ECONOMICS & SOCIETY

What Will U.S. Health Care Look Like After the Pandemic?

by Robert S. Huckman

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Even the most vocal critic of the American health care system cannot watch coverage of the current Covid-19 crisis without appreciating the heroism of each caregiver and patient fighting its most-severe consequences. Hospitals are being built in parks and convention

centers, new approaches to sterilizing personal protective equipment (PPE) for reuse are being implemented, and new protocols for placing multiple patients on a single ventilator have been developed. Most dramatically, caregivers have routinely become the only people who can hold the hand of a sick or dying patient since family members are forced to remain separate from their loved ones at their time of greatest need.

Amidst the immediacy of this crisis, it is important to begin to consider the less-urgent-but-still-critical question of what the American health care system might look like once the current rush has passed. In particular, what can the system learn from the existential challenges it faces due to the spread of Covid-19? A few broad lessons are already emerging.

Medicine is medicine, no matter how and where it's practiced.

As the crisis has unfolded, we have seen health care being delivered in locations that were previously reserved for other uses. Parks have become field hospitals. Parking lots have become diagnostic testing centers. The Army Corps of Engineers has even developed plans to convert hotels and dormitories into hospitals.

While parks, parking lots, and hotels will undoubtedly return to their prior uses after this crisis passes, there are several changes that have the potential to alter the ongoing and routine practice of medicine.

As concerns over the spread of Covid-19 in the United States grew during March, several arcane regulations that have long constrained American health care showed signs of easing. Most notably, the Centers for Medicare & Medicaid Services (CMS), which had previously limited the ability of providers to be paid for telemedicine services, increased its coverage of such services. As they often do, many private insurers followed CMS' lead. To support this growth — and to shore up the physician workforce in

regions hit particularly hard by the virus — both state and federal governments are relaxing one of health care's most puzzling restrictions: the requirement that physicians have a separate license for each state in which they practice.

These moves have provided a boost to pure-play telemedicine companies such as Teladoc Health, which reported an increase of 50% in its visit volume during the week ended March 13 and saw its stock price increase by almost 43% during the week starting March 16. Most notably, however, these regulatory changes, along with the need for social distancing, may finally provide the impetus to encourage traditional providers — hospital- and office-based physicians who have historically relied on in-person visits — to give telemedicine a try.

Prior to this crisis, many major health care systems had begun to develop telemedicine services, and some, including Intermountain Healthcare in Utah, have been quite active in this regard. That said, nationwide use of telemedicine had been limited. John Brownstein, chief innovation officer of Boston Children's Hospital, noted that his institution was doing more telemedicine visits during any given day in late March that it had during the entire previous year.

The hesitancy of many providers to embrace telemedicine in the past has been due to restrictions on reimbursement for those services and concern that its expansion would jeopardize the quality — and even continuation — of their relationships with existing patients, who might turn to new sources of online treatment.

For the health care system truly to embrace the potential for change, physicians and hospitals must get to the point where they realize that telemedicine is not an inferior substitute for face-to-face care but rather simply a different technology to use in delivering it. Their experiences during the pandemic could bring about this change. The other question is whether they will be reimbursed fairly for it after the pandemic is over. At this point, CMS has only committed to relaxing restrictions on telemedicine

reimbursement “for the duration of the Covid-19 Public Health Emergency.” Whether such a change becomes lasting may largely depend on how existing providers embrace this new model during this period of increased use due to necessity.

We must expand the notion of what it means to be a “health care provider.”
Prior to the onset of this crisis, health care providers were experiencing high and increasing levels of burnout. A key driver of this trend has been the need for physicians to manage a host of non-clinical issues related to their patients’ so-called “social determinants of health” — factors such as a lack of literacy, transportation, housing, and food security that interfere with the ability of patients to lead healthy lives and follow protocols for treating their medical conditions. A recent study in the *Journal of the American Board of Family Medicine* found that physicians who perceived that their clinic had a high capacity to address the social needs of patients — typically with the availability of non-physician providers — had significantly lower levels of physician burnout.

The Covid-19 crisis has simultaneously created a surge in demand for health care due to spikes in hospitalization and diagnostic testing while threatening to reduce clinical capacity as health care workers contract the virus themselves. And as the families of hospitalized patients are unable to visit their loved ones in the hospital, the role of each caregiver is expanding. This increased mismatch between patient needs and provider capacity highlights one of the most pervasive inadequacies of the U.S. health care system.

