SOLUTIONS BRIEFS

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SUSTAINING CAPITALISM

A series focused on nonpartisan, reasoned solutions in the nation's interest to the central challenges we face in order to provide prosperity for all Americans.

Health Care Policy After the Pandemic

Both the rising cost of health care and increasing utilization of it as the population ages are driving greater health care spending. Total US health care spending, both public and private, comprises nearly one-fifth of GDP and, relative to GDP, is continuing to rise. Cost, while important, is not, however, the only factor in health policy reform. Also critical is whether the nation is receiving value for money and what policy reforms will deliver greater quality and more affordable, accessible care for all in the wake of the pandemic.

This Solutions Brief addresses a series of urgent and major health care policy issues as the Nation has emerged from the pandemic with the ending of the Public Health Emergency (PHE) on May 11, 2023.

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- **According to the Congressional Budget Office (CBO), federal spending on health care programs was 6.6 percent of GDP in 2022; by 2052, CBO expects that share to rise to 10.2 percent of GDP.** Health care programs, such as Medicare and Medicaid, are the largest drivers of our national debt, which stands today at $33 trillion (at a ratio of 100 percent debt to GDP). Spending for health care programs is expected to exceed all other categories of federal spending by 2030. Aging of the population accounts for one-third of that growth; two-thirds is additional cost growth in the programs themselves, demonstrating the urgency of significant cost reforms.

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- **Spending on Medicare is projected to account for more than four-fifths of the increase in spending on major health care programs** over the next 30 years as a percentage of GDP, according to CBO.[1]

- **Medicare's Hospital Insurance (HI) fund is expected to end full payment of benefits in 2031.** In the event of insolvency of the HI fund, mandatory spending cuts beginning at 11 percent would occur. For fiscal year 2023, Medicare is projected to spend $820 billion. Costs for Medicare will likely rise with the approval of new innovative treatments, for instance for Alzheimer's Disease.

- **Medicaid for fiscal year 2023 is projected to spend $589 billion.** CBO estimates that the federal share of Medicaid will grow to $879 billion by 2033, about 2.2 percent of US GDP, a significant and growing share of overall national health spending and a growing need for this assistance in the US.

- **Enrollment trends and policy changes can affect Medicare's costs.** Medicare Advantage (MA) Plans cover 56 percent of all beneficiaries and will likely cover 69 percent by 2032. Premiums in traditional Medicare have grown, but premiums for MA enrollees have declined since 2015. Regular primary care visits for Medicare beneficiaries lead to savings for the system as a whole and higher savings for more complex clinical cases as problems can be addressed early.

- **While pandemic relief legislation prohibited states from disenrolling people from Medicaid, once that provision expired with the end of the public health emergency, states have begun disenrolling people ("Medicaid redetermination").** Adding urgency to reform, in 2022, the percent of Americans without health insurance fell to 7.9 percent, but this was because pandemic-era provisions on Medicaid remained in place. However, the Congressional Budget Office expects that the percentage of uninsured will rise to 10.1 percent by 2033[2] as these provisions are sunset.

- **Medicaid spending has a strong impact on private health care providers as well as the budget.** More than 70 percent of people enrolled in Medicaid are in managed care organizations. From March 2020 to June 2022, enrollment in these plans grew by 38.3 percent, from 30.1 million to 41.6 million.

- **States have had sharply differing outcomes in Medicaid redetermination.** Virginia has handled Medicaid redetermination well, automating 66 percent of renewals and rejecting only seven percent of reapplications for procedural concerns. In contrast, Texas, has automated fewer than one percent and by August had disenrolled 66 percent because of paperwork issues.

- **When the waiver of a regulation over the course of the pandemic resulted in greater access to care, the regulation should be a strong candidate for permanent repeal.** For example, telehealth expanded access to the more than 61 million Americans who live in rural areas. Waivers of state and federal regulations (which in the past prevented wider use of telehealth) should be permanently extended.

- **The nation faces an acute health care workforce shortage in all sectors and at all levels, which persists after the pandemic:** a possible physician shortfall of 124,000 by 2033 and possible shortages of 3.2 million medical assistants, home

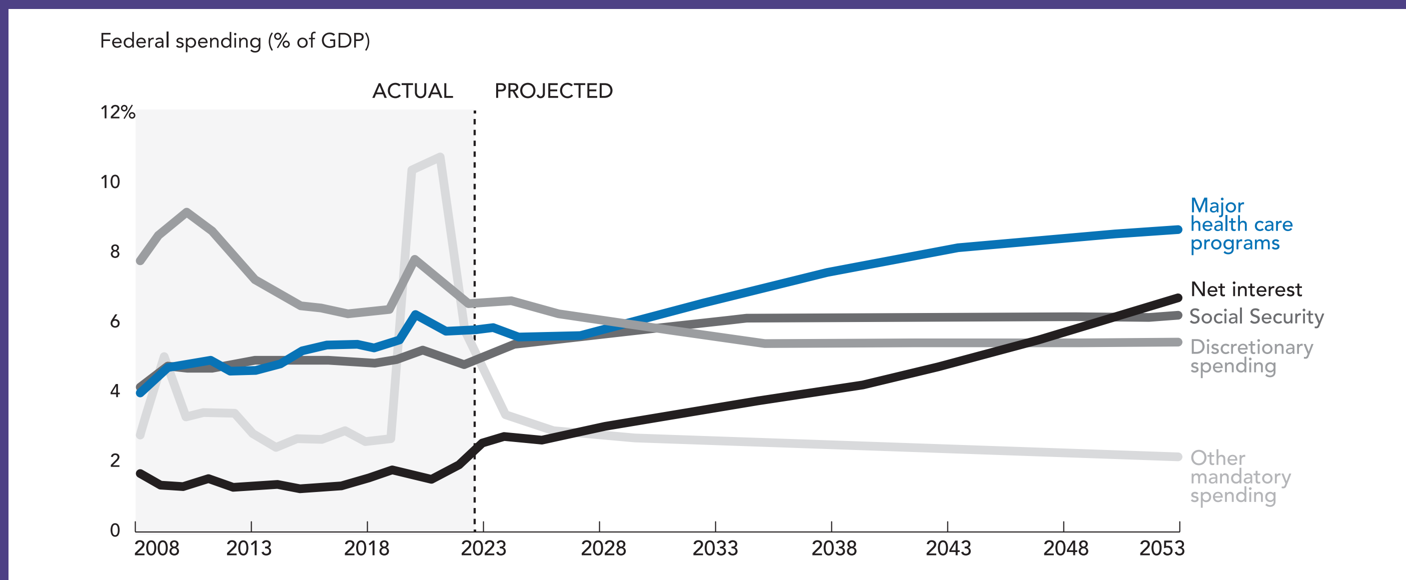
health aides, and nursing assistants by 2026. The post-acute sector was hit hard during the pandemic, with insufficient reimbursement and staffing 13 percent below prepandemic levels.

