

POLICY NOTE

Long-term changes to the U.S. health care system after the COVID-19 crisis

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Key Findings

1. Temporary changes in the U.S. health care system were needed to treat the surge in COVID-19 patients. As Americans return to a more normal life after the COVID-19 pandemic, the question is whether the health care delivery system will retain those temporary changes on a permanent basis.
2. As the pandemic passes, employer-paid health insurance will continue, even though workers would have greater security if they owned their own health coverage.
3. As people lost their jobs, it has become clear that tying health insurance to work is a poor health care policy. A much better plan would be to allow workers to have their own health insurance through health savings accounts and high-deductible insurance.
4. Fee-for-service in health care remains popular in the U.S. However, the COVID-19 crisis may make the health maintenance organization model more attractive for both hospitals and physicians.
5. Telemedicine has proved to be very effective. It increases access to health care while holding down costs. As people become more comfortable with on-line meetings, telemedicine will undoubtedly expand.
6. Single-payer advocates will continue to argue for more government involvement and control of the U.S. health care system, even though the resources of private health care are essential in fighting COVID-19.
7. Private health insurance companies will continue to have a major role in the U.S. health care system, especially in the employer market place.
8. To combat future community health crises, public health funding must become a priority of government.
9. From a practical and financial standpoint, it makes no sense for hospitals to increase their number of beds in anticipation of another once-in-a-century catastrophe.

Introduction

The COVID-19 crisis has had a devastating impact on the U.S. health care delivery system. Hospitals have seen their emergency rooms and intensive care units overburdened with critically ill patients. Doctors, nurses, and other first line responders have worked long hours over extended periods of time treating these desperately sick individuals.

Not all areas of the country have been effected the same. Large metropolitan communities with dense housing and mass transit have experienced a much higher incidence of infection and mortality.

Likewise, the virus has targeted various patient demographics in different ways. The elderly and those people with pre-existing medical conditions have had a higher mortality rate, while the virus spared those in middle-age. Children, while not dying, have suffered other medical problems from the virus, such as rare vasculitis conditions.

The country-wide lock-down undoubtedly slowed the spread of the virus, but at a cost to the over-all economy. The unemployment rate reached an all time high. The government stepped in to provide unemployment payments, loans, stimulus money, as well as health insurance. Individuals with other medical conditions have been denied timely access to health care while the delivery system prioritized the treatment of the COVID-19 patients.

As Americans return to a more normal life, the question is whether the health care delivery system will retain those temporary changes on a permanent basis. This Policy Note examines those changes and the likelihood they will be extended indefinitely.

Changes in employer-based health care

Millions of Americans were laid off or furloughed as businesses of all sizes closed or downsized. Before the pandemic, half of all Americans received their health benefits through their employer or their spouse's employer. Job-based health insurance has been part of the U.S. since 1943 and survives because of the U.S. tax code favoring employers and because of tradition.

As people lost their jobs, it has become clear that tying health insurance to work is a poor health care policy. A much better plan would be to allow workers to have their own health insurance through health savings accounts and high-deductible insurance. In that way, whether

employed or not, people would still have their own health benefits. Changing the tax code so workers could take the same tax deductions as employers now do would be fair and would solidify this arrangement.

Employer-paid health benefits are popular among workers and employers and, after seventy years, are part of the employment landscape. As the pandemic passes, employer-paid health insurance will continue, even though workers would have greater security if they owned their own health coverage.

How will providers be paid?

Although some hospitals and medical personnel were overwhelmed with COVID-19 patients, many facilities and doctors were placed in financial peril. Physician specialists and most hospitals rely on elective medical procedures to maintain financial stability. Because COVID-19 patients were prioritized and because of the risk of viral spread to elective patients, hospitals and doctors have experienced the same economic-shutdown as other businesses.

There has been a trend in the U.S. toward physicians being employed by hospitals, or even employed by insurance companies. The pandemic and the economic impact on providers may very well accelerate this employment model.

Fee-for-service in health care remains popular in the U.S. However, the COVID-19 crisis may make the health maintenance organization model more attractive for both hospitals and physicians. Patients in HMOs pay a fixed amount of money for all medical treatments they receive. Providers would then receive payments regardless of how many procedures and treatments they performed.

Will telemedicine continue?

Telemedicine or telehealth expanded dramatically during the pandemic. It has been an extremely efficient way for patients to consult with doctors while sheltering safely at home. Medicare, as well as some private insurance companies, changed their payment models to reimburse doctors at the same rate as in-person office visits.

States, including Washington, need to address the issue of provider licensing. To fully exploit the potential of telemedicine, states must allow physicians to treat patients across state lines.

Telemedicine has proved to be very effective. It increases access to health care while holding down costs. As people become more comfortable with on-line meetings, telemedicine will undoubtedly expand.

