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Invited Commentary | Equity, Diversity, and Inclusion

Reforms to Support the Health Care Industry to Address Adverse Health–Related Social Factors

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The US Healthy People 2030 vision is "a society in which all people can achieve their full potential for health and well-being across the lifespan,"[1] yet the US health care system and its financial underpinnings are not designed to meet the medical and social needs of patients and communities.[2] Using 2021 Medical Expenditure Panel Survey data, Mohan et al[3] found that social determinants of health (SDOH) were associated with health care expenditures by insurer. Lower educational attainment, economic insecurity, medical discrimination, and lower availability of parks were associated with higher expenditures. Mohan et al[3] conclude SDOH could be used by health insurers and policymakers to identify and control health care expenditures and advance health equity.

Why, then, have health care industry efforts to address adverse SDOH been so limited? What policies could support and incentivize the health care industry to address SDOH sustainably at scale?

Addressing adverse SDOH has great societal value for our nation's health and economic future, but the health care system's financing structure is not designed to maximize everyone's health.[1] The case for the health care industry addressing adverse SDOH is premised on 2 assumptions: that the health care system's goal is to maximize patient and community health and well-being and that the nation and health care system care about the health and well-being of all persons. Unfortunately, too often that is not the case.

We would all be better served by a comprehensive paradigm, akin to the Indigenous approach, viewing health and well-being more holistically and incorporating SDOH and our relationship with land, sea, climate, and ecosystem.[1] Today's business case for payers, health insurance plans, and health care delivery organizations to address adverse SDOH is too weak.[1] Most health care systems work under rules and incentives that reward generating revenue from patients covered by higher-paying insurers, rather than caring for the entire community. When outcomes and quality of care are considered, institutions usually concentrate on traditional clinical performance metrics rewarded by payers, such as childhood immunization rates or diabetes control, rather than more holistic measures of community health and well-being, such as healthy days at school and work.

Troyen Brennan, MD, JD, Executive Vice-President and Chief Medical Officer of CVS Caremark Corporation, stated: "As a hospital executive, your key strategy, perhaps your only strategy, has been to increase in size, gain leverage with insurers, bargain for better fee-for-service rates, and do more procedures."[4] While in theory the value in value-based care represents a ratio of overall benefit to cost, in practice, health care institutions' organizational behavior emphasizes the financial cost denominator, a phenomenon exacerbated by health care's financialization and rise of private equity.[5]

The second incorrect assumption is that the nation and health care system care about every person's health and well-being, including those in marginalized communities. While polls show that two-thirds of the public agree that "our society should do whatever is necessary to make sure that everyone has an equal opportunity to be healthy,"[2] supporting policies have not followed. Health care delivery organizations that would like to advance health equity view the incentives to do so as weak. A foundational problem is that we tolerate a multitiered health care system where some persons are uninsured or underinsured, creating perverse incentives for health care delivery organizations to limit care for underresourced, marginalized, and racially and ethnically minoritized populations, such as patients with Medicaid insurance.[6]

We must change the rules to enable addressing SDOH, and implement regulations and incentives that create a business case for each industry stakeholder, including payers, health plans, and health care delivery organizations, to maximize health and well-being of all patients and communities.[1,2,6,7] A mission-driven business case would reward social return on investment (SROI), which emphasizes a holistic vision of community health and well-being, rather than narrow financial ROI. Stakeholder priorities should include caring for overall geographic populations and managing total cost of care to incentivize providing high-value care and eliminating waste.[1,4] Yet, many health care delivery organizations caring for underinsured patients and those with more social risk prioritize shifting costs to more highly reimbursing payers or increasing the percentage of highly-reimbursed patients in their payer mix. Moreover, business time horizons must shift from short-term financial gains for themselves to medium- and long-term value to the community.

Payment reforms to create the business case require expanding access to health insurance and resourcing the Medicaid program to support care that can adequately address medical and social needs.[6] All-payer rate systems such as in Maryland, where reimbursement rates are the same across payers, reduce perverse incentives to avoid caring for underinsured and complex patients.

Additionally, payment and policy levers can work synergistically to support the business case, including[1,2,6,7] (1) paying for reducing disparities and advancing health equity, like what private payers such as Blue Cross Blue Shield Massachusetts and some state Medicaid Accountable Care Organization (ACO) programs do; (2) flexible funding to address adverse SDOH (eg, 1115 waivers in Oregon, California, and North Carolina allow Medicaid funds to pay for community navigators, community-based organizations that address SDOH, and enabling services such as transportation); (3) risk adjusting payment for social risk to provide additional resources to care for patients with more health-related social needs, such as in the Medicaid ACO programs of Massachusetts and Minnesota; and (4) total cost of care systems, such as in Maryland, which hold health care systems responsible for the total cost and quality of care of a defined population; this creates much stronger incentives to address health-related social needs and invest in structural SDOH interventions to decrease costly health care visits and hospitalizations.

These financing and payment reforms are designed to support and incentivize activities that holistically address patient and community health and advance health equity. Activities can focus on health care, unmet health-related social needs (eg, screen individual patient for economic insecurity), and systemic, structural adverse SDOH (eg, partner with broad coalitions to tackle problem of economic insecurity in communities).[2] The health care industry should address all 3 collaboratively with cross-sector partners, including community-based organizations, to maximize community health and well-being.

The Centers for Medicare and Medicaid Services (CMS) States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model addresses adverse SDOH, drawing upon these 4 payment and policy levers, especially as operationalized in the Maryland Total Cost of Care, Vermont All-Payer ACO, and Pennsylvania Rural Health Models.[4] While promising, AHEAD has limitations. Challenges include getting private payers to participate if they believe they can financially profit more from opportunities in other parts of the market that do not prioritize SROI, competing diametrically opposed incentives from fee-for-service in many markets, and limited state experience in population health management and cost control needed for successful implementation.[4]

Wider public and political support for maximizing community health and well-being and advancing health equity is essential.[2] Multisectoral national and state initiatives are aligning payment and care transformation with SROI and health equity. For example, the CMS Health Care Payment Learning and Action Network Health Equity Advisory Team and Robert Wood Johnson Foundation Advancing Health Equity: Leading Care, Payment, and Systems Transformation program are developing, implementing, and evaluating such efforts. To succeed, we must all affirm that the purpose of the health care system must be, first and foremost, to maximize health and well-being for all, and align the business case for the health care industry with this national imperative.

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