Vital Directions in Health and Medicine in Uncertain Times

Victor J Dzau, MD
President, National Academy of Medicine

Dr. Raymond C Grandon Lecture
Jefferson College of Population Health, Philadelphia
May 24, 2018
Post-July 1, 2015 Structure: The National Academies of Sciences, Engineering and Medicine

National Academy of Sciences

National Academy of Engineering

National Academy of Medicine

NRC: Programs of the Academies

Division of Behavioral & Social Sciences & Education
Division on Earth & Life Sciences
Division on Engineering & Physical Sciences
Gulf Research Program
Health & Medicine Division
Policy & Global Affairs
Transportation Research Board
Setting the Agenda in Medicine and Health

We Advise, Convene, Catalyze, Set Agenda & Influence policy

2015 Global Summit on Human Gene Editing co-hosted with the NAS, Royal Society and Chinese Academy of Sciences

High-quality and high-impact reports and recommendations to inform future direction health and medicine
Authoritative Reports

Examples of Impact & Influence

1999 - To Err is Human
1986 - Confronting AIDS
1988 - Mapping and Sequencing the Human Genome
2011 - Toward Precision Medicine
2016 - Human Genome Editing
2017 - Global Infectious Disease Risk
1997 - SODIUM INTAKE IN POPULATIONS

PATIENT SAFETY
AIDS RESEARCH AND CARE
HUMAN GENOME PROJECT
PRECISION MEDICINE
GLOBAL INFECTIOUS DISEASE RISK
HUMAN GENE EDITING
US DIETARY GUIDELINE
A Critical Inflection Point

This is a time of unparalleled dynamism for policy and practice in the nation’s health, health care, and biomedical science communities. The past decade has seen tremendous developments in medical science and care delivery with the advent of big data, biomedical innovations, new forms of health care financing, and an emphasis on greater accountability. Precision medicine, novel drugs and devices, and new diagnostic capabilities are expanding treatment options. Digital technologies such as m-Health allow patients to take a more active role in their health and health care decisions. Locally and regionally, community innovators are designing coordinated care delivery models that hold significant promise for increasing efficiency and value. Furthermore, a growing focus on population health, wellness, and prevention is driving improvements in health and quality of life in the United States.

Alongside such meaningful progress, US health care faces critical challenges. The health system is increasingly strained by growing complexity, demand, and unsustainably costs. Health care spending accounts for 17.5% of the US gross domestic product in the most recent report—a rate substantially greater than any of its peer countries—yet 1 in 10 US residents report their health as poor or only fair, and overall life expectancy priorities are available to policy makers as well as other key decision makers, opinion leaders, and the public. The initiative will identify existing gaps and areas of opportunity and explore national policies that are immediately actionable and hold promise for improving care quality, increasing access, lowering costs, and accelerating progress across health science and policy.

Recognizing that the overall health of the nation is imperative to its prosperity and success, the NAM seeks to identify avenues for bipartisan collaboration to advance 3 overarching goals: better health and well-being, high-value health care, and strong science and technology.

Better Health and Well-Being

Key barriers and challenges exist to achieving uniformly good health and well-being across the country. Many individuals in the United States experience worse health than those in other countries. In a 2014 report, the United States ranked last among 11 highly industrialized nations in quality, efficiency, and equity of care. Rates of avoidable chronic conditions continue to increase, contributing to the country’s poor health and increasing health care costs. Behavioral issues and other preventable factors account for approximately half of early deaths in the nation, yet effective prevention strategies are poorly applied.

Poor
Need for Healthcare Reform in US:

US spends $3T or ~18% of its GDP on health care, yet trails peer nations in terms of:

- Population health outcomes and indicators
- Access
- Efficiency
- Equity

Accessibility of many healthcare services is limited.
Quality of services is variable.
Affordability of care remains a major challenge.

