By William H. Shrank, Nancy-Ann DeParle, Scott Gottlieb, Sachin H. Jain, Peter Orszag, Brian W. Powers, and Gail R. Wilensky

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COMMENTARY

Health Costs And Financing: Challenges And Strategies For A New Administration

ABSTRACT **It is likely that 2021 will be a dynamic year for US health care policy. There is pressing need and opportunity for health reform that helps achieve better access, affordability, and equity. In this commentary, which is part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we draw on our collective backgrounds in health financing, delivery, and innovation to offer consensus-based policy recommendations focused on health costs and financing. We organize our recommendations around five policy priorities: expanding insurance coverage, accelerating the transition to value-based care, advancing home-based care, improving the affordability of drugs and other therapeutics, and developing a high-value workforce. Within each priority we provide recommendations for key elected officials and political appointees that could be used as starting points for evidence-based policy making that supports a more effective, efficient, and equitable health system in the US.**

William H. Shrank (Wshrank@humana.com) is chief medical and corporate affairs officer of Humana in Louisville, Kentucky.

Nancy-Ann DeParle is a managing partner and cofounder of Consonance Capital Partners, in New York, New York.

Scott Gottlieb is a resident fellow at the American Enterprise Institute, in Washington, D.C.

Sachin H. Jain is president and CEO of the SCAN Group and Health Plan and an adjunct professor of medicine, Stanford University School of Medicine, in Stanford, California.

Peter Orszag is the CEO of Financial Advisory at Lazard Freres and Co., LLC, in New York, New York.

Brian W. Powers is deputy chief medical officer at Humana in Boston, Massachusetts.

Gail R. Wilensky is a senior fellow at Project HOPE, in Bethesda, Maryland.

It is likely that 2021 will be a dynamic year for US health care policy. More than a decade after the Affordable Care Act (ACA) was passed, health reform remains a top concern for the American public.[1] The number of uninsured Americans is rising. Affordability—at both the system and individual levels—is eroding. And the numerous ways in which racism and prejudice drive unacceptable disparities in health and well-being are increasingly evident. The coronavirus disease 2019 (COVID-19) pandemic, which placed historic stress on an already strained system, has only exacerbated many of these shortcomings.

Against this backdrop, the National Academy of Medicine convened the Vital Directions for Health and Health Care: Priorities for 2021 initiative, which, following a 2016 initiative of the same name,[2] aims to provide expert guidance on several focus areas for US health policy. In this article we draw on our collective backgrounds in health financing, delivery, and innovation to offer a set of consensus-based policy recommendations focused on health care costs and financing.

System Goals

Our recommendations are grounded in three overarching goals for the US health system: access, affordability, and equity.

ACCESS Every American should have access to health care. However, the US has a large and growing uninsured population. After reaching a nadir of 28.7 million (8.9 percent of the population) in 2016, the number of uninsured people is expected to rise to 37.2 million (10.6 percent of the population) by 2028.[3] This comes at a time when a growing body of research links insurance coverage to improvements in financial security, health, and longevity.[4–6]

AFFORDABILITY Every American should have access to affordable health care. However, health

care spending continues to grow at an unsustainable rate. Whereas spending growth initially slowed after implementation of the ACA, it has accelerated once again.[3,7] The consequences of this acceleration are well established and include a growing national debt; strained federal, state, and local budgets; stagnant wages; and increased financial insecurity for Americans.[2,8,9] Even for those with insurance coverage, health care is increasingly unaffordable: Roughly half of US adults have delayed or avoided care because of cost.[10]

EQUITY Every American should have equal access to affordable health care. However, there remain unacceptable inequities in health care access and outcomes by race, ethnicity, socioeconomic status, and other dimensions.[11,12] This has been made painfully obvious during the COVID-19 pandemic, which has taken an unacceptably high and disparate toll on underserved communities and people of color.[13–15]

INTERRELATED GOALS These three goals of access, affordability, and equity are deeply interrelated. In some cases, improvements are complementary. Increased access can improve equity.[16] In others, conflicts arise. Expanding access presents a substantial affordability challenge at the system level. Although difficult trade-offs are inevitable, we believe there are opportunities to simultaneously improve access, affordability, and equity. When identifying policy recommendations, we aimed to identify those most likely to yield balanced improvements across all three areas.