- **The US also faces significant challenges in supply chains for pharmaceuticals which could lead to shortages of key drugs.** This is a national health security imperative. China holds about 40 percent of the global market for active pharmaceutical ingredients; the US share is about 14 percent. Over the last decade, China has increased its share of the US penicillin market to 52 percent (from 1 percent) and to 37 percent (from 14) in the market for antibiotics. According to HHS, about 90–95 percent of generic sterile injectable drugs used for critical acute care in the US rely on key starting materials from China and India.

This Solutions Brief will examine and propose solutions in these areas, with the goal of developing a system based on cost-responsible consumer choice among competing private health care plans to drive the US health care system toward quality, affordable care for all.

Figure 1

Spending for the major health care programs will continue to climb rapidly over the long term



Source: Peter G. Peterson Foundation, 2023, Congressional Budget Office, The 2023 Long-Term Budget Outlook, June 2023. Note: The major health care programs include Medicare (NET), Medicaid, the Children's Health Insurance Program, and spending to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act and related spending.

Recommendations

CED has long advocated a shift in health care from a fee-for-service model to one that promotes cost-responsible consumer choice among competing private health care plans. Such a shift would drive the system toward quality, affordable health care for all, in a more connected system that encourages strong patient care outcomes holistically, through innovations such as team-based care. CED also continues to support recommendations from our previous Solutions Briefs on the pandemic. These include taking urgent action to address shortages in the health care workforce and health care supply chains, undertaking a review (in conjunction with the private sector) of regulations waived during the pandemic to see which may be repealed permanently without harm to quality of care, and expanding telehealth, a success of the health care system during the pandemic.

The federal budget for health care programs is projected to rise by 78 percent over the next decade and will exceed all other categories of federal spending in 2030. Reforms in cost and quality of care are urgent priorities that private and public sector leaders must address. Following are recommended pathways forward:

Addressing Medicaid

- Automating the system will ensure more accurate coverage decisions. No one should receive public funding who is not entitled to it, but no one who is entitled to it should be cut off because of paperwork issues.
- Given the risks, states may also wish to look for alternatives to quick unwinding that would inaccurately determine coverage and consider other pathways for coverage.
- States should consider restricting the use of provider taxes to finance Medicaid; a step which has the potential to save $600 billion over ten years, according to the CBO.

Reforming Medicare

- Medicare Advantage offers many benefits for beneficiaries, but policymakers should consider if benchmarks can be reduced without harming enrollment or patient care.
- Policymakers should consider other ways to reduce costs, including updating premium support models and examining drug spending to achieve cost savings that will not impact the quality of care. Policymakers should be cautious on proposals for automatic reimbursement of innovative therapies approved by FDA.
- Policymakers and insurers should reinvigorate efforts against waste and fraud in the system.
- Policies encouraging the utilization of primary care will save money in the long run.

Regulatory reform

- Policymakers should use smart regulation in developing postpandemic regulations; the Department of Health and Human Services (HHS) should review the pandemic waivers to determine which waivers should be made permanent and which regulations may be eliminated.

- Telehealth, along with increasing reimbursement, was a success in the pandemic and should be expanded as widely as possible with necessary guardrails.
- Dedicated funding will best ensure the success of higher minimum standards in the postacute sector.

Workforce challenges

- A greater focus on developing and retaining primary care physicians is essential, along with accelerated efforts to reach traditionally underrepresented groups including targeted recruitment efforts and steps to encourage careers in health care early in education.
- Immigration reform will help resolve shortages. Immigrants already comprise a strong proportion of the US health care workforce.
- Expanding training and professional development opportunities strongly encourages retention. Apprenticeships show realistic opportunities for careers in health care.
- Congress should consider grants to expand places at nursing schools to relieve the nurse shortage.
- Team-based care will help ensure that all health care workers are practicing "at the top of their license," make the profession attractive through opportunity for greater responsibilities, and help relieve physician burnout. Medical schools should teach team-based care.
- States should consider modernizing their scope of practice regulations.
- Public-private partnerships can expand the health care workforce quickly. Businesses can partner with training programs in community colleges and public universities to target communities with shortages of workers, work with them on developing curricula, and ensure that graduates have jobs upon graduation.

Supply chains: A national health security imperative

- Building pharmaceutical supply chains for resilience and redundance is a national health security imperative involving both incentives for domestic production and nearshoring and friendshoring, including throughout the Western Hemisphere.
- Both business and policymakers should seek new linkages to diversify medical supply chains of all types.

A future system

- Policymakers should pursue reforms that will promote cost-responsible consumer choice among competing private health care plans, with the goal of driving the system toward quality, affordable health care for all in a more connected system that drives strong patient care outcomes holistically.
- The shift away from fee-for-service is, ideally, a shift toward some form of value-based pricing, whether in the public sector or through private insurers, so that consumers can make informed decisions. Further study and innovation with value-based models will help push the system toward a focus on overall wellness.

- A greater focus on preventative care and wellness, rather than treating problems once they occur, will improve the quality of health care and overall health outcomes and lower costs in the system over time.