The future of government health insurance plans

Medicaid

Although Medicaid began as a safety-net government health insurance entitlement, it has become a piggy-bank for a number of social programs. It has expanded and has been used extensively during the pandemic. As workers became unemployed and lost their health insurance, the government through Medicaid covered the insurance needs of millions of unemployed people.

Medicaid was already expanding under Obamacare and is one mechanism to force the country closer to a single-payer, government-run health care system. As people return to the employment market, they will drop off of Medicaid. However, by lowering the eligibility requirements, government officials can continue to increase Medicaid enrollment. It is virtually impossible to reform or decrease an entitlement once it has begun. As we have seen over the past 50 years, the cost of the program and the impact on taxpayers will explode.

Medicare

Medicare is a single-payer, government-controlled health insurance plan for seniors 65 years of age and older. The program has undergone multiple changes since it began in 1965. The largest change with the pandemic was the provider reimbursement model for telemedicine as stated above.

Single-payer advocates will continue to argue for an expansion of Medicare by lowering the eligibility age. Supporters will use the fact that millions of people lost their employer health insurance as a reason to expand Medicare. Although a percent of Medicare is paid for by payroll taxes and patient-paid supplements, an ever-growing portion of the entitlement is paid for by the federal general tax fund. The general tax fund percent of payments will only increase as more Americans are added to the Medicare rolls.

Obamacare

Obamacare expanded Medicaid to any low-income able-bodied adult between the ages of 18 to 34 years. Single-payer advocates are also pushing for a public option, or government-run health insurance, in the Obamacare exchanges. So far, Washington state is the only state to have passed a public option, which is set to begin in 2021.

Other states that have considered a public option have placed that legislation on hold because of the dramatic drop in tax revenue caused by COVID-19. However, single-payer advocates will continue to use the pandemic as a reason to increase the government's role in the U.S. health care delivery system.

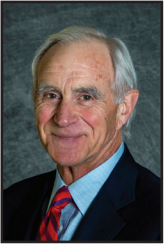
Will private health insurance survive?

Private health insurance companies have a very strong presence in Washington, D.C. and state capitols. They will continue to have a major role in the U.S. health care system, especially in the employer market place.

Before the pandemic, private health insurance companies were employing providers and purchasing medical facilities. As providers seek financial security, these activities may increase in the future.

Will funding for public health organizations increase?

The COVID-19 pandemic exposed the short-comings of the country's public health organizations. Through no fault of their own, these organizations have been underfunded by government officials for years. Even though public health should be a priority of government, entitlement spending has exploded to the point where public health became dangerously underfunded.



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To combat future community health crises, public health funding must become a priority. Hopefully, elected officials in the future will recognize this important role of government.

Will hospitals increase their capacity?

As the pandemic spread, hospitals in certain areas of the country were overwhelmed. Emergency rooms and intensive care units were functioning above capacity in many locations. From a practical and financial standpoint, it makes no sense for hospitals to increase their number of beds in anticipation of another once-in-a-century catastrophe.

Medical and government leadership should, however, re-evaluate the supply of protective gear and necessary equipment (ventilators, for example) that would be required for another pandemic.

Conclusion

The COVID-19 crisis has challenged the U.S. health care delivery system like nothing else that Americans have experienced for generations. Emergency measures have been required to treat the overwhelming number of patients and combat the spread of the virus.

The pandemic offers a chance for the country to re-evaluate our health care delivery system and not only improve public health but also improve patient access to quality, low-cost medical care.

Countries with socialized health care were already at a maximum for their treatment capabilities. Long wait times for routine care are standard in those countries that have some form of “Medicare for All.” Adding thousands of new coronavirus patients undoubtedly led to no care or insufficient care for many people in those countries.

In spite of alarming predictions, the coronavirus crisis will eventually pass. Americans are smart to maintain the best, most responsive health care system in the world. This is a system that is based on a vibrant private market, supported as needed by robust government action, that can deal with such a wide-spread medical event. This system also provides the best platform for developing a vaccine against the COVID-19 virus.

To control costs, increase choice and maintain or improve quality, patients must be allowed to control their own health care dollars and make their own health care decisions. No third party, whether it is the government or an employer, is more concerned about a person's health than that person is. Patients, as health care consumers, should be allowed to be informed about, to review the prices of, and to gain access to the best health care available in a fair, open and free marketplace.

For a complete explanation of patient-centered health care, please see “Health care reform; lowering costs by putting patients in charge” at [https://www.washingtonpolicy.org/library/docLib/Stark- Health care reform and alternatives to the Affordable Care Act.pdf](https://www.washingtonpolicy.org/library/docLib/Stark-Health%20care%20reform%20and%20alternatives%20to%20the%20Affordable%20Care%20Act.pdf).