Policy Priorities

We propose five policy priorities to advance these system goals: expand insurance coverage, accelerate the transition to value-based care, advance home-based care, improve the affordability of drugs and other therapeutics, and develop a high-value workforce. Within the broad domain of health costs and financing, there surely are many other policy priorities worth considering. These five represent our view of the most promising near-term opportunities to leverage health care financing and payment to improve access, affordability, and equity.

EXPAND INSURANCE COVERAGE From 2010 to 2016, policies in the ACA led to a steady decline in the number of uninsured Americans.[17] These coverage gains have led to improved health, equity, and financial well-being.[4–6,16] When the original Vital Directions initiative was convened in 2016,[2] the uninsurance rate was at an all-time low. Since then, the number of uninsured Americans has risen steadily.[3,17] The COVID-19 pandemic will only accelerate this trend and has highlighted the limitations of employer-sponsored insurance. During the height of the pandemic, millions of Americans lost their jobs and their access to employer-based insurance coverage over the span of several months.[18,19]

Multifaceted and fiscally prudent approaches to closing the growing coverage gap are necessary but face significant barriers. There remains political resistance to expanding coverage through mechanisms set forth in the ACA. Twelve states have not expanded Medicaid, several coverage-related provisions in the ACA have been repealed, and support of the Marketplaces for individual coverage has been uneven. Bipartisan approaches and public-private partnerships are needed.

Sustainable financing presents another challenge. Mechanisms for publicly financing coverage expansion—through deficit spending, new revenue sources, or revenue transfers—come with inherent trade-offs and will require bipartisan compromise. We believe that reallocating the substantial resources spent on care that does not improve health[20] represents an opportunity to expand coverage without sacrificing affordability or quality, but the impact of associated revenue reductions on providers needs to be closely considered.

ACCELERATE TRANSITION TO VALUE-BASED CARE A central action priority identified in the original Vital Directions initiative was to "pay for value"—specifically, to "drive health care payment innovation providing incentives for outcomes and value."[2] Since that time, value-based payment has grown notably. According to the Health Care Payment Learning and Action Network, the share of health care payments administered via alternative payment models increased from 23 percent in 2015 to 36 percent in 2018.[21,22] Although selected models have generated significant savings,[23–25] the overall impact of new payment models on cost and quality has been mixed.[26–28]

We believe that significant potential remains for payment models to accelerate value-based care delivery, but several barriers must be addressed. First, most alternative payment models remain anchored in a fee-for-service architecture. Only 5 percent of health care payments in 2018 were population based (for example, global budgets).[22] Broader adoption of advanced population-based payment is needed. Second, the penetration of value-based payment lags among commercial and Medicaid payers. In 2018, 40.9 percent of payments in traditional Medicare and 53.6 percent of payments in Medicare Advantage occurred through advanced value-based models, compared with 23.3 percent in Medicaid and 30.1 percent among commercial

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payers.[22] Medicare can serve as a catalyst for payment reform, but fundamental changes in the delivery system will not occur without multipayer alignment. Finally, there are growing concerns that certain value-based payment models may exacerbate inequities or penalize organizations that care for vulnerable populations.[29] It is essential that value-based payment help ameliorate, not exacerbate, disparities.

Accelerating the transition to value-based care necessitates more than new payment models. Redesigning care delivery to provide more value to patients requires new tools, competencies, and infrastructure.[2,30] To that end, it is necessary that payment models be accompanied by technical assistance and infrastructure support. This will be especially important to encourage participation and ensure success for independent providers, who appear to be most successful when engaging in value-based models.[24]

Infrastructure improvements at the system level are also needed. Robust, interoperable data exchange is a prerequisite for value-based care.[31] There has been important progress on interoperability since the original Vital Directions initiative.[2] In early 2020 the Department of Health and Human Services (HHS) issued a final rule implementing interoperability and the patient access provisions of the 21st Century Cures Act of 2016, although enforcement has been delayed because of the COVID-19 pandemic.

ADVANCE HOME-BASED CARE Improvements in internet, video, and remote monitoring capabilities increasingly allow for the delivery of health care services in more cost-effective, patient-centered settings. Patients now can receive home-based acute care,[32] primary care,[33] and behavioral health services[34] of equal or better quality compared with facility-based delivery, and at a lower cost. Despite promising evidence, few programs have reached meaningful scale. In 2018 only 2 percent of commercially insured people had a telehealth visit with a provider, with rates even lower in Medicare and Medicaid.[35] Home-based acute, postacute, and long-term care occur at even lower rates.