National Academy of Medicine
Rising health care costs exert downward pressure on other programs

Data from the Congressional Budget Office
Excess costs and care misalignment

- Care decisions and treatment too often are inconsistent with patients’ goals and preferences, or are unnecessary
- Total excess costs approaching $750B (IOM, 2013)
Income-related disparities in health status

- Income-related disparities in mortality risk and life expectancy are rising nationally
- Life expectancy rises with income

Patient Protection and Affordable Care Act (ACA)

Signed into law by President Barack Obama on March 23, 2010

The law has 3 primary goals:

• Coverage expansion to reduce the number of uninsured
• Health insurance reform to improve affordability of coverage
• Delivery system reform to improve quality and contain costs

Source: www.healthcare.gov, Kaiser Family Foundation
Impact of the ACA: Progress

• Decrease in number of uninsured
  • 21 million adults gained coverage (2016) through HIE and expansion of Medicaid
    • 32 states (including DC) expanded Medicaid
  • Uninsured rate for non-elderly adults (ages 18 to 64) declined between
    • Late 2013: 20.3%
    • Early 2016: 11.5%
    • Late 2017: 12.2%

• Reduction in health spending
  • Growth slows to rate of GDP from 2010-2013
  • Lower CBO 10 year Medicare projections

• Improvement in quality
  • Medicare hospital admissions down
  • 21% decline in HACs in Medicare patients from 2010-2015
    • 125,000 deaths avoided and cumulative savings of $28 billion
  • Mortality rates within 30 days after hospital admission decreased slightly for some conditions.
Impact of the ACA: Challenges

• Exchange consumers have little choice and face high premiums in many markets
  • 21% of exchange enrollees have choice of only one insurer in 2017 versus 2% in 2016
  • 25% (on average) premium increase for exchange plans in 2017
• Several major insurers have withdrawn from health insurance exchanges
  • 5 states have only one exchange insurer (2017)
• Challenges encouraging young and healthy individuals to sign up for insurance coverage
• Uncertainty regarding future stability of health insurance exchange markets and the future of Medicaid
2017 Efforts to Repeal the ACA

The House Voted to Repeal ObamaCare. Will the Senate Follow Through?

Chicago Tribune

GOP effort to repeal ObamaCare on verge of collapse as 3rd Republican opposes bill

Senate GOP abandons latest effort to unwind the Affordable Care Act
Need for Vital Directions

Cut through the noise of repeal and restore attention to the necessary fundamentals of improving health at lower cost:

- Coverage and access to care for all
- Significant challenges in health care that go beyond coverage provisions
- We are failing to achieve access, affordability, efficiency, and equity.
- Critical and necessary changes to healthcare are needed.
- Need for a nonpartisan, evidence-based effort to provide a succinct blueprint for building a better health care system
The Vital Directions Steering Committee

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National Academy of Medicine

Mark McClellan, M.D., Ph.D. (Co-chair)
Duke University

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xG Health Solutions

Pamela Thompson, M.S., R.N.
American Organization of Nurse Executives
American Hospital Association

Elias Zerhouni, M.D.
Sanofi
• 18 months of collective review, analysis, and deliberation

• Core goals:
  • Better health and well-being
  • High-value health care
  • Strong science and technology

• Commissioned 150+ experts to write 19 discussion papers
Better Health and Well-being
Systems strategies for better health throughout the life course
Addressing social determinants of health and health disparities
Preparing for better health and health care for an aging population
Chronic disease prevention: tobacco, physical activity, and nutrition for a healthy start
Improving access to effective care for people who have mental health and substance use disorders
Advancing the health of communities and populations

Strong Science and Technology
Information technology interoperability and use for better care and evidence
Data acquisition, curation, and use for a continuously learning health system
Innovation in development, regulatory review, and use of clinical advances
Targeted research: brain disorders as an example
Training the workforce for 21st-century science

High-Value Health Care
Benefit design to promote effective, efficient, and affordable care
Payment reform for better value and medical innovation
Competencies and tools to shift payments from volume to value
Tailoring complex care management, coordination, and integration for high-need, high-cost patients
Realizing the full potential of precision medicine in health and health care
Fostering transparency in outcomes, quality, safety, and costs
The democratization of health care
Workforce for 21st-century health and health care
Vital Directions for Health and Health Care Priorities From a National Academy of Medicine Initiative

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**IMPORTANCE** Recent discussion has focused on questions related to the repeal and replacement of portions of the Affordable Care Act (ACA). However, issues central to the future of health and health care in the United States transcend the ACA provisions receiving the greatest attention. Initiatives directed to certain strategic and infrastructure priorities are vital to achieve better health at lower cost.