Ending the Public Health Emergency

On May 11, 2023, the declaration of the national Public Health Emergency (PHE) for the COVID-19 pandemic came to an end.[3] Under the PHE, the Centers for Medicare and Medicaid Services (CMS) issued over 100 waivers of regulations applicable to any health care facility that receives Medicare or Medicaid funding. Many of these waivers were matched by private insurers, extending their reach. Now, both health care providers and patients are adapting to the new reality.

While some changes were relatively minor, affecting the provision and reimbursement for COVID-19 related treatment, others that affected areas such as the scope of medical practice, staffing, patient safety, and other aspects of health care systems have forced major changes in health systems operations. A few waivers that began under the PHE will continue,[4] either from congressional legislation or HHS determinations. For instance, Congress continued CMS' Acute Hospital Care at Home Initiative. Originally designed to help hospitals address a surge in COVID-19 patients, the initiative provides inpatient care in an individual's home at Medicare reimbursement rates through December 31, 2024. Separate provisions of the Omnibus appropriations act for fiscal year 2023 delayed proposed Medicare cuts for physician reimbursement and extended pandemic flexibilities on telehealth and acute home care for two years. However, telemedicine coverage is also subject to state rules on the practice of medicine, limiting the impact of the extension. CMS also extended the waiver permitting virtual supervision, rather than physical presence, by a health care professional until December 31, 2023.

Medicaid Redetermination

The most important impact of the end of the PHE—for millions of Americans and for the federal budget—concerns Medicaid, the federal/state program providing health care for the poor. The Families First Coronavirus Response Act (FFCRA) offered states additional federal funding in exchange for guaranteeing that Medicaid recipients would retain coverage during the pandemic. Now, with the expiration of the national PHE, Medicaid's "continuous enrollment" provision has ended.

Medicaid is a joint federal-state program; the federal government bears a share of costs according to the Federal Medical Assistance Percentage (FMAP) formula, typically ranging from 50 to 83 percent of program costs. The FFCRA boosted this percentage across the board by 6.2 percent until the end of the PHE.[5] The law also included a "continuous coverage" requirement that prohibits states from terminating enrollees' coverage unless they ask to be disenrolled or move from the state. The Congressional Budget Office (CBO) estimated that the provisions would raise Medicaid spending by about $72 billion per year from 2020 through 2023.[6] Under the provision, the number of Americans enrolled in Medicaid and the Children's Health Insurance Program (CHIP) rose sharply. In February 2020, Medicaid/CHIP enrollment stood at 71.1 million. Enrollment

reached 92,340,585 in December 2022, a 30.7 percent increase, with more than one in four Americans covered under the program.[7]

In the Fiscal Year 2023 Omnibus Appropriations Bill, Congress ended the moratorium prohibiting states from terminating coverage for enrollees effective April 1, 2023. States must begin reviews to determine continued eligibility for Medicaid within 12 months and complete them within 14 months. While this is expected to save more than $22 billion, a portion of those funds will be reallocated within Medicaid to pay for two permanent expansions in coverage. First, states must continue providing 12 months of continuous coverage for children on Medicaid (or CHIP). CBO expects that expansion to cost roughly $230 million per year beginning in 2023. Separately, states have the option to offer 12 months of coverage to postpartum women, a provision set to expire in 2027.

In August 2022, the Department of Health and Human Services (HHS) estimated that 17.4 percent of Medicaid and CHIP enrollees (approximately 15 million individuals) will leave the program as a result of the end of the continuous enrollment provision, based on historical patterns of coverage lost. More specifically, HHS estimates that "[a]pproximately 9.5 percent of Medicaid enrollees (8.2 million) will leave Medicaid due to loss of eligibility and will need to transition to another source of coverage. Based on historical patterns, 7.9 percent (6.8 million) will lose Medicaid coverage despite still being eligible ("administrative churning"), although HHS is taking steps to reduce this outcome. Almost one-third (2.7 million) of those predicted to lose eligibility will likely qualify for Marketplace premium tax credits, with 60 percent (1.7 million) expected to be eligible for zero-premium plans in the Health Insurance Marketplace under the provisions of the American Rescue Plan (ARP). Another 5 million are expected to obtain employer-sponsored health insurance coverage.[8]

Policy Responses: Minimizing Coverage Losses, Medicaid Expansion

Minimizing coverage losses

The redetermination process is terminating coverage for those found to be ineligible. Administrative churning is another reason for lost coverage apart from ineligibility, which can occur if enrollees have difficulty navigating the renewal process, states are unable to contact enrollees due to a change of address, or other administrative hurdles. People of color and children are most at risk of losing coverage due to administrative churning despite eligibility status.[9]

Redetermination is proceeding. By August, over 4,000,000 people had lost coverage, and the Administration warned against people losing coverage because of paperwork problems, call center wait times, and slow processing.[10] By September 13, 2023, at least 6,438,000 Medicaid enrollees had lost coverage, with a national average of 36 percent disenrolled. State percentages on disenrollments vary widely, from 69 percent in Texas to 9 percent in Michigan.[11]

While Medicaid is a public health program funded through federal and state tax dollars, more than 70 percent of people enrolled in Medicaid are in managed care organizations. According to a 2022 report by the Georgetown University Health Policy Institute, the COVID-19

pandemic and pause on disenrollments allowed for robust growth of the nation's top five Medicaid managed care businesses. From March 2020 to June 2022, enrollment in Medicaid managed care organizations grew by 38.3 percent, from 30.1 million to 41.6 million.[12]

Along with Medicaid disenrollments comes the risk of financial losses for insurers and health care providers. Hospitals have been financially squeezed since the beginning of the pandemic, with higher labor costs amid the health care worker shortage and higher demand for care. Approximately half of US hospitals finished 2022 with a negative margin as growth in expenses outpaced revenues.[13] In addition to grappling with higher labor costs, hospital leaders worry that they may be left footing the bill of more uninsured patients as disenrollments occur, with many hospitals taking the proactive approach of informing enrollees about the upcoming eligibility reviews and steering them towards other types of coverage.

