EDITORIAL

US Health Policy—2020 and Beyond
Introducing a New *JAMA* Series

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Health care is always on the minds of the public, usually ranking among the top 3 concerns. Virtually all of the Democratic presidential candidates have discussed or will shortly detail health care proposals, whereas President Trump and the current administration recently expressed support for repealing the Affordable Care Act. With the presidential election just 18 months away, it is an opportune time to introduce a new health policy series in *JAMA*.

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While various proposals to improve US health care will certainly differ in content, they will all by necessity share a common theme—a focus on reducing health care costs. In 2017, US health care spending reached $3.5 trillion, and such costs now consume approximately 18% of the gross domestic product (GDP).[1] Even though there has been a slight slowing in the annual growth of health care expenditures,[2] a recent projection suggested that by 2027, health care will consume 22% of the GDP,[3] outpacing the annual rate of inflation and increases in GDP over the next 5 years. This is an unsustainable trajectory.

At the same time, there are also crises of access and equity. Recent estimates suggest that nearly 14% of US residents are uninsured, and these numbers are markedly higher among people living in poverty compared with those who are wealthier, as well as among racial and ethnic minority populations compared with white populations. According to the 2017 National Healthcare Quality and Disparities Report, an estimated 40% of adults reported lacking a usual source of care, of which 15% indicated a financial or insurance reason for lacking regular access; these figures are also higher among impoverished persons and individuals of racial or ethnic minority.[4] Quality, though improving overall, remains inequitable as well: substantial differences across a range of quality domains persist for black and Hispanic individuals compared with white individuals.

The key question for policy makers is whether there are achievable health policies that will reduce the annual increase in health care expenditures yet at the same time increase access to care (fewer uninsured or underinsured), improve quality, and reduce inequities. Feasible policies likely must also maintain choice, which the majority of people repeatedly maintain is important to them.

To set the stage for a constructive policy debate, the first step requires defining the current starting point in coverage and spending (**Table**). For its population of 325 million in 2017, the United States spent $3.5 trillion on health care. Private health insurance covered approximately 197 million individuals and accounted for $1.2 trillion in health care spending. Medicare covered approximately 57 million individuals and accounted for approximately $706 billion in expenditures, and Medicaid covered approximately 72 million individuals and accounted for approximately $582 billion in health care spending.[2]

These coverage numbers represent a significant shift over the past decade. Medicare has had relatively stable enrollment growth in its core populations of individuals aged 65 years or older and individuals younger than 65 years with end-stage renal disease, amyotrophic lateral sclerosis, or disabilities. However, the proportion of Medicare beneficiaries enrolled in private Medicare plans (ie, Medicare Advantage), which are administered by private insurance companies, has increased to approximately one-third in 2018.[5] Even more marked changes have taken place in Medicaid. Medicaid is a heterogeneous program and covers children, pregnant women, and adults living in poverty or with disabilities.

Table. US Health Care, 2017

Measure	Data
US population[1]	325 Million
Health care spending, by coverage, $[2,3]	
Commercial/private insurance (197 million covered)	1.2 Trillion
Medicare (57 million covered, approximately one-third by Medicare Advantage)	706 Billion
Medicaid (72 million covered)	582 Billion
Health care spending, by type, $[2]	
Total	3.5 Trillion
Hospital care	1.1 Trillion
Physician/clinical services	694 Billion
Retail prescription drugs	333 Billion
Health/residential/personal care services[a]	183 Billion
Nursing care facilities and continuing care retirement communities	166 Billion
Dental services	129 Billion
Home health care services	97 Billion
Other professional services[b]	97 Billion
Nondurable medical products[c]	64 Billion
Durable medical equipment[d]	54 Billion

[a] Includes mental health and substance abuse facilities, ambulance services, and medical services in schools, community centers, and workplaces.

[b] Includes independent health care practitioners and services (excluding physicians and dentists) such as physical therapy, optometry, podiatry, or chiropractic care.

[c] Such as over-the-counter medicines, medical instruments, and surgical dressing.

