Of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation*, Robert Mechanic et. al., Health Affairs, Vol. 34, No. 11, November 2015

³⁷ *Global Budget Payment Model lowers medical spending, improves quality*, Eureka Alert, Harvard Medical School press release, July 11, 2012

³⁸ *The Role of Private Payers in Payment Reform*, Song and Chokshi, JAMA, 2015;313(1):25-26. doi:10.1001/jama.2014.15904

³⁹ *Overkill*, Atul Gwande, The New Yorker, May 11, 2015

Goals and policy features for health system transformation

Glowing examples, lofty goals and some limited early research showing promise aside, we face the enormous challenge of achieving transformative practice throughout the system. The following, in broad strokes, are policies that should be considered to achieve the goals of affordability, quality, equity, and population health. These policies are focused on changes in how the delivery system is organized and how care is paid for.

System affordability. In the name of affordability, sometimes insurance premiums have been kept lower by raising what individuals must pay out of pocket if they receive care. Instead, the goal must be total system affordability, including all appropriate health services and all payers, not just a shell game of shifting costs from insurers or providers to patients. The overall policy framework would include:

1. The government will set capitation rates for all health delivery systems for government payers, including Medicare, Medicaid, and ACA subsidies; and private payers including individual coverage outside of the exchanges and employer sponsored coverage (through the lever of tax deductibility of health benefits).
2. The capitation will cover comprehensive health services, including dental, vision and behavioral health.
3. The capitation rates will be risk-adjusted for the population served (age; health status including disability; socio-demographic factors like poverty) and the local cost of living.
4. The federal government will set prices for prescription drugs and major medical equipment, because they are significant costs that reach across all delivery systems.
5. There will be payment incentives to reward systems that exceed quality and health goals and penalize systems that fall short.

Individual affordability. Today, the prevalence of insurance policies with high out-of-pocket health spending inappropriately reduces demand for services because people seek care based on what they believe they can afford, rather than what they truly need. To assure that care is affordable and is not underused, these three dimensions must be addressed: 1) payments for getting covered; 2) payments for accessing services; 3) payments for services not included in coverage. The key policies to assure individual affordability are:

1. Assuring that coverage is affordable by: placing income-based limits on how much employees must contribute toward the cost of their coverage at work; reducing the share of income people pay for coverage in the ACA exchanges; and extending subsidies above 400 percent of federal poverty level (the maximum income eligible for subsidies under the ACA).
2. Requiring comprehensive health services in all coverage, including medical, dental, vision and behavioral health.
3. Low out-of-pocket costs: no deductibles and low co-payments (with none for people who are low-income and none for preventive care).

4. Prohibiting consumers from being charged for any health care treatment, other than standard out-of-pocket costs. That means no “surprise medical bills” or costly out-of-network charges.

Quality. The parameters of quality care include:

- Delivering safe, necessary and appropriate care, based on the best evidence and practice known, in a timely manner.
- Assuring access to the full range of health practitioners most capable of providing care.
- Assuring that people understand how to access their care and what to do if they are not getting the care they need.
- Paying particular attention to people with chronic health conditions and assuring that the system supports their care needs.

The key policies to promote quality are:

1. Requiring health systems to have a full range of providers, including: academic medical centers; centers of excellence; community hospitals; community health centers; home care; rehabilitative care; and the primary and specialty care providers needed to offer all medically necessary care.
2. Coordinated care for patients with chronic illness, and access to highly specialized care.
3. Objective, standardized quality measures that include: preventive and primary care; chronic physical and behavioral health conditions; rates of potentially preventable events; patient outcomes; patient engagement; and caregiver engagement.
4. Comprehensive consumer protections for access and due process.
 - a. Clear, plain-language and multiple language information on all aspects of accessing care and consumer protections.
 - b. Information on all system performance on quality standards made public and organized and reported in such a way as to be understandable to lay people.
 - c. Due process protections, including the right to appeal denial of services to independent external review agents.
5. Patient representatives, including representatives from consumer health organizations, as members of system governance structure.

