

Ten Ways to Improve Health Care, Right Now

BY SACHIN H. JAIN, MD, MBA

DURING THIS ELECTION SEASON, in-depth discussions of health care have not been at the forefront of political discourse. Nevertheless, improving the system that accounts for 20% of our economy remains as important as ever. Here are 10 concrete, immediately implementable, and highly impactful measures that could significantly improve the US health care system. Though you're unlikely to see any of them in a political ad, these ideas represent practical steps that could expand access, reduce costs, and lead to substantial improvements in the health and well-being of millions of individuals in the US.

1. **LOWER THE MEDICARE ELIGIBILITY AGE.** We all know the old saying about an ounce of prevention. And yet 11,000 people in the US age into Medicare every day,¹ with many of them never having had access to preventive medicine. Among those in this category are the 10% of people who lack health insurance and report "less preventive health screening than their insured counterparts, including lower screening for high cholesterol, cervical cancer, and prostate cancer."²

With so many people aging into the program who have never benefited from consistent care, too many of our health care dollars go toward the treatment of existing conditions instead of prevention. One way to fix this is to lower the age of eligibility to 55 years, which would bring an additional 3.45 million people into the health care system,² providing them with the kind of regular, preventive care that improves outcomes—and ultimately, it should be stressed, saves money.

2. **BOOST ANTITRUST ENFORCEMENT.** There were 1887 hospital mergers between 1998 and 2021, leading to a 25% reduction in the number of hospitals nationwide.³ Approximately 50% of physicians now work for large health systems, some of which are being consolidated under the authority of venture capital firms.

As long as commitment to care and prioritization of patient needs drive business decisions, consolidation in itself isn't a problem. However, a growing body of research shows that consolidation in health care is leading both to higher costs⁴ and reduced quality of care.³

Voters have a right to understand that what seems like an abstract market process is costing them more and making it more difficult for them to obtain quality care. I, for one, am encouraged by the Biden administration's recent promise "to stop anticompetitive mergers and anticompetitive practices by dominant corporations in health care markets."⁵ But I'd like to see a full-throated debate about the issue, including suggestions for guardrails that could ensure that the profit motive behind consolidation does not take precedence over the need to lower costs and improve outcomes.

3. **CREATE MULTIYEAR PLAN ENROLLMENT.** As someone who works for a Medicare Advantage (MA) plan, I can tell you that one of the difficulties we face is that the populations we cover change all the time. In government-sponsored plans such as mine, people shop around yearly and change plans based on benefit offerings that may not do much to keep them healthy. In private insurance, people switch insurers and plans whenever they change jobs.

Instead, we should create systems with longevity built in. If health plans knew they could have a customer for the long term, they would have far more incentive to think about prevention and investment in that customer's health.

I'd like to see the the creation of new models of health insurance under which people would be required to stay, with plans for a set number of years that are portable between jobs and retained during periods of unemployment. Under this arrangement, plans would receive incentives to keep large populations of customers healthy and be required to report regularly on patient population outcomes across a defined set of measures.

4. **INCENTIVIZE MA BROKERS AS COMMUNITY HEALTH WORKERS.** New research shows that trust in physicians and hospitals is declining.⁶ That's alarming; trust is the backbone of the health care system and something we must work to rebuild. A good place to start is with a group of



people who are already trusted in their communities: health care brokers. Brokers not only help clients select a plan, but they also help them navigate and access the health system, guide them toward community resources that can improve health outcomes, and promote health habits and behaviors that can obviate the need for expensive medical care.

Not everyone will agree with this list, and these 10 ideas alone won't completely fix our health care system. But we have to start somewhere. It's time to discuss these ideas and make real changes. Let's get started.

It's time to codify and standardize this work in order to ensure that these services are not nice-to-have benefits but rather standard offerings one can expect from every broker. Brokers receive fees for signing up new members and reenrolling them; as such, the existing structure already creates the financial model through which to incentivize them to make providing community health services an integral part of their jobs.

5. **MANDATE STANDARDIZED BENEFIT DESIGN.** One of the key reasons Congress created the MA program was to inject competition into health care markets. This concept is especially pronounced in benefit design. Under pressure to keep costs and out-of-pocket expenses low while competing to gain the business of beneficiaries, MA plans create benefits that meet beneficiaries' needs and provide them with economic security. Most plans offer worthy benefits such as low co-pays, zero-cost medications, and dental and vision coverage.

However, in recent years, in an attempt to gain market share, we've seen some plans take this idea too far. A well-known plan recently offered potential enrollees pickleball paddles, fishing rods, and golf clubs.⁷

Benefits such as these, while competitive, do little for people when they need care.