Any change affecting millions of people is difficult and time-consuming to implement. Additional complications result from the large number of people going through redetermination and the Medicaid reenrollment process for the first time and who may not have provided updated or correct contact information to the state Medicaid agency, leading to procedural errors.[14] Before the expiration of the PHE, CMS issued a proposed rule on Ensuring Access to Medicaid Services that recommended actions to avoid wrongful termination of Medicaid coverage and offered states toolkits to improve access to health care through Medicaid.[15]

One state that has handled the process well thus far is Virginia. As of September, the Commonwealth had processed nearly 900,000 applications, over one-third of the total necessary, and denied only under seven percent for procedural concerns.[16] Virginia automated the system, eliminating problems that can arise when paper forms lead to wrongful disenrollment. Virginia was able to automate 66 percent of renewals, a sharp contrast to Texas, which automated fewer than 1 percent of renewals and disenrolled 66 percent (over 400,000 people) by August because of paperwork issues. In Indiana, up to 86 percent of initial removals were done on procedural grounds.[17] Personalized outreach can help ensure accurate determinations of eligibility, but it is expensive.

No one should receive public funding who is not entitled to it, but no one who is entitled to it should be cut off because of paperwork issues. Automating the system will ensure more accurate coverage decisions. Given the risks, states may also wish to look for alternatives to quick unwinding. Oregon[18] and Washington decided to permit children under six to remain in Medicaid without requiring renewal, even if their parents lose coverage. Waivers for State Medicaid programs that permit states to measure the health effects of housing, nutrition, and other services for eligible Medicaid beneficiaries enjoy strong bipartisan support and have the potential to lower costs while driving positive health outcomes.

With evidence that coverage disruptions enhance mortality risk and coverage expansion benefits positive health outcomes in areas such as maternal and mental health,[19] states should consider new options for coverage, including 12-month enrollment. Twenty-three states offer this enrollment for children to reduce "Medicaid churn" without drastic expansion of costs, as most enrollees in the program were relatively healthy; New York has offered something similar.[20]

Medicaid expansion

Another policy response is formal expansion of coverage under the Medicaid program to new states. The Affordable Care Act (ACA) gave states the option to expand Medicaid coverage to nearly all adults with incomes up to 138 percent of the Federal Poverty Level and provided states with an enhanced federal matching rate (FMAP) for their expansion populations. To date, 41 states (including DC) have adopted Medicaid expansion, including six that have implemented it since the pandemic began (Arkansas, Missouri, Montana, Nebraska, Oklahoma, and South Dakota). North Carolina adopted a law to expand Medicaid but has not yet begun implementation.

After a favorable court decision, Georgia also began its "Georgia Pathways" partial expansion in July. That program has a mandatory work or "community engagement" requirement and will cover only those with incomes up to 100 percent of the Federal Poverty Level, rather than 138 percent. As a result, the state will receive a considerably smaller share of federal matching funds, and its expansion is projected to cover only 64,000 people rather than an estimated 477,000 in a traditional expansion, likely leaving the state with higher administrative costs to cover fewer people.[21]

Costs

Rising costs remain a significant issue for the program as a whole. The federal government spent $592 billion on Medicaid in 2022. As states have expanded Medicaid, federal spending on the program has risen as well. CBO estimates that the federal share of Medicaid will grow to $879 billion by 2033, about 2.2 percent of US GDP. Even as Medicaid has expanded to include new states, it will be important to consider ways to introduce greater cost discipline in the program without harming service or beneficiaries, including greater efficiency of responsibilities between the federal government and the states.

Some states are increasingly financing their share of Medicaid through means other than general revenues, such as taxes on providers. By increasing state revenues, this raises the federal matching share as well, leading to higher federal Medicaid costs. The Congressional Budget Office believes that restricting states' use of provider taxes to finance state Medicaid programs could save $600 billion over ten years.[22] Greater transparency and better data collection are important here. More generally, CBO estimates that spending caps on the federal portion of Medicaid could save between $501 billion and $836 billion over ten years[23]—but this would put greater pressure on states and likely lead to significant reductions in services as the population ages unless states are willing to increase Medicaid budgets, as well as withstand a negative impact on the managed care organizations with which states contract for Medicaid.

More fundamentally, as one former Medicare trustee has noted, "[t]he problem is not a lack of spending; it is how the money is being spent"; Medicaid should work for its beneficiaries, and states should "have the flexibility to design health solutions that work well for their residents."[24] Developing those reforms will require major attention from policymakers in the years ahead.

Medicare

In 2020, 17 percent of the US population was 65 or over and thus eligible for Medicare; by 2060, that share is expected to grow to 23 percent. Within that cohort, the number of older elderly (80 or above) will also rise, from one-quarter in 2020 to one-third of all elderly people by 2060,[25] which will sharply increase the cost of care. For the next 15 years, more people will convert to Medicare in America than people being born. The pipeline of costs for the American taxpayer over the next twenty years will continuously put pressure on HHS and Congress to enact measures to curb national health care spending.

The need for action is urgent. While Medicare spending was lower than expected in 2022, part of this resulted from excess deaths among the elderly during the pandemic. Higher inflation will raise the level of payroll tax receipts supporting Medicare in the short run; however, this will be more than offset by the inflationary effect on the cost of care. While the overall picture has improved somewhat, Medicare trustees reported earlier that Medicare's Hospital Insurance (HI) fund, financed through the Medicare payroll tax, will be technically insolvent in eight years (2031), an improvement from the earlier estimate of 2028. They expect that total Medicare spending will grow from its current rate of 3.7 percent of GDP to 6.0 percent by 2046.[26] In the event of insolvency in the HI fund, mandatory spending cuts beginning at 11 percent would occur. Other parts of Medicare, including reimbursement to physicians and prescription drug benefits, are financed both through premiums paid by beneficiaries and contributions from general federal revenues. These costs will also rise, putting greater pressure on beneficiaries, who generally pay these premiums through deductions from their Social Security payments.