Population health. Addressing population health moves the focus of health delivery systems from just treating disease to promoting good health. Many of the policies in this section address both racial equity and population health, largely because the most severe population health challenges are in communities of color and low-income communities. Key policies to promote population health include:

1. Risk adjustment to capitation should include socio-economic factors like; poverty; education level; housing quality; and access to nutritious food.

2. Health delivery systems should include community groups and agencies that support social services, jobs, transportation, housing, and nutrition.
3. Health delivery systems should be required to focus particular attention on quality and accessibility of services in low-income communities.
4. Quality standards for reimbursement should include impact on racial, ethnic and socioeconomic health disparities.

Equity. Additional steps, beyond those included in population health, are needed to promote racially and ethnically equitable access to quality health. These policies include:

1. Quality measures for standards of care that account for differences based on race.
2. Recruitment and training of health practitioners from communities of color and diverse ethnic cultures.
3. Cultural competence training and support for all health care practitioners.
4. Making professional translators (not family members) available to patients and assuring that health information is available in languages spoken by patients.

Affordable health coverage for all. The foundational value of the health care system should be that health care is a human right. Within the current framework of a multi-payer, private and public health financing system, key policies should include:

1. Assure seamless coverage, with automatic enrollment in an ACA exchange or Medicaid to anyone who does not have another source of coverage.
2. Making all people who reside in the United States eligible for coverage, regardless of immigration status.
3. Assure that the health premiums are affordable to individuals based on their ability to pay (see proposals above).
4. Making Medicare available in every ACA health exchange, so that all individuals covered through the exchanges have access to a public insurance plan.

Timeline

The proposals above provide a progressive roadmap for the health system changes that are already underway. Though it maintains the framework of our current multi-payer public/private health financing system, even under the most optimistic of scenarios, a generation and more will be needed to build the public will and implement the full vision of the health care system described above.

Still, there are policy and political opportunities now – in some form, in some localities, states or health systems – to advance at least some of these proposals. As the examples above illustrate, many of these initiatives are being tested now. There are state campaigns to push for others. Some require action at the federal level; they are worth putting on the national agenda, even if their realization seems impossible to imagine in the next few years.

How can we organize to advance beyond the ACA to a health care system that works for all of us?

Where the public is now

I began by emphasizing that any movement must be founded on real problems people face. Clearly, the biggest and growing problem people face in relation to health care are high out-of-pocket costs, exacerbated at a time of stagnant wages, shaky retirement savings and job insecurity.

Now, high out-of-pocket costs are becoming a political issue, as illustrated by Hillary Clinton's campaign proposals on health care, which take aim at lowering out-of-pocket costs and high prescription drug prices⁴⁰.

An extensive public opinion research project by Consumers Union found that high out-of-pocket costs, particularly deductibles, are by far people's biggest concern about the health care system⁴¹. The research found that when people understand that high costs are driven by profits and not inevitable – as evidenced by the huge variance in price – they get angry.

Such anger is a necessary ingredient for any organizing push for political change. The other ingredient is hope. If people don't have hope that problems can be addressed and a better world created, their anger turns into despair.

Advocates must make high out-of-pocket costs central to the public narrative on creating a health system that works for all of us, even if a major focus of the advocacy is health delivery and reimbursement changes. If that strategy sounds obvious, it's not; the vision statement for health system transformation proposed by one major health advocacy organization makes no mention of the financial barriers to care.

Advocates too often compartmentalize issues: this is about affordability; that is about the delivery system. But if we are to be successful in moving the public to care about the direction of the delivery system, we must tell one story and provide solutions that address both issues.

Before describing what such a story might be, a few further insights from the Consumers Union research into a potential narrative are worth noting:

- People blame insurance companies and drug companies for high prices and costs.
- They will also blame hospitals when they have information on price variation, mark-ups and profits.
- The high rate of hospital-acquired infections shook people's faith in the quality of health care (focus group participants were told 10,000 people are killed each year by drunk drivers and 70,000 by hospital-acquired infections).