To expand capacity, hospitals have redirected physicians and nurses who were previously dedicated to elective treatments to help care for Covid-19 patients. Similarly, non-clinical staff have been pressed into duty to help with patient triage, and fourth-year medical students have been offered the opportunity to graduate early and join the front lines in unprecedented ways. In addition, as it did with telemedicine, the federal government took steps in late March to ease restrictions on the health care workforce and thereby expand capacity. For example, the government temporarily allowed nurse practitioners, physician assistants, and certified registered nurse anesthetists (CRNAs) to perform additional functions without physician supervision.

Outside of hospitals, the sudden need to collect and process samples for Covid-19 tests has caused a spike in demand for these diagnostic services and the clinical staff required to administer them. Further, nonprofit and military organizations have deployed staff and volunteers to support clinical efforts around the country. Considering that patients who are recovering from Covid-19 or other health care ailments may increasingly be directed away from skilled nursing facilities, the need for additional home health workers will eventually skyrocket.

Some might logically assume that the need for this additional staff will decrease once this crisis subsides. Yet while the need to staff the specific hospital and testing needs of this crisis might decline, there will remain the numerous issues of public health and social needs that have been beyond the capacity of current providers for years. This raises the question of how the U.S. health care system can capitalize on its ability to expand the clinical workforce in this crisis to create the workforce we will need to address the ongoing social needs of patients.

We can only hope that this crisis will convince our system — and those who regulate it — that important aspects of care *can* be provided by those without advanced clinical degrees. These new caregivers could be retail associates who have been displaced from store positions and are able to obtain the needed training to enter basic health professions. Walmart's LiveBetterU program, which subsidizes store employees who pursue health care training, is a case in point.

Alternatively, these new health care workers could come from a to-be-established public health workforce. Taking inspiration from well-known models, such as the Peace Corps or Teach For America, this workforce could offer recent high school or college graduates an opportunity to gain a few years of experience before beginning the next step in their educational journey. This group would not only be able to mobilize in acute moments of national crisis but would, during calmer periods, be available to support the efforts of the health care system to address the social needs of patients suffering from undertreated chronic illness.

We need an entirely new model of health insurance.

Even before the passage of the Affordable Care Act (ACA) in 2010, the debate about health care reform centered on two topics: (1) how we should expand access to insurance coverage, and (2) how providers should be paid for their work. The first issue led to debates about Medicare for All and the creation of a "public option" to compete with private insurers. The second revolved around whether the prevailing and flawed system of fee-for-service reimbursement should be replaced by approaches that pay providers based on their performance in meeting the overall health needs of the patients they serve. Ten years after the passage of the ACA, the U.S. system has made, at best, only incremental progress on these fundamental concerns.

The current crisis has exposed yet another inadequacy of our current system of health insurance: It is built on the assumption that, at any given time, a limited and predictable portion of the population will need a relatively known mix of health care services. Predicting health care needs is thus assumed to be a stable and straightforward actuarial exercise.

Our health insurance model is not built to cover health care spending during a novel, mass pandemic, when patients with urgent needs descend upon providers at unprecedented rates. Despite the wealth of billing codes that we have in our health care system — including, for example, a specific code for treating a patient who is "injured while knitting or crocheting" — we do not have specific billing codes for time spent on activities such as acquiring scarce personal protective equipment or ventilators, converting lobbies into hospital wards, comforting patients as they take their final breath, or providing support to colleagues who are witnessing patient despair at unprecedented scale and intensity. Collectively, these activities are but illustrative parts of the true "unfunded mandate" of our health care system.

While insurance companies continue to collect premium payments from covered enrollees, massive reductions in elective procedures and office visits have eliminated a major source of their cash outflows. Most insurers are moving to models that temporarily relieve patients of copayments and deductibles while also guaranteeing coverage for Covid-19 related costs. But what about the costs that hospitals face that cannot be cleanly

attributed to any single patient? A recent proposal suggests a very sensible approach: for insurers to provide hospitals with global payments that roughly reflect the historical monthly amounts that they have paid those hospitals in recent years. Such an effort would put much needed cash in the hands of hospitals whose normal sources of revenue have evaporated at a time when they have been asked to operate well beyond their capacity.

While such approaches may help offset some of the financial pain facing hospitals in the current crisis, they are a band-aid placed over the larger wound of a health insurance model that does not insure patients in moments when the risks to their health are at a peak. Addressing this vulnerability does not necessarily require a shift to universal coverage such as Medicare for All. But it would require that private insurers not only to cover health care needs during periods of "normal" system operations but also to contribute to funds that would support pandemic or emergency response in the markets in which they operate. In essence, insurers would be assessed a "tax" to fund emergency response.