As the logistics and infrastructure to support home-based care mature, reimbursement and financing models present a substantial barrier to widespread adoption. Although telehealth services were reimbursed by many payers before 2020, payment rates did not support the process and workflow changes needed for adoption at scale. For other home-based services such as acute, postacute, and long-term care, there are scant reimbursement models outside of small pilots. The COVID-19 pandemic has made clear the drastic impact that reimbursement policy can have on the adoption of telehealth and home-based care. Facilitated by the introduction of reimbursement parity, there has been a rapid transition to virtual visits in the ambulatory setting during the pandemic.[36] Shifting care to the most appropriate and cost-effective settings will require permanent reimbursement changes for telehealth and tailored financing models for home-based care across the continuum of disease severity.

IMPROVE THE AFFORDABILITY OF DRUGS AND OTHER THERAPEUTICS Access to novel therapeutics is a distinguishing feature of the US health system, but also a key driver of high spending.[37–39] The crisis of affordability for drugs and other therapeutics has only intensified since the original Vital Directions initiative was convened in 2016.[2,37] Highly effective therapeutics may lower aggregate spending by reducing the need for costly interventions or hospitalizations, but many of these novel medicines command high prices.[40] More challenging is the fact that high prices are not always aligned with value. Prices on existing, branded drugs have increased substantially during the past decade, limiting affordability and access.[37,41,42] And even in circumstances where the benefits are unclear or modest, many new therapeutics are still reimbursed at high rates.[37,43]

With continued innovation on the horizon—including gene therapy—these challenges will become more acute. Broadening the pool of Americans who can obtain and afford high-value therapeutics will require reimbursement structures that align payment with value and balance affordability with the continued need for innovation. Such efforts face a number of challenges: regulatory barriers that limit generic and biosimilar development; a lack of robust informa-

tion from which to base comparative effectiveness, coverage, and reimbursement decisions; and societal discomfort around limiting access to any therapies, including those that are of low value.

DEVELOP A HIGH-VALUE WORKFORCE The US benefits from a highly skilled health care workforce and is home to premier training institutions. But there are significant and growing workforce shortages in the areas of primary care, behavioral health, and dental care.[44] A coordinated strategy to train, deploy, and support a diverse health care workforce is an essential enabler of access, quality, and value, particularly in underresourced communities.

Regulatory restrictions remain a key barrier to progress. Current licensure and credentialing requirements and state-by-state variation in scope-of-practice laws limit the opportunity to leverage technology and advanced practice providers to address workforce shortages, improve access, and provide the most cost-effective care.[45,46] The response to COVID-19 has shown the benefit of relaxing such structures. During the pandemic, regulatory bodies and payers moved quickly to augment in-person workforce capacity in regions experiencing surges in COVID-19 cases and to allow for telehealth to serve as a substitute for in-person care. Many state medical boards waived licensing requirements for telehealth and provided expedited, temporary licenses for out-of-state providers.[47] Formalizing these changes outside of the pandemic will be important.

Alongside reducing regulatory barriers, developing a high-value workforce will also require a better use of community members and less specialized individuals (for example, community health workers and navigators) to support care delivery in uniquely effective, efficient, and culturally appropriate ways.[48]

Recommendations For Key Elected Officials And Political Appointees

The priorities we have outlined represent near-term opportunities to improve access, affordability, and equity. To help catalyze action along these dimensions, we developed a short list of recommendations for key stakeholders. We focus on three key federal leaders—the secretary of HHS, the administrator of the Centers for Medicare and Medicaid Services (CMS), and the commissioner of the Food and Drug Administration (FDA)—and state governors, because of their ability to quickly and effectively affect change. Comprehensive reform will require close collaboration with other elected officials and political appointees and commensurate attention, activity, and innovation from the private sector.

EXPAND INSURANCE COVERAGE The HHS secretary should develop alternative pathways to insurance coverage, including strengthening and better supporting the individual insurance Marketplaces and working with Congress to decrease the age of Medicare eligibility to fifty-five. Doing so will help ensure coverage, improve affordability, and offer greater choice for older Americans unable to obtain employer-based coverage.