Medicare Advantage

The Medicare Modernization Act of 2003 shifted Medicare to accelerate the growth in private plans covering Medicare beneficiaries. When beneficiaries enroll in a Medicare Advantage (MA) plan, Medicare pays a fixed amount to the plan which supports the beneficiary's participation in Part A (hospital), Part B (physician), and sometimes Part D (prescription drug) coverage; plans often include benefits for vision, hearing, and dental care as well. MA has grown rapidly since its inception. It had already reached 11 million (24 percent of) beneficiaries by 2010 and 56 percent by 2022; it is expected to reach 69 percent of all beneficiaries by 2032.[27]

There are many reasons for this shift. One benefit is cost discipline. Premiums in traditional Medicare have grown, but premiums for MA enrollees have declined since 2015.[28] One study of more than 9,000,000 beneficiaries found that for conditions involving ambulatory care, participants in MA plans were less likely to be hospitalized and more likely to receive observation stays and direct discharges, saving expenses on the system.[29] However, another study found that in 22 of 33 [interventions] studied, there was lower utilization among MA beneficiaries, though that study did not examine whether this was the result of underlying health conditions that might have led to hospitalization and thus did not determine the reason for lower utilization.[30]

The Affordable Care Act of 2010 provided reductions in benchmark payments to plans to redress spending imbalances between MA and traditional Medicare and thus avoid skewing enrollment to MA. But MA continued to grow, as more and more beneficiaries

prefer participating in private plans, often offered by the same companies that offered insurance in their working years. MA plans can offer real value for money for beneficiaries, showing that market competition in health care can work as insurers work to reduce costs while preserving benefits.

Cutting costs in Medicare

None of this changes the need for Medicare to consider significant reform, however. One idea that has been considered is premium support, under which Medicare would provide a single sum for all beneficiaries, including those in traditional Medicare. (This idea was discussed in the Breaux-Thomas Medicare Commission in 1999, by Rep. Paul Ryan and Senator Ron Wyden in 2011, and elsewhere.) Premium support offers the potential to reduce the growth in Medicare costs, but the proposals need to be reexamined in light of today's health care markets and refined to consider methods to determine the level of premium support, how support would differ in different parts of the country, and how to address current beneficiaries in traditional Medicare. Medicare's testing of the Making Care Primary Model in eight states to help improve care coordination between primary and specialist care should be encouraged to improve health care outcomes while lowering costs,[31] while taking into consideration the wide variation in costs among regions of the country.

Another idea is to reduce the benchmarks paid to MA plans, which CBO estimates would save $392 billion over ten years.[32] But how to do this without reducing the attractiveness of the plans to both beneficiaries and participating plans will be challenging. While MA seeks to reduce the growth in spending and deliver better care through the use of benchmarks, it is also true that if sicker beneficiaries opt for traditional Medicare, this leads to underpayments in counties where MA plans have less market share and overpayments in counties where the plans have higher market share." One analysis suggests this led to overpayments of up to $10 billion between 2017 and 2020. And indeed, up to 80 percent of MA's growth since 2020 results from beneficiaries switching from traditional Medicare, while those who switch from MA to traditional Medicare tend to be less healthy.[33] Happily, one study found that cuts did not reduce growth in enrollment,[34] offering the possibility that cost reductions and MA enrollment growth are compatible.

MA plans that receive a high star rating (on Medicare's five-star quality rating system) for quality receive a bonus; 83 percent of MA beneficiaries were enrolled in plans earning a bonus in 2020, costing the US $6 billion that year and $10 billion in 2022. Policymakers should examine the current quality bonus payment system, which is tied to MA contracts rather than a specific local area, to ensure that bonuses are well deserved and evaluate quality differences in local markets, given the important role of local health networks in overall quality.[35] This emphasis on quality should characterize the health care system as a whole, so that consumers are able to choose well among competing health care plans.

Drug spending offers opportunities for reductions in Medicare costs as well. One study showed that some of the most popular drugs for which Medicare paid (accounting for $19.3 billion in spending in 2020) did not provide notably higher therapeutic value when compared to others whose therapeutic value had been studied by Canadian and European regulators. Even using the most favorable benefits in the comparison, these findings raise the question of whether less costly drugs can offer essentially equivalent

therapeutic benefit or whether prices on these drugs can be lowered under the provisions of the IRA.[36] The inflationary rebates in the IRA also offer some savings. Had the provisions been in effect from 2018–2020, they would have saved $3.7 billion, according to one study.[37] But capping the cost of drugs could also have a negative impact on US R&D, which is a major strength of the US system. Finding the balance here will be challenging.

Costs for Medicare will likely rise with the approval of new innovative treatments, for instance for Alzheimer's Disease. Policymakers will need to address the challenge of incorporating new drugs and technologies into federal health programs. Private employers and insurance plans will not be able to absorb the entire costs of new therapies. To ensure that the cost of new therapies to push patients out of the market for commercial insurance, there should be some way to neutralize the cost. Perhaps the closest analogy is Medicare's End Stage Renal Disease program, under which patients suffering permanent kidney failure are in many cases eligible for Medicare irrespective of age.[38]

Some bills in Congress would essentially require Medicare to cover any FDA-approved therapy rather than exercising discretion through CMS' own review process. For instance, the Ensuring Patient Access to Critical Breakthrough Products Act would require four years of Medicare coverage for medical devices that FDA deems "breakthrough" devices, even if they have been through only Section 510k equivalence review rather than a formal premarket approval process. Similarly, the Access to Innovative Treatments Act would permit a review process when CMS declines to cover treatments approved by FDA.[39] Caution in this area is warranted.