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The concept of "wartime production" has been referenced frequently in discussion about how this pandemic might transform industries such as manufacturing, retail, and hospitality. There are, no doubt, major changes that are coming to the overall economy — and to society as a whole — as a result of this crisis. Hopefully, the health care system will evolve as well. For those in the thick of this current battle, there is no doubt that the immediate priorities are clear: care for the sick and comfort those in need. But for those of us who are not on the front lines, it is critical to start considering how the lessons of this crisis can be captured not only to make the next crisis easier to manage but also to ensure that the ongoing operation of our health care system is improved in a fundamental manner.

Disclosure: The author serves as an advisory board member to three private health care companies — Arena, Carrum Health, and RubiconMD — that operate in areas related to topics discussed in this article. He is also a non-compensated trustee of the Brigham and

Women's Physicians Organization and has received compensation in the past 12 months for teaching for Brigham Health and Kaiser Permanente.

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JAN MACLEOD 3 days ago

Medicine is medicine, no matter where it is practiced. Absolutely true. Providers have known this for eons. They have no boundaries in location or time or commitment to care.

This as a great article. There is so much in it that needs our collective attention and deep understanding. Continuing on the track of business as usual will have consequences we cannot afford as a society. Most important, provider devaluation and burnout. Everyone can rally now because we have no choice but to see the impact of running health organizations skinny. When this is over, will we still see providers as heroes? Or will we go back to squeezing their time and money, making decisions for short-term positives that lead to long-term negatives?

Insurance companies' income is smooth and actuarially based. They pick and choose what they will pay for. It's like the fox in the chicken coop. It is not risk sharing at all if they also do not share in the pain of a population

illness spike like COVID. Hospitals/providers stopped all non-emergency surgery to take care of COVID patients and limit spread of the virus. Surgery is the lifeblood of income for hospitals. Insurance companies should not get to keep premiums that they would have paid out for surgery. That's is truly an asymmetric risk-taking situation. In this Black Swan event, they can and should participate.

"...the prevailing and flawed system of fee-for-service reimbursement should be replaced by approaches that pay providers based on their performance in meeting the overall health needs of the patients they serve."

The RBRVS approach to physician payments is antiquated. It pays some more than others for reasons that are impossible to understand. It does not consider lifetime cost & health benefits of early intervention. It minimizes payments for procedures that can detect cancer early, for example colonoscopy, and pays more for end of life care. It encourages gaming the system to see high RVU patients and put off low RVU patients. It discourages an equitable distribution of patients among providers, as some selfishly motivated types rack up high RVU case volume at the expense of colleagues and patients. They may still be great providers at the point of care, but it creates unnecessary conflict among teams and friction within system operations; friction costs money. In some institutions, teaching or medical administration is paid for on an RVU basis. So, the more you game the system, the more you get paid for teaching or administration, even if you actually DID less of either. Providers are still working many, many, many hours, sacrificing personal time for years; experiencing, repeatedly, patients' last days; dealing with grieving families; dealing with patients and insurance companies who don't value their time or expertise, and delay or don't pay at all; all while doing far more paperwork than ever before.

What is an alternative to RBRVS payments? Medicare for all is not likely the right answer. It does not solve the underlying issues of the antiquated system of fee for service payment and certainly does not give patients any skin in the game- - It's easy to undervalue what you don't pay for. Medicare for all will bring on segmentation and privatization, its own form of rationing. The population needs to value what providers know and do, not just in a crisis. What I learned in business school was 'incentives matter' and 'solve the right problem.' I don't have an answer but continuing to squeeze and tweak a faulty system isn't it.

Telemedicine certainly can work for some disciplines as an adjunct offering. It may get healthcare, including mental health services, to people who otherwise may not have had access (due to transportation issues, inability to time off from work, inability to pay for a babysitter etc). I am in favor of telemedicine as a way to get healthcare to more people. I am concerned, however, that it will become yet another way to reduce/undervalue the expertise of physicians. Is the "work" of a 30-minute telemedicine appointment different than a 30-minute office visit? What is work but Time X Knowledge/Experience?

The current payment system would pay a surgeon $45 for a 30-minute phone visit; $0 for all the calls not scheduled. Think about that for a minute. All the years of training, experience and personal sacrifice is worth $45? Or $0?!! It costs $300 to get my oil burner cleaned; $250 to have my septic system pumped. At least $200 for a plumber to fix a leaking pipe. At some point, the time sacrifice, the exposure to getting sick themselves, and the continuous devaluing of knowledge and experience will be too much. Doctors will quit. Especially our most experienced. We as a society need to think about the consequences of continuing to squeeze.

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