[d] Such as eyeglasses, contact lenses, and hearing aids.

Although children represent approximately 44% of Medicaid recipients (34 million of a total of 72 million), they account for only approximately 19% of the cost.[6] Medicaid has expanded substantially with the passage of the Affordable Care Act, with an increase in the number of individuals covered from approximately 50 million in 2010 to an estimated 76 million by 2020, as additional states have indicated that they will expand Medicaid.[7]

Across these payers, how does the United States spend $3.5 trillion in health care dollars? Various estimates are available, but overall, hospitals account for approximately 33% of spending,[1,2] physician and clinical services approximately 20%,[1,2] and prescription drugs (including retail, ambulatory, and hospital costs) about 18%.[8] Skilled nursing facilities, nursing homes, dental care, home health care, other health and residential care services (such as mental health and substance abuse facilities and ambulance services), and durable and nondurable medical equipment also contribute to the $3.5 trillion, but virtually none of those services or products individually exceed 5% of total expenditures.[1,2] An additional important expense involves the cost of medical devices, and with a continued increase in the number of hip and knee replacements each year, and expanding use of devices like transcatheter aortic valves and mitral valve clips, it is likely that the cost of devices, like the costs of drugs, will increase substantially in the coming years.

Because of efforts to reduce costs and improve quality, the past 8 years have seen a number of new initiatives in payment reform. For example, the Centers for Medicare & Medicaid Services has been at the center of a major transition to value-based payment via many programs created or expanded under the Affordable Care Act. These include mandatory hospital-based programs like the Hospital Readmissions Reduction Program, voluntary programs like accountable care organizations and bundled payments, and ambulatory care payment programs like the Merit-based Incentive Payment System.[9-12] At the state level, there has been additional experimentation, including global budgeting in Maryland[13] and a rural hospital global payment model in Pennsylvania,[14] among others. Private insurers have also been involved, with major shifts toward value-based care, innovative delivery models, and new experiments in vertical and horizontal integration. Care delivery organizations have consolidated substantially as well. In part because of this complexity, it is difficult to estimate the percentage of the US insured population that receive care under a value-based or alternative payment model, although it is clear that the proportion continues to increase.

Even though the Affordable Care Act and the health care industry in general have been modestly successful at improving coverage, there has been less progress in improving quality or reducing health care costs. Most delivery system reform efforts have been iterative rather than transformative, although it may be too early to assess whether these efforts are at least setting the stage for more major and sustained effective subsequent changes. Nonetheless, even though current health statistics do not necessarily reflect the entire health of a nation, the recent decline in life expectancy,[15] the recent increase in cardiovascular disease deaths and prevalence of cardiovascular disease morbidity and mortality,[16] the ongoing epidemic of opioid-related deaths,[17] and the sustained high prevalence of obesity in the United States, with substantial differences by race, ethnicity, and extent of urbanization,[18-20] raise the issue of whether the United States is addressing the health of its population effectively and spending $3.5 trillion wisely.

Many potential solutions have been proposed or may be possible. Some may be market based and some may rely more on regulation; some may prioritize population health and wellness and others may focus on innovation in technology and cures. All will require difficult choices, compromise, and prioritization. Simply spending more on health care will not be an effective approach.

The new *JAMA* series on health policy will consist of scholarly and evidence-based Viewpoints that will focus on solutions aimed at controlling health care costs, expanding access to care, and improving quality and value, with an emphasis on needed modifications of current health care programs and policies, and analysis of various proposals introduced by governmental agencies and by presidential candidates. In the first article in this series, Schulman and Milstein[21] discuss the implications of proposals that advocate for a "Medicare for all" approach for US health insurance as it would relate to hospitals. The authors explore the potential ramifications of a universal application of Medicare payment rates to hospitals, which currently account for the largest share of US health care spending. As epitomized by this scholarly Viewpoint, the goal of this new series is to ensure robust, enlightened, and meaningful discussion and debate about how health care should be paid for and delivered in the United States—not just for today or in 2020, but importantly, well beyond.

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