Advances in technology will also positively affect costs in Medicare, for which planners must account. The rise of artificial intelligence (AI) will bring efficiencies to the system, both in administrative services and clinical tools. AI tools for health care administration can automate billing systems and other tasks and help organize and analyze large quantities of data, potentially reducing administrative costs significantly. Clinical tools can help doctors with diagnosis and recommend a course of treatment.[40] Each type of tool will free physicians and other health care professionals to focus on the most important tasks for which they were trained, helping improve health care outcomes for patients (which will itself reduce costs in the system) and help avoid clinician burnout.[41] Robotics is another area of innovation; the global robotics market in health care is expected to reach $12.7 billion by 2025, including robots used for routine surgeries, for completing routine logistical tasks, and for performing services such as cleaning hospital rooms and assisting with patient rehabilitation.[42] Increasing use of robots in health care can reduce the cost of care while enhancing health care technology.[43]

Unfortunately, fraud persists in the system. The Government Accountability Office continues to warn of high levels of waste and fraud in both Medicare and Medicaid. A renewed effort to attack this problem, including robust enforcement strategies, will help ensure that increasingly scarce funds are used to help beneficiaries.[44]

Sometimes, however, it requires spending money to save money in the long term. One study found that regular primary care visits for Medicare beneficiaries led to savings for the system as a whole and higher savings for more complex clinical cases[45] because problems could be addressed before they became acute or require hospitalization.

Reforming Medicare cannot be done without hard choices. Simply crediting savings from prescription drug pricing to the HI fund, as the Administration has proposed, would permit higher HI fund spending (as it would postpone the fund's insolvency) but not actually address the underlying issues. Instead, new and expanded spending should be fully financed.[46]

In all events, Medicare will need to slow the growth of its spending, raise the age at which beneficiaries become eligible for Medicare, or find additional revenues. The problem is urgent. As former Medicare Trustee Charles Blahous has written, "Medicare finances are not simply a matter of abstract lines plotted on graphs. There are real people behind all these numbers, and they suffer real hardship so long as Medicare finances remain uncorrected."[47]

Regulatory Reform

Another important part of building a strong post-pandemic health system concerns regulatory reform. There are, of course, many strong reasons why health care should be regulated: physicians should be licensed, drugs and medical devices must be evaluated for safety and efficacy before use, and hospitals receive enormous amounts of federal funding. As the regulatory waivers during the pandemic illustrate, the need for and the possibility of genuine regulatory reform in health care also exists, so that the system can move quickly to address growing public health needs.

CED has long advocated the principle of "smart regulation"[48]—the idea that regulation should achieve the purpose for which it was imposed at the lowest possible cost and with the maximum possible benefits. Smart regulations are well designed, using appropriate subject matter experts at the outset, and must be reviewed, revised, or sunsetted, particularly given the rapid pace of technological change. The process of adopting these regulations requires strong input from all stakeholders who have expertise in how they would be implemented in practice, including from those who would be subject to the regulations, and the process of reviewing regulations likely requires data on how those regulations are implemented in practice over time.

During the pandemic, hundreds of regulations, including some directly related to the practice of medicine, were waived or modified. This raises the question of whether the need for those regulations remains valid without harm to public health. CED's Solutions Brief *Preparing for the Next Public Health Crisis: Lessons from the Pandemic,*[49] recommended that the Department of Health and Human Services (HHS), in conjunction with the private sector, should undertake a comprehensive review of the exercise of regulatory flexibility during the pandemic. This recommendation remains valid. Public policy and business leaders should seize this opportunity for a clear, data-driven evaluation of the effectiveness of those regulations, including the balancing of benefits and costs. Public-private collaboration is essential in this effort, so that each side can understand the benefits and risks associated with regulatory policy.

An additional and related challenge concerns electronic health records. Both patients and providers have been frequently frustrated by how they work in practice. Greater

interoperability, transparency, portability, and cybersecurity are vital to ensure EHRs do not burden providers but provide easy access to information necessary for medical care.

Telehealth

The dramatic growth in telehealth was a significant feature of the pandemic years; telehealth usage grew 88-fold between 2019 and 2020[50] and has remained at high levels since. But because the states regulate the practice of medicine, changing policies on telehealth requires their cooperation. Telehealth can reduce costs for users; one study showed cost reductions of 23 percent compared to in-person care.[51] Telemedicine is one area in which pandemic-era easing of regulations has continued; prescription of controlled medicines via telemedicine is permitted until November 11, 2023, with a grace period until November 2024.[52] HHS and the Drug Enforcement Administration should renew that rule in response to high patient and provider interest as part of a comprehensive set of regulations on telemedicine.

Telehealth helps solve local health care workforce shortages, raises opportunities for care among the elderly and the more than 61 million Americans who live in rural areas, and connects patients to all types of care. Its availability should be expanded as much as possible, and Congress should give impetus to this reform[53] by supporting continued telehealth reimbursement across state lines in Medicare and Medicaid. While the Interstate Medical Licensure Compact[54] is a way forward in the interim by permitting multiple licensing on the payment of fees, reciprocal licensing among the states on the model of the Nurse Licensure Compact and South Dakota's law on physician licensing offer the best long-term solution.[55]

Post-acute sector

The post-acute sector, including 15,076 Medicare and Medicaid-certified facilities in 2022 serving nearly 1.2 million people,[56] was hit notably hard during the pandemic. Medicare and Medicaid reimbursement is generally the primary source of revenue for facilities, but insufficient reimbursement has made it difficult for many facilities to operate. Staffing remains 13 percent below prepandemic levels.[57] Absent greater pay, workers will leave to move to other sectors, making the problem of staffing shortages worse and making it more difficult to deliver care. One in five workers in the long-term care sector are noncitizens, showing the importance of immigration reform in addressing staffing shortfalls. In the post-acute sector, PHE waivers were generally not extended.[58]

Recently the Administration proposed establishing minimum staffing standards "to address ongoing safety and quality concerns" for residents in certified long-term care (LTC) facilities, stating that the proposed rule results from lessons learned during the pandemic and is designed to address "chronic understaffing in LTC facilities," particularly among registered nurses and nurse aides. The proposal also states that "staffing levels are closely correlated with the quality of care that LTC facility residents receive, and with improved health outcomes [.]"[59] The new regulation would require a registered nurse on site at all times (rather than just nursing services) "to provide skilled nursing care to all residents in accordance with resident care plans" as well as heightened requirements for RNs and NAs based on the number of facility residents.