⁴⁰ *Hillary Clinton's Health Care Proposals, Focused on Cost, Go Well Beyond Obama's*, Robert Pear, New York Times, October 6, 2015

⁴¹ *Engaging Consumers on Health Care Cost and Value Issues*, Consumers Union, October 2014 - <http://consumersunion.org/wp-content/uploads/2014/10/Engaging-Consumers-on-Health-Care-Cost-and-Value-Oct-2014.pdf>

- People are not troubled by health care system complexity; medical delivery system reforms do not elicit much of a response, with people seeing them as common-sense measures.
- People are frustrated with the amount of time and effort required to coordinate their care.
- People understand that they have some personal responsibility for health system costs, based on life-style behaviors like smoking and eating right, as well as using too many services.

Our story on health care

Here's a first cut of a narrative on building a health care system that works for all us.

Our quest. What do we need for good health and good health care? We need to be able to afford good coverage and to afford to use it when we are sick. We need to know we'll get quality care, from knowledgeable health professionals who know us and who can help us make good health choices. We need doctors, hospitals, nurses and counselors who work together in our communities to keep us healthy and treat us when we are sick.

The problem with who is responsible. But today, skyrocketing insurance company imposed deductibles, high hospital charges and prescription drug company price gouging are making it harder to get the health care we need, when we need it. Too many people still can't afford health insurance. Big hospital chains are marking up prices to hundreds of times beyond actual costs, boosting their profits, at the same time that 70,000 people die each year because of hospital-acquired infections. Too many big corporations – and even hospitals and doctors – are making money off our being sick instead of being paid to keep us healthy.

What we can do. We need a system that works for our health, not corporate profits. We must:

- Make sure that everyone can afford good coverage, with insurance premiums based on what we earn and can afford.
- Make sure we can afford to obtain care when needed, by eliminating deductibles, lowering co-payments and putting an end to drug company profiteering by requiring affordable prescription drugs prices.
- Insist on getting value for our health care dollars, with common sense measures that pay hospitals and doctors for the quality, not the amount of their care; and by providing incentives to coordinate care, keep us healthy, help us take care of our own health, and improve the health of our communities.
- Assure that all of us, regardless of our gender or our race or ethnic background, get access to quality care, investing in research and services that take account of our differences, our communities and our cultures.

Call to action. We can insist that our elected officials stand up to the insurance companies, drug companies, and hospital chains and write the rules so that they put the health of our families and communities before their profits. We can demand that everyday people have a voice in the health care system. Americans are proud of the best of our health care. It's time we worked together to make the best of American health care work for all of us.

Politics: Supporters, allies and opponents

I've proposed policies designed to shape U.S. health care delivery system transformation to meet the values and goals of quality, affordable, equitable health care for all. I've also sketched a narrative that taps into people's anger at the high cost of accessing health care and directs that anger towards a hopeful vision and actions to achieve that vision.

The third big challenge is related to the major constituencies and forces of health care: can we rally enough supporters and accommodate enough other players to overcome opponents?

Supporters. There is something in the proposed policies to attract all the organizations and constituencies who were active supporters of what became the Affordable Care Act: organizing networks; labor unions; health care advocates; progressive netroots groups; health care professional organizations with progressive values; and constituency groups representing seniors, people of color, women, and people with chronic illness and disability.

In some cases, the policy proposals have the potential to increase the level of engagement. Progressive health professionals will welcome the shaping of the delivery system to promote prevention, primary health, and wellness. Groups representing people with chronic illness and disability will welcome provisions designed to assure both affordability and quality. The focus on equity and on community health will appeal to community organizations and public health professionals⁴². Many labor unions, concerned with the trade-off between health care costs and wages, are committed to value based health delivery and should welcome a progressive version.

However, we should not expect the same level of engagement as in years leading up to and during the campaign to enact the ACA. One reason is the incremental and technical nature of many of the policy changes, making it harder to galvanize broad, intense effort. The other reason is that the ACA, for all its shortcomings, has come close enough to meeting the demand for a government guarantee of health coverage.

Still, there will be a myriad of opportunities to advance policy campaigns.

Allies or opponents? Given the complex pushes and pulls between controlling costs and increasing quality, advocates seeking policy changes should look for a shifting set of allies and opponents.

To take one example: we want to lower out-of-pocket costs and to create health systems where all care is high-value. Major employers are very interested in lowering out-of-pocket costs for high-value care. While this interest doesn't mean that employers will leap to support eliminating deductibles and lowering co-payments across the board, it does mean they can be supportive of doing so where care is of higher quality.