**OBJECTIVES** To review the most salient health challenges and opportunities facing the United States, to identify practical and achievable priorities essential to health progress, and to present policy initiatives critical to the nation’s health and fiscal integrity.

**EVIDENCE REVIEW** Qualitative synthesis of 19 National Academy of Medicine–commissioned white papers, with supplemental review and analysis of publicly available data and published research findings.
Summary: The Priorities

ACTION PRIORITIES
• Pay for value
• Empower people
• Activate communities
• Connect care

ESSENTIAL INFRASTRUCTURE NEEDS
• Measure what matters most
• Modernize skills
• Accelerate real-world evidence
• Advance science
Pay for Value: Shifting from volume to value
High Value Health Care: National Landscape

- Patient Protection and Affordable Care Act (2010)
  New Payment Systems and Policies (Alternate Payment Models)
  - Hospital value-based purchasing
  - Bundled payments
  - ACOs, Shared Savings

  - Value-Based Payment Goals
    - Goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent by the end of 2018

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Replaced SGR formula
  - Quality Payment Program shifts payment system from volume to value
    - Merit-based Incentive Payment System (MIPS)
    - Advanced Alternative Payment Models (APMs)
In January 2015, HHS announced goals for value-based payments in the Medicare program. The goals are as follows:

- **2011**: 0% Alternative payment models, 68% FFS linked to quality, 32% All Medicare FFS.
- **2014**: ~20% Alternative payment models, >80% FFS linked to quality.
- **2016**: 30% Alternative payment models, 85% FFS linked to quality.
- **2018**: 50% Alternative payment models, 90% FFS linked to quality.

The figure compares the historical performance (pre-announcement) with the goals set by HHS.
## INCENTIVES: Payment Reform Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Limited in Medicare fee-for-service</td>
<td>- Hospital value-based purchasing</td>
<td>- Accountable care organizations</td>
<td>- Eligible Pioneer accountable care</td>
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<tr>
<td>- Majority of Medicare payments now are linked to quality</td>
<td>- Physician Value-Based Modifier</td>
<td>- Medical homes</td>
<td>organizations in years 3-5</td>
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<tr>
<td></td>
<td>- Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>- Bundled payments</td>
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<td>- Comprehensive primary care initiative</td>
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<td>- Comprehensive ESRD</td>
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<td>- Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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APM MEASUREMENT EFFORT

Public and private health plans, managed FFS Medicaid states, and FFS Medicare voluntarily participated in a national effort to measure the use of alternative payment models (APMs) as well as progress towards the LAN's goals of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

2016 PAYMENTS*

43% LEGACY PAYMENTS IN CATEGORY 1
28% LINK TO QUALITY IN CATEGORY 2
29% PAYMENTS IN APM CATEGORIES 3 & 4

*Participants categorized payments made to providers in 2016 according to the original LAN Framework and the LAN aggregated results.

REPRESENTING OVER 245 MILLION AMERICANS AND...

APPROXIMATELY 84% OF THE COVERED POPULATION IN FOUR MARKET SEGMENTS
Growth Of ACOs

• 923 active public and private ACOs across the United States, covering more than 32 million lives.
• More than 10 percent of the U.S. population is now covered by an accountable care contract.
Early Results

- Progress in increasing value-based payment and accountable care models
  - Though slower than expected
- Cost growth leveling off
- But cost and quality still variable
  - Evidence on Medicare payment and delivery system reforms is mixed.
  - Overall net savings to Medicare has been relatively modest. (Kaiser Family Foundation)
- Moving the needle on some national metrics, e.g.,
  - Readmissions
  - Line Infections
Hospital Acquired Conditions 2010-2015