While the recommended staffing levels would enhance care, they also increase pressure on facilities. Where will they find qualified workers? Enhanced staffing recommendations should come with increased funding; 44 states increased Medicaid funding for this purpose in 2022.[60] Another study from during the pandemic showed that dedicated funding programs may be associated with higher staffing hours in nursing homes.[61] At the same time, this also increases pressure on state budgets, given Medicaid's significant role (about $53 billion) in financing long-term care. While there is no substitute for staff on-site, telemedicine is an important tool for care for LTC residents. Yet telemedicine use here has fallen rapidly since 2020 from 24 percent to 10 percent of visits;[62] the post-acute sector is yet another reason why telemedicine access should be expanded as much as possible.

Workforce

While shortages of health care workers predate the pandemic, the pandemic not only accelerated the challenges but also pointed the way to several solutions. In January 2022, during the height of the Omicron wave, 22 percent of hospitals reported staffing shortages.[63] Overall, the country may face a physician shortfall of 124,000 by 2033; in 2021, a report estimated shortages of 3.2 million medical assistants, home health aides, and nursing assistants by 2026.[64] Certain sectors have been more impacted than others. Supportive roles, which account for about 20–25 percent of workers, have high turnover rates, in part because of competition from other sectors. Here, raising compensation will help; so will greater opportunities for training and professional development. Addressing shortages of health care workers is urgent to promote both quality in the system and accessibility to it.

Both primary and specialty care face shortages or maldistribution of workers, in which rural and other underserved communities lack adequate access to care. Incentives such as payment policies play a role here, as does graduate medical education, as physicians locate at a higher rate where they receive graduate medical education. Telemedicine can also help improve the effective distribution of workers.

The causes of shortages are varied, including chronic underinvestment in STEM education, underinvestment in training programs, inadequate reimbursement that places a greater burden on those who deliver care, and excessive regulations and poorly designed electronic medical records systems that add to administrative burdens. Whatever the causes, the problem must be solved: as one scholar concluded, "[i]f burnout becomes too great and sufficient numbers of personal care aides, nurses, and physicians leave practice, the result could be an implosion of the health care system."[65] Solutions involve both attracting people to the industry and retention.

A greater focus on primary care and primary physicians

While health care worker shortages are expected in all areas, a greater focus on attracting primary care physicians is essential and cannot be overstated. As noted above, regular visits to primary care physicians contribute strongly to overall health and reduced mortality and thus to reducing health care costs throughout the system while delivering better health outcomes. Yet the current system provides economic disincentives to

choose primary rather than specialty care as a career, which will require a reevaluation of how medical education—and its associated debt—too often steers physicians away from a career in primary care or pediatrics.

Efforts to encourage more students to pursue primary care, including from traditionally underrepresented groups, adding seats in medical schools, the Primary Care Extension, and reconsidering the length of medical education, will reduce shortages, leading to better health outcomes.[66] It will also help address the mismatch between the number of students graduating from medical school and the smaller number of medical training slots to continue their education. Immigration reform will also help. A strong proportion of the health care workforce is already composed of immigrants.[67] Congress should increase visas for qualified medical workers; states can bridge credential gaps by offering a role lower than in their home country and then permitting testing to the US equivalent of a foreign license.

Expansion of training and professional development needed

Throughout the system, greater opportunities for training and professional development strongly influences both attraction and retention. State earn-as-you learn programs, such as Pennsylvania's Nursing Pathway Apprenticeship Industry Partnership program, should be expanded, also providing examples of pathways for health care careers. Several health systems are offering medical MA certificates and free tuition to high school students, then paying for these students to become LPNs and RNs, while also establishing their own postsecondary institutions. Apprenticeships show realistic possibilities for careers in health care; training encourages retention by helping people rise in their careers.[68] Limitations on training also cause shortages; more than 80,000 applicants to nursing schools in 2020 could not find places.[69] Congress should consider grants to nursing schools, particularly in areas and among communities which are underserved or face acute shortages. More broadly, Congress should appropriate funding for the National Health Care Workforce Commission, in existence since 2010,[70] and task it with a comprehensive report on the issue.

Coordination with team-based care improves quality and accessibility

Team-based care, a delivery model in which patient needs are coordinated across different providers and levels of specialization, ensures that everyone in the system is practicing at "the top of their license." This addresses shortages in two ways: 1) by making health care more attractive, with greater responsibilities for those practicing at the top of their license, and 2) by ensuring the best utilization of health care professionals of all types as well as strongly encouraging retention.[71] By 2019, one-fourth of US health care visits were delivered by nurse practitioners and physician assistants rather than physicians, and this trend will grow.[72] Education on team-based care should be provided in medical schools, to foster trust and understanding of the new system. During the pandemic, professionals such as physician assistants and nurse practitioners could practice to the fullest extent possible under a state's emergency preparedness plan. This mindset can be fostered once again in the health care system. States modernizing scope of practice regulations can help.[73] By promoting better coordination among health care professionals and ensuring that all professionals are practicing at the top of their license,

including direct interactions with patients, expanding team-based care furthers both quality and accessibility in the overall health care system.

Team-based care can also offer a whole-person approach to holistic well-being for employees in demanding health care jobs, particularly for older workers but also for younger ones eager for more responsibility. Empowering employees brings positive results: one Dutch home health care organization permits nurse teams to make important decisions often left to physicians; its patient satisfaction rates and retention are higher, while overheads are lower.[74]

It can even help combat physician burnout, which can harm patient care.[75] Other efforts to reduce physician stress include reforming electronic medical records,[76] so clinicians spend more time seeing patients, as they entered the profession to do.

Public-private partnerships to improve outreach

Public-private partnerships in this area can help expand the workforce relatively quickly. Businesses can partner with training programs in community colleges and public universities to target communities with shortages of workers, work with them on developing curricula, and ensure that graduates have jobs upon graduation. Apprenticeship programs can lead directly to health care careers, with funding from education institutions, economic development agencies, and government.