Another example is including socio-economic factors in risk-adjustment for capitation. While all hospital systems will lobby to get the highest possible capitated payments, systems in major urban

⁴² We should also acknowledge the potential tension between lowering health care costs and boosting quality and equity, a tension that the health care industry will exploit by scaring (and funding) organizations that represent the chronically ill and low-income communities.

areas, which serve large low-income populations, will be strong advocates for expanding risk adjustment to include socio-economic factors.

I do not mean to imply that the politics of any of the policies proposed will be easy, just that there will be opportunity for a variety of alliances – “strange bed-fellows” – and positive compromises.

Conclusion: The next health care movement?

Let me turn to one question that may be particularly relevant in a time in which we see emerging movements in the United States: Black Lives Matter; the Fight for \$15; the young immigrant Dreamers; the struggle against climate disruption. Can we build a movement for a vision of health reform that really does work for all of us?

For me, answering that question starts with asking whether we had such a movement driving the passage of the ACA. My short answer is that while we had movement elements, including people who identified strongly as being part of the health care movement, in the broader historical definition of movement, the answer is no.

In my long involvement with health care – beginning in 1986 with the run-up to what would become the Clinton effort – I worked with a cadre of people who saw themselves as part of the health care movement. These were people who dedicated themselves to fighting the for-profit health care system and building support – some as volunteers, some professionally – for health care as a human right. Their persistence and leadership were instrumental in laying the groundwork for passage of the ACA, and they played key roles in the fight for its passage.

We saw other movement elements in the campaign to enact the ACA, most realized by people whose activism was driven by the tragedy and hardship inflicted by our for-profit health care system, particularly the insurance industry. Their sharing their stories with elected officials, with the press, through organizing in their communities, was essential to the ACA’s passage. They did what movement activists have long done: put themselves on the line to make their issues visible. And in doing so, as part of a community working together for change, were themselves transformed.

The campaign for passage of the ACA held rallies with hundreds and even thousands. We organized sit-ins and civil disobedience to protest insurance industry abuses. In August 2009, activists turned out in droves at town meetings to counter the Tea Party anger.

Still, we did not have a movement in the historic sense, where the movement takes on a life of its own, where tens of thousands participate and where the culture is transformed. We ran an historic legislative campaign, but it was not driven by an historic movement.

The huge gains achieved by the ACA will make it even harder to replicate the movement aspects of the decades of organizing that led to its passage. Finally, we have a framework for a government guarantee of affordable coverage for every U.S. citizen (if not everyone who resides here). No more the terrifying insecurity of losing your job with no way to get health coverage, or of being turned away by a health insurance company. When 91 percent of people have health coverage – a proportion that will continue to expand – the number and political clout of those

left out keeps going down. The biggest remaining issue for the public – affordability- will be able to drive legislative campaigns, but does not have the moral urgency of movements. Achieving legislative changes around the issues of quality, health and health equity may be even more challenging.

But these realities do not mean that leaders and advocates for health care as a right cannot become part of, and be catapulted by, broader movements for economic and racial justice. The history of the United States shows that with a few exceptions – the ACA being one – most major progressive advances come in waves. The challenge for health care advocates is to see themselves – and our vision of health care – as part of the young movements that are now building toward that next great progressive wave.

Can we make affordable health care part of the wave for economic justice? Can we make shaping the corporate forces in health care to the public will part of the wave for a government that works for working people, not corporate CEOs? Can we make equity in health access part of the wave for racial justice? Can we make community health part of the wave for protecting our lives, communities, and planet from climate destruction? We can if we move out of a health care silo to connect our work to today’s broader movements.

I conclude where I began, by celebrating our victory in establishing a framework, however flawed, for a government guarantee of affordable health coverage. The passage of the ACA fundamentally changes the political context for health care policy in the United States. Health care now takes its place among other major advances in social policy – public education, Social Security, labor standards, equal rights under law, and more – as established pillars of American life. These policies are constant subjects of political contention: expanded at times, rolled back at other times. But, despite right-wing rhetoric and ambitions, they are never seriously in dispute. Not when they are valued and of great value to so many Americans, when they are now woven into the fabric of our lives, our community and society, as health care is now.

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