By adopting standardized plan benefits rooted in the provision of health care treatments, the federal government could maintain competitive incentives in the MA industry while ensuring that consumers are able to choose plans on the basis of health outcomes, which should be the most important metric in their decision-making process.

6. **MAKE STAR RATINGS MATTER.** MA Star Ratings often measure processes rather than outcomes. Researchers who looked at medication adherence measures, for example, found that "because the measures reward the purchasing of medication rather than medication use itself, health plan behavior may be increasingly delinked to actual beneficiary behavior."⁸

Every health plan should be able to tell prospective customers how well their members have fared after common events in the aging journey such as a first fall, a new disease diagnosis, or the transition from curative treatment to hospice care. There are solid data about what separates good from great care on these and other important fronts, so we should compel plans to actually compete on how well they manage these moments that matter.

7. **FIX RISK ADJUSTMENT.** It's high time that CMS used technology to adjudicate risk coding in real time. Currently, CMS uses small-sample retrospective audits that look at unrepresentative data and require plans to expend resources tracking down old paper charts to look for diagnosis codes that don't align with the true cost of caring for members.

When anomalies are detected, the government demands repayment and fines health plans. But what about all the anomalies that occurred *after* the audit year? A better way forward, in this era of computerized data transmission and algorithmic data analysis, would be to conduct more immediate audits so that if problems are flagged, health plans can make rapid corrections.

8. **REFORM NATIONAL LICENSURE.** Let me call this what it is: allowing people to access doctors who don't live in their state. Under the current state licensure system, if you want to see a doctor in another state, you have to go there. That's one of the reasons commuter flights from Chicago, Illinois, to Rochester, Minnesota, where Mayo Clinic is located, are often booked to capacity.

But in an era of telemedicine, it should be much easier for people to consult with physicians across state lines. Reforming the outdated system of state-based medical licensure would also address the growing physician shortage and improve access to care in rural and medically underserved areas.

The only way this can happen is for licensure to be reformed at the federal level, which makes this an

important topic not just for presidential candidates but for all potential federal officeholders.

9. **SOLVE THE UTILIZATION MANAGEMENT CONUNDRUM BY INCENTIVIZING CAPITATED CARE.** We hear a lot these days about insurers using various utilization management methods to deny care. It's beyond time to change the dynamic between payers and providers through the widespread adoption of global capitation, the payment model by which providers receive a fee to manage all of a plan member's health care expenses. By steering payers and providers into these arrangements, CMS could ensure that more provider organizations and health systems, as opposed to health plans, manage utilization.

Many physicians and hospital systems reject capitation because they don't want the pressure of assuming financial risk for patient care. But this is shortsighted. Capitation enables clinicians to make necessary investments in order to manage costs and do what's right for patients.

10. **CREATE A MATERNAL MOONSHOT.** Maternal mortality rates in the US shot up during the COVID-19 pandemic. Results of a CDC study show that deaths from maternal causes were 40% higher in 2021 than in 2020.⁹ Women from minority groups and those living in rural areas and small cities were most severely affected.

Researchers in one study attributed the increase to the pandemic's effects on social determinants of health.¹⁰ Whatever the cause, the US now has the highest maternal mortality rate among developed countries. It's time this shameful statistic spurs the person in the Oval Office to make radical changes.

What can they do? Some ideas include the following:

- **REQUIRE STATES TO PROVIDE MEDICAID COVERAGE TO WOMEN FOR AT LEAST 1 YEAR AFTER THEY GIVE BIRTH.** Under current rules, it is up to states to decide whether women will get a full year of postpartum care. The federal government shouldn't give states the option. Giving birth should trigger more health care, not less.
- **INCREASE FUNDING TO STUDY MATERNAL MORTALITY.** In 2019, the National Institutes of Health launched its Implementing a Maternal health and PRenancy Outcomes Vision for Everyone (IMPROVE) initiative,¹¹ which supports research to reduce maternal deaths and improve health for women before, during, and after pregnancy. And the Biden administration recently launched the White House Initiative on Women's Health Research.¹² All these programs are a step in the right direction. Now let's take a leap.
- **INCREASE CULTURALLY COMPETENT CARE.** According to *The New York Times*, "Black women

are 9 times more likely to die from pregnancy or childbirth than White women in New York City."¹³

It's time to match patients with clinicians who understand their needs and backgrounds.

- **EXPAND PROGRAMS SUCH AS THE NURSE-FAMILY PARTNERSHIP.** This program, which connects women who are pregnant with their first child with registered nurses who provide home visits until the child's 2nd birthday, has been shown to improve maternal health, child health, and economic security.

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AUTHOR INFORMATION

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