Governors should also create opportunities for expanded coverage in their states. Optimal use of the Medicaid program offers the greatest opportunity to expand coverage and promote health equity. Governors in states that have not yet expanded Medicaid should work closely with their legislative bodies to do so. Outside of Medicaid expansion, governors—working with their insurance commissioners—should support the individual Marketplace by offering risk-management mechanisms to private payers providing individual coverage via state-based exchanges and by extending open enrollment periods.

ACCELERATE TRANSITION TO VALUE-BASED CARE The CMS administrator should increase the adoption of advanced value-based payment models. Value-based payment in Medicare has grown, but most value-based payments remain anchored in a fee-for-service architecture. Population-based payment has the greatest potential to improve outcomes and lower costs. The CMS administrator should set a goal of having 25 percent of Medicare payments administered via population-based payments by 2025.

The CMS administrator also must align payment models with equity. Value-based payment has the potential to advance health equity but may inadvertently exacerbate health disparities. The administrator should conduct a thorough review of existing payment models to evaluate their impact on equity while developing new payment models that create financing flexibility to address structural racism and social determinants of health and explicitly reward reductions in health disparities.

It will also be important for CMS to help stabilize independent primary care providers. COVID-19 has placed significant financial strain on independent primary care providers. This is especially troubling, as these clinicians provide critical access to health care for much of the US population and have been uniquely successful at delivering value-based care.[24] The administrator should take action to stabilize finances for independent primary care providers by providing prepayment to offset lost fee-for-service revenue as a path to population-based payment.

Any effort at reform will occur in the shadow of the COVID-19 pandemic.

The CMS administrator can also play an important role in broadening value-based insurance design. Expanding on existing pilot programs in Medicare Advantage, the administrator should use the authority of the Center for Medicare and Medicaid Innovation (CMMI) to reduce cost sharing for cost-effective, high-value services in traditional Medicare and Medicare Advantage.

In addition, Medicare Advantage should be strengthened. More than a third of Medicare beneficiaries are now enrolled in Medicare Advantage plans.[49] The program benefits from strong bipartisan support[50] and has catalyzed the adoption of advanced value-based payment models.[21] Strengthening the program could position it to serve as a chassis for coverage expansion. To achieve this goal, the administrator should continue to increase flexibility for Medicare Advantage plans to design new benefit packages, incentivize healthy choices, and redistribute funding to reduce disparities and improve equity. As voluntary enrollment in Medicare Advantage begins to outpace that in traditional Medicare in some regions, the administrator will need to reconsider financial models that determine benchmark payments as well. Finally, the administrator should continue to explore new approaches to sustainable risk adjustment for Medicare Advantage plans.

The CMS administrator can help accelerate the transition to value-based care by enforcing regulations that promote interoperability. Interoperable data exchange supports care coordination and the delivery of high-quality, cost-effective care.[30] Although it was appropriate to delay enforcement of key interoperability provisions of the 21st Century Cures Act in the context of the COVID-19 pandemic, the administrator should avoid any further delays.

State governors can also play an important role in accelerating the transition to value-based care models by expanding their use in Medicaid. The penetration of value-based care in Medicaid lags behind Medicare and commercial markets, limiting the ability to achieve cost-effective, high-quality care for vulnerable populations. Governors, working with their Medicaid directors, should expand the use of value-based payment through Medicaid managed care contracting and Section 1115 waivers. Governors should aim to achieve the goal set by the Health Care Payment Learning and Action Network of having 50 percent of Medicaid payments in advanced value-based payment models with downside risk by 2025.[51]

ADVANCE HOME-BASED CARE To advance home-based care, the CMS administrator should formalize changes to telehealth reimbursement. Working with Congress where needed, the administrator should make permanent some of the changes to telehealth reimbursement that were instituted under the COVID-19 public health emergency. Approaches could include continued reimbursement at parity for audiovisual telehealth visits, with more modest payments for telephonic and asynchronous interactions. It will be important to ensure that reimbursement policies position telehealth as a substitute for more expensive and less accessible sites of care and do not induce unnecessary spending and utilization.

The CMS administrator should also develop reimbursement models for home-based care. Under the authority of CMMI, the administrator should create and test new payment models for home-based acute, postacute, and long-term care.