Public-private partnerships are essential to reach underserved communities. The classes entering US medical schools in 2021 as the pandemic continued included the most representation of traditionally underserved groups thus far, with 12.7 percent Hispanic origin and 11.3 percent Black.[77] But as the US becomes more diverse, the challenges of reaching all Americans with health care will continue. Given the correlation between greater numbers of Black primary care physicians in a community and a decrease in Black mortality,[78] the issue is urgent.

Similar problems affect medical care in rural areas. In the Consolidated Appropriations Act of 2021, Congress established the rural emergency hospital, which provides only outpatient and emergency services and receives additional federal funding. The designation could potentially apply to over 1500 hospitals in rural areas;[79] now, the question will be whether those facilities are able to attract sufficient personnel and to develop strong referral networks to larger hospitals to provide a continuum of care. Interprofessional teams and greater use of telehealth, as well as expanding existing rules on the scope of practice, will help redress the deficit of providers in rural health care, as will expanding the number of medical residents in rural areas; rural areas accounted for only 2 percent of Medicare funding for residency training in 2020.[80]

It will take time to build the health care workforce the nation needs for an aging population and strong demand. Education, training, increased immigration, flexibility in staffing, and reducing worker burnout are all essential to address workforce shortages. Those workers also need the physical tools to do their jobs.

Supply Chains: A National Health Security Imperative

The pandemic also focused attention on the need for robust and resilient supply chains in all aspects of the health care system as an urgent issue of national health security. The US cannot wait until the next significant public health crisis and face the possibility of a supply chain that cannot deliver needed medicines and supplies to our health system. Perhaps nowhere is solving this challenge more urgent than in addressing shortages of drugs. Over 300 medicines were in short supply in the second quarter of this year—more than at almost any other time in the past decade. For example, earlier in 2023, the US faced shortages of important cancer drugs such as cisplatin, simply because of supply chain challenges and a negative result from an FDA inspection of a plant in India; some pediatric drugs were also in short supply.[81] Issues regarding supply chains of drugs and all types of health care supplies have a particular impact on underserved communities.

China holds about 40 percent of the global market for active pharmaceutical ingredients (APIs), including "key starting materials" and "intermediates" necessary for producing drugs. In sharp contrast, the US global share of APIs is only about 14 percent.[82] As the head of the Japan Pharmaceutical Traders' Association has noted, "[i]f you follow the supply chain, you will bump into China sooner or later." For instance, India, a source of many generic drugs globally, imports about 70 percent of its APIs from China, including ingredients for very common drugs such as ibuprofen.[83] China produces 90 percent of the essential ingredients that go into medicines for treatment of severe COVID-19 infections; over the last decade, China has increased its share of the US penicillin market to 52 percent (from 1 percent) and to 37 percent (from 15) in the market for antibiotics.[84] About 90-95 percent of generic sterile injectable drugs used for critical acute care in the US rely on key starting materials from China and India. China's large share of the industry also arises in the challenge of combating synthetic drugs and illegal imports of fentanyl.[85] This level of market dominance raises fears of interruptions to supply in the event of geopolitical conflict or export restrictions.

This is a global challenge that will require global solutions, but building supply chains for resilience and redundance is essential. This will involve both incentives for domestic production as well as nearshoring and friendshoring of APIs for essential drugs. As CED wrote in 2021, Latin America and the Caribbean could play an important role in health supply chains of all types, including the provision of personal protective equipment (PPE) but extending much further up the value chain as well. Both business and policymakers should seek these linkages.[86]

Toward a Future System

The pandemic highlighted and magnified already existing disparities in the US health care system. While it offers the best care in the world and unparalleled research,[87] it is also the case that millions of Americans lack access to health care or cannot afford it. All Americans should have access to health care. Our goal should be an efficient, high-quality, patient-centered system, one that will deliver better overall health outcomes.

The time to begin that reform is now. In short, the best reforms will promote cost-responsible consumer choice among competing private health care plans, with a goal of driving

the system towards quality, affordable health care for all in a more connected system that drives strong patient care outcomes holistically through innovations such as team-based care. There are many ideas for reform, including ways that will increase saving for health care expenses, but the overall direction seems clear.[88]

Going forward, the US will need to continue to respect the importance of innovation and lessons learned from the pandemic such as telehealth,[89] and the country will need to invest more in public health, with a particular focus on underserved communities. This includes issues of health equity, where a more diverse health care workforce will help.

For some groups, such as the disabled, the calculus is more challenging. While the premise for value-based health starts with keeping people healthy, for some groups, such as the disabled, the population served is by definition not healthy and requires greater ongoing care. Solutions that may work well in the broader system could have an adverse impact on our most vulnerable population. However, policies can and should be developed that take into account this population. For instance, providing the right technology for disabled patients can avoid pressure ulcers, keeping patients more mobile and independent, reducing expenses for hospitalization and costs associated with co-morbidities.

In addition, the system should continue a shift that is already occurring towards a greater focus on redefining health care as wellness and prevention, rather than simply treating disease once it occurs. This will improve the quality of care as well as lowering costs for the system over time. Everyone in the health care system needs to participate in teaching patients how to be healthier. This starts with healthy habits such as receiving proper and timely immunizations, adopting a healthier diet, changing lifestyle habits that weaken or damage health, improving exercise, and other steps that raise overall levels of health and thus increase resistance to disease.[90] More broadly, because physicians see patients who present symptoms to them, the fee-for-service system does not do a good job of encouraging physicians to perform a broader set of analytics that would show steps necessary to maintain good health. Once again, this shows the importance of primary care physicians, and regular visits to them, in improving overall health and reducing costs throughout the system.

In addition, the system will need a renewed focus on mental health. The pandemic highlighted both growing demand for mental health services and the signal importance of mental health to overall health.

Any shift away from fee-for-service is, ideally, a shift toward some form of value-based pricing, whether in the public sector or through private insurers, of which there are many models. More than half of US health care payments are still based on fee-for-service[91] models. Further study and innovation with value-based models will help push the system toward a focus on overall wellness, rather than individual procedures. And that would be both a worthy goal for policymakers and a lasting benefit from the pandemic era.

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