- 21 percent decline in hospital-acquired conditions (HACs) since 2010
- A cumulative total of 3.1 million fewer HACs were experienced by hospital patients over the 5 years
- Nearly 125,000 fewer patients died in the hospital as a result of the reduction in HACs from 2010 to 2015
- Mortality rates within 30 days after hospital admission have decreased slightly for some conditions.
- Medicare Hospital Admissions down
- Cumulative savings from 2010-2015 is $28 billion (AHRQ, 2016)

<table>
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<tr>
<th>Adverse Drug Events</th>
<th>Pressure Ulcers</th>
<th>Catheter Associated Urinary Tract Infections</th>
<th>Surgical Site Infections</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>42% ↓</td>
<td>23.0% ↓</td>
<td>15.2% ↓</td>
<td>2.4% ↓</td>
<td>2.9% ↓</td>
</tr>
</tbody>
</table>

Adverse Drug Events
- Pressure Ulcers
- Catheter Associated Urinary Tract Infections
- Surgical Site Infections
- Falls
Figure 2

ACOs that accepted risk in 2016 produced net Medicare savings relative to their benchmarks, unlike no-risk ACOs

Net Medicare spending on ACO models, in millions:

<table>
<thead>
<tr>
<th></th>
<th>ALL ACOs</th>
<th>No-risk ACOs</th>
<th>At-risk ACOs</th>
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<tbody>
<tr>
<td></td>
<td>MSSP Track 1</td>
<td>MSSP Track 2</td>
<td>MSSP Track 3</td>
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<tr>
<td>Net Costs</td>
<td>$72m</td>
<td>-$18m</td>
<td>-$14m</td>
</tr>
<tr>
<td>Net Savings</td>
<td>-$47m</td>
<td></td>
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</table>

No. of ACOs:
- ALL ACOs: 458
- No-risk ACOs: 410
- At-risk ACOs: 6, 16, 8, 18

NOTES: Analysis excludes Comprehensive ESRD Care Model. AP and AIM ACOs are included in their respective MSSP tracks. SOURCES: Kaiser Family Foundation analysis of 2016 public use files for MSSP, Pioneer, and Next Gen ACOs and unpublished CMS data.
CMMI Accountable health communities

• Launched in 2017
• Addresses a critical gap between clinical care and community services
• Tests whether addressing the health-related social needs through screening, referral, and community navigation services will impact costs and reduce utilization

There are currently 31 organizations participating in the Accountable Health Communities Model.
“There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us.”

-Alex M. Azar
Remarks to Federation of American Hospitals
March 5, 2018
Azar outlined 4 priorities for value based care

1. Allow patients to access their medical records.
2. Increase transparency.
3. Medicare and Medicaid to drive value based transformation:
   a. Use of MACRA and CMS Innovation Center.
4. Reduce government burdens.

“The key theme uniting these four priorities is the recognition that value is not accurately determined by arbitrary authorities or central planners. It is best determined by a marketplace of many players — in the case of healthcare, patients and, where necessary, their third-party payers.”
Activating Community: Address Social Determinants of Health
Determinants of Health

Factors outside healthcare play a large part in determining health.

Figure 1. Determinants of Health and Their Contribution to Premature Death.
Adapted from McGinnis et al.¹⁰
Comparable total health and social services expenditures to peer nations – but different mix

In OECD, for every $1 spent on health care, about $2 is spent on social services. In the US, for $1 spent on health care, about 55 cents is spent on social services.
Addressing the social determinants

Address root causes of health inequities
• Tackling socioeconomic factors and reducing social inequities
• Expanding and aligning social services and support
• Building healthy environments and communities
• Health in all policies

Collaborative cross-sector partnerships

Care delivery and payment
• Align primary care and public health
• Clinic & community partnership
• Integrate medical & social services
• Social Risk Adjustment for Reimbursement

Data and Information
• Capture social and behavioral measures in EHRs
• Data and health information exchange throughout the community

Addressing social determinants

• Capturing Social and Behavioral Domain Measures in EHRs
• Systems Practices for the Care of Socially At-Risk Populations
• Accounting for Social Risk Factors in Medicare Payment
Communities in Action: Pathways to Health Equity (2017)

• To address health inequity, one must address its root causes: poverty, structural racism, and discrimination

• Solutions have to come from multiple stakeholders working together in communities.