IMPROVE AFFORDABILITY OF DRUGS AND OTHER THERAPEUTICS The FDA commissioner should expand on recent efforts to reduce barriers to generic and biosimilar development and market entry with the goal of increasing competition, improving access, and reducing prices. Potential strategies include enabling more efficient pathways for the approval of safe and effective generic and biosimilar versions of complex drugs that often face no or limited competition, even after patents and exclusivities have lapsed; closing regulatory loopholes that can be exploited to maintain a monopoly through the granting of patents and other exclusivities; harmonizing regulatory filing requirements for generic medicines with other global regulators; and fostering the development of advanced manufacturing platforms that lower costs and improve quality and reliability. This is especially important for biologics, for which manufacturing challenges are a barrier to the entry of biosimilars.

The FDA commissioner also should accelerate efforts to build a robust real-world evidence program and develop rigorous, science-based criteria for how real-world evidence can be used to inform decisions about the safety and effectiveness of new therapeutics. Such a framework not

only would expand opportunities for pre- and postmarket evidence on safety and efficacy but also would be available to payers and other entities to support comparative effectiveness and cost-effectiveness analyses. This infrastructure is a prerequisite for any effort at value-based pricing for therapeutics.

The CMS administrator can also play a key role in improving the affordability of drugs by developing value-based reimbursement models for high-value therapeutics. Under the authority of CMMI, the administrator should expand on recent efforts to create and test new payment models for prescription drugs,[52] including reference pricing, outcomes-based payment, and Medicare Part B payment reform. As multiple models of reimbursement are tested, it will be important to both guard against and monitor for efforts at gaming different pricing models.

DEVELOP A HIGH-VALUE WORKFORCE Through a partnership with state governments and private payers, the HHS secretary should facilitate the development and deployment of a national workforce of community health workers. Evidence suggests that such a program could reduce disparities, improve health outcomes, and lower health care spending.[53–55] This workforce could also aid in pandemic response (for example, contact tracing) and support insurance education and enrollment. Outside of the benefit to patients, it would provide valuable economic opportunity for the workers themselves, who should be recruited from the historically disadvantaged communities they serve.

Governors could promote the development of a high-value health care workforce by removing barriers to affordable telehealth access. They should, in collaboration with state licensing bodies, formalize changes to state licensure laws made during the COVID-19 pandemic that reduce or eliminate the barriers facing out-of-state providers who wish to provide telehealth services and coordinate care across state lines.

Conclusion

As 2021 begins, there is pressing need and opportunity to reform health care financing to better support access, affordability, and equity. Any effort at reform will occur amidst the COVID-19 pandemic, which has placed unprecedented strain on policy makers and public institutions. There will simply not be the same capacity or appetite for sweeping regulatory changes that would have been present in other circumstances. Limited attention and resources will require disciplined prioritization and a willingness to accept incremental progress and small wins. Furthermore, reforms will need to occur under increasingly strained federal and state budgets. Achieving meaningful change in this environment will require significant resolve from policy makers and public support for difficult decisions (for example, less coverage for low-value services and technologies). We hope that the policy priorities and recommendations articulated in this commentary provide a focused starting point for evidence-based policy making that supports a more effective, efficient, and equitable health system in the US. ■

William Shrank reports equity holdings in Humana and serving as a director at GetWellNetwork. Nancy-Ann DeParle (administrator of the Health Care Financing Administration [HCFA], now the Centers for Medicare and Medicaid Services [CMS], from November 1997 to September 2000) reports being a director of CVS Health, HCA Healthcare, Psychiatric Medical Care, and Sellers Dorsey. Scott Gottlieb (commissioner of the Food and Drug Administration from 2017 until April 2019) is affiliated with New Enterprise Associates and CVS Health and sits on the boards of Pfizer, Illumina, Tempus, and Aetion. Sachin Jain reports equity holdings in Anthem, Merck, Blink Health, DataVant, Thrive, Curisium, Valera, Firefly, and Vital and serving as a director at Abode Hospice. Peter Orszag (head of the Office of Management and Budget from 2008 until July 2010) reports employment by Bloomberg. Brian Powers reports employment by Mass General Brigham, prior employment by Anthem and Fidelity Investments, and equity holdings in Humana. He is the editor of *Healthcare: The Journal of Delivery Science and Innovation* (Elsevier). Gail Wilensky (administrator of HCFA [now CMS] from 1990 until 1992) is a director for Quest Diagnostics Inc. and UnitedHealth Group and a trustee for the United Mineworkers of America Combined Benefits Fund. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of their employers. [*Published online January 21, 2021.*]

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