• Identifies 9 innovative communities that are working to address health inequity – these communities provide many important lessons learned

NASEM Report, 2017
Community-level Work

Phase 1: Summer Listen and Learn “Tour”

- Identify leading communities and understand the process through which they have advanced health equity
- Determine if there are common principles that can be applied broadly to other communities

11 Communities Listen & Learn “Tour”
Focus groups: partners, local leaders, funders

Phase 2: Communities in Action Network

- Pair the leading communities with other nearby communities that want to advance health equity.

Communications

- Visualize Health Equity Art Show: November 2017
- Community Video Series: Released Fall 2017
- Community Health Heroes Spotlight Series
- Promotional Materials
Connected Care: Data and technology to drive a learning health system
Technology Innovation: Health in the Digital Age

- **Electronic health records (EHRs)** – drive a learning health system
  - aggregate the clinical, administrative, claims, and research data; and use it to inform clinical decision making
- **Biosensors**
- **Telemedicine/remote monitoring**
- **mHealth**
- **Diagnostic devices**
- **Robotics**
- **Big data and analytics**
- **Artificial Intelligence**
Learning Healthcare Systems

A learning health care system is one in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families active participants in all elements, and new knowledge captured as an integral by-product of the care experience. –IOM, 2012

- Use of integrated clinical & research data to develop care redesign and novel care model
- Use of large datasets and informatics to improve health
- Use innovation to transform health

Achieving the goals of Connected Care

Source: IOM Roundtable on Value & Science-Driven Health Care, 2012.
Foundational elements of Connected Care

- Digital infrastructure
- Real-time evidence generation
- Data utility, interoperability, and analytic capability
- Effective telehealth tools to link clinicians to patients and families
- Patient-clinician partnerships
- Patient access, ownership, and protection of health data
Connected Care and Population Health

Population Health Intelligence Commons

• A shared data & analytics infrastructure to provide *timely, locally relevant, and actionable* intelligence to local public health agencies & health care systems to address social determinants of health

![Proportional Contribution to Premature Death](image)

*Figure 1. Determinants of Health and Their Contribution to Premature Death.*
Adapted from McGinnis et al. 

[Image of pie chart showing proportional contribution to premature death]
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ESSENTIAL INFRASTRUCTURE NEEDS
• Measure what matters most
• Modernize skills
• Accelerate real-world evidence
• Advance science
Measure what matters most: Vital Signs
“Measures ought to be basic at the core, tailored at the margin, provide continuous learning milestones for improvement throughout all elements of the system.”
Vital signs – what’s next? Driving Adoption and Implementation

Alignment/coordination/partnership with other federal initiatives
- CMS Meaningful Measures
- MyHealthEData Initiative: led by the White House Office of American Innovation with:
  - HHS • CMS • ONC • NIH • VA
- Patients over paperwork (CMS)
- Streamlined QPP (Quality Performance Program): consolidates multiple legacy data submission pathways into one website.
CMS Meaningful Measures

• Launched in 2017
• Identifies high priority areas for quality measurement to improve outcomes while also reducing burden on clinicians and providers.
21st Century Science and a Robust Workforce
Advance science: forge innovation-ready clinical research processes and partnerships

• Support basic and translational sciences
• Promote practices and policies for scientific innovation and collaboration
• Support an adaptive and patient-driven regulatory framework
• Foster cross-disciplinary and public-private partnerships for continuous learning
• Create new education and training pathways to maintain a robust science workforce
Modernize skills: train the workforce for 21st century health & healthcare

- Skills and expertise aligned with the emergence of new sciences
  - Data science
  - Social and behavioral sciences
  - Regulatory science
  - Economics
  - Convergence

- Education and training

- Reform health workforce training to emphasize teams, interprofessional practice, innovation, and continuous improvement

- Invest in the science of performance measurement

- Workforce composition
Summary: Vital Directions for Health and Healthcare

• Better health and wellbeing
  • Increased focus on prevention and life course perspective
  • Integrating clinical care and public health
  • Increased focus on social determinants of health

• High value healthcare
  • Focus on value is here to stay
  • Continued shift from FFS to alternative payment models
  • Increased focus on post acute care (e.g., preventing readmissions)

• Strong science and technology
  • Potential for new treatments through new scientific advancements
  • Data: new sources; integration into research and practice
The National Academy Of Medicine's Vital Directions For Health: Forging a Path for our Future

GOP health care debate misses the point, experts say

A radical idea for health-care reform: Listen to the doctors

How to improve the U.S. health system? Well ... A high-profile committee at the National Academy of Medicine on Tuesday released a blueprint to address challenges to U.S. health care that go beyond insurance coverage, Pro's Arthur Allen writes.

Vital Directions and National Will

NAM: American Healthcare Needs Overhaul
National Academies Work to Advance Vital Directions:

- Roadmap to value-based care (meeting)
- Innovation Collaborative: Value Incentives & Systems
- Regulatory priorities to advance value-based care (meeting)
- Models of Care for High-Need Patients (meeting series and publication)
- Innovation Collaborative: Care Culture & Decision-making
- The Future of the Public's Health in the 21st Century
- Innovation Collaborative: Digital Learning
- Clinician-EHR interface (meeting)
- Optimizing clinical decision support
Vital Directions offers a practical framework of achievable priorities that will advance health, health care and scientific progress. The ideas presented not only directly address the issues of cost and improved outcomes, but they build on interests around which there is considerable bipartisan support.

-Tom Daschle and Mike Leavitt
Failure to repeal but Executive and State Actions....
Executive Orders

• Jan. 20, 2017: On his first day in office, Trump issues an executive order to “minimize the unwarranted economic and regulatory burdens” of the health law.

• Oct. 12, 2017: Trump signs an executive order pushing federal officials to make it easier for people to purchase insurance that does not meet the regulatory standards of the Affordable Care Act.
Administration and State Efforts to Weaken ACA

• April 2018: CMS issues a final rule that allows states to select essential health benefits

• CMS expands so-called “hardship exemptions” from the law’s individual mandate
  • exemptions cover people who object to plans covering abortion and people in counties with either no exchange plans or just one plan option

• CMS eliminated the health care law requirement that “navigators” be physically present in the state, and that at least one navigator be a nonprofit.
Administration and State Efforts to Weaken ACA

Medicaid

- Medicaid expansion
  - 32 states and DC expanded
  - 4 considering
  - 14 not expanded
- January 2018: CMS issues guidelines that allow states to make “work or participation in other community engagement activities” … conditions for Medicaid eligibility for able-bodied, working-age adults
  - Arkansas, Kentucky, and Indiana are in the process of implementing these requirements. Additional states have pending proposals before CMS.
Where are we now?

• 8.8 million Americans signed up for coverage on the marketplace in 2018 (despite a shortened registration window)
  • 3.7% reduction in sign ups from 2017
• 26% of exchange enrollees have choice of only one insurer in 2018 versus 2% in 2016, and
  8 states have only one exchange insurer (2018)
• 29% average premium increase for exchange plans in 2018
  • 2019 premiums projected to increase substantially due to discontinuation of cost sharing reduction payments and loss of low risk pool
• Individual mandate set to end in 2019 (per the Tax Cuts and Jobs Act)
White House Proposes Cuts to Health Spending

- CHIP
  - Proposed $7 billion cut

- CMMI
  - Proposed rescinding (cutting) $800 million from the HHS Center for Medicare and Medicaid Innovation (CMMI)
More work to be done: Recent NAM efforts

- Action Collaborative on Countering the Opioid Epidemic
- Action Collaborative on Clinician Well-Being and Resilience
- Making medicines affordable
- Healthy Longevity Grand Challenge
“The years of rancorous debate [surrounding healthcare reform] … have highlighted the profound divisions in our political system.

But, it has also obscured the encouraging reality that most Democrats and Republicans actually share a common goal – the creation of a high quality, high-performance, high-value health care system.

We cannot continue to spend more than $3 trillion a year on health care, yet lag behind much of the developed world in overall health outcomes.”

Tom Daschle and Bill Frist
Thank you

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