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Healthcare Policy Priorities for the Biden Administration

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Healthcare Policy Priorities for the Biden Administration

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With a new Administration in the United States comes an opportunity for new policies in all arenas, healthcare being no exception. In fact, among the Administration’s first acts was an Executive Order addressing Medicaid and the Affordable Care Act, with an extension of the open enrollment period (Biden, 2021). Surely there will be more executive orders, laws, rules and regulations addressing the many healthcare needs of the country. What should be the Administration’s priorities for which needs get addressed?

All of the major healthcare trade associations have put forth their policy priorities. Selected association’s priorities are listed in the table below in the order presented on their statements. While the broad labels suggest some variation in policies proposed, there are a number of points listed under each title that narrow the variation a bit. There is no shortage of demands for policy action by the Administration.

American Association of Medical Colleges (2020)	American Hospital Association (2021)	American Nursing Association (2020)
Ensuring High-Quality Care for Patients	Supporting the Fight Against COVID-19	Health System Reform
Driving New Discoveries	Advancing Affordability in Health Care	Agencies and Regulations
Training Tomorrow's Health Care Workforce	Sustaining the Gains in Health Coverage	Care Coordination
Investing in Healthier Communities	Protecting Patients’ Access to Care	Health Information Technology
	Advancing Health System Transformation	
	Enhancing Quality, Patient Safety and Equity	

And, of course, many members of Congress have also expressed their policy priorities (Connolly, Nadella & Grande, 2020). Nearly 80 percent of incoming Representatives have some form of health policy platform. Protection for preexisting conditions and lowering prescription drug prices were both widely noted, with the later not being a common policy priority for the associations. As would be expected, Democrat and Republican Representatives have varying priorities.

As with the accompanying Special Feature on the Affordable Care Act, we are not alone in addressing the topic of healthcare policy priorities. Earlier this year, the *Journal of Health Politics, Policy and Law* published a special issue focused on health policy and the Biden Administration (Oberlander, 2021). Still, we wondered if there weren't more thoughts and questions to be answered or posed, particularly among members of the Finance, Economics & Insurance Faculty Forum and the Health Policy Faculty Forum of the Association of University Programs in Health Administration (AUPHA).

The 19 contributions to this Special Feature cover a broad range of policies. Health insurance coverage continuation or expansion, health information technology, more equitable treatment for specific populations, and integration of private and public health resources are some notable themes. With more time and outreach we might very well have covered all of the priority areas listed by the major healthcare trade associations. As it stands, those topics covered provide food for thought on what the Administration might address in the coming years and what we will be thinking about in our research, teaching and service activities.

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For the Biden Administration's Agenda: Medicaid's Role as a Safety Net during COVID-19 Recession

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The Biden administration took office at a time of massive stress on the U.S. health care system and the economy as a whole. Peak unemployment during the COVID-19 pandemic reached 14 percent in April 2020 – as at least 14 million Americans were estimated to have lost jobs during the early months of COVID-19. While unemployment has stabilized in recent months, the Medicaid population continues to grow. As the impact of the COVID-19 pandemic on health and health care evolves, there are lessons to be learned by focusing on the role of Medicaid.

The recession caused by the COVID-19 pandemic led to some of the largest increases in Medicaid enrollment since states expanded Medicaid eligibility under the Affordable Care Act (ACA). Between March and June 2020, the first three months of the pandemic in the United States, Medicaid enrollment increased nationally by 1.7 million (Frenier, Nikpay & Golberstein, 2020). The proportion of these new enrollments that stem from job loss is still under debate, but Medicaid enrollment due to job loss is not a new phenomenon. While Medicaid enrollment tends to increase during recessions, households affected by job loss in states with more expansive eligibility guidelines have better access to Medicaid to buffer against becoming uninsured due to unemployment (Benitez, Perez & Seiber, 2020).

Market losses in health coverage also threaten the financial viability of local healthcare providers. The economic downturn caused by the pandemic created substantial uncertainty about the financial viability of hospitals in areas hard hit by the virus, a particularly worrisome situation for hospitals serving vulnerable communities (Khullar, Bond & Schpero, 2020). Declining economic conditions raise the risks for hospital closure, whereas Medicaid expansion was associated with improved hospital financial health (Blavin, 2016). Much of what we know about Medicaid's societal value stems from improving access to health care; however, we may understate the value of Medicaid if we overlook its role as a safety net for health care systems as well. In addition to improving the financial standing of poorer hospitals, expanding Medicaid has been linked to lifting people out of poverty. Suspension of elective procedures in Spring and Summer 2020 elevated hospitals' risk of closure, but we have yet to see how expanded Medicaid may have insulated them from some of the more harmful effects of the recession. These protections could prove even more substantial for safety net hospitals.

Most policy debates about Medicaid treat the public health insurance program as an entitlement program. However, Medicaid may be functioning as a safety net, thereby enhancing the financial and anti-poverty protections normally associated with cash assistance programs like

Unemployment Insurance, Temporary Assistance to Needy Families, or the Supplemental Nutrition and Assistance Program. For this period of heightened economic distress, expanded access to a more robust safety net should provide greater economic stability for households affected by job loss (East & Simon, 2020), in particular. By extension, expanded access to federal dollars via the enhanced Medicaid match rates for expansions could provide broader financial stability to vulnerable health care systems in the face of financial distress. While the protective effects of expanded Medicaid during COVID have yet not been realized, states have been considering multiple Medicaid financing mechanisms to bolster their programs and stabilize health care access for both affected families and vulnerable health care providers and systems (Gifford, et al., 2020).

The essential role of Medicaid in preserving health care access and health systems during the pandemic has policy implications that will become clearer during 2021. The Biden administration will have the opportunity to shore up and build on Medicaid's progress, positioning the Affordable Care Act to achieve its far-reaching potential.:

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A New Deal for Health: Priority Areas for the Biden Administration

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After a four-year long crisis that has left the United States less free, less equal, and sicker, now is the time to push for fundamental change of the healthcare landscape. The next two years of a Democratic-controlled Congress and Executive Branch can build on the foundation of the Affordable Care Act (ACA) to leave a generational legacy of health, equity and progress, similar to the New Deal. There are three key areas the Administration can prioritize: expanding healthcare access beyond the ACA, promoting health equity, and caring for the elderly and their caregivers.

Expanding Healthcare Access Beyond the ACA. The Biden Administration could make sweeping improvements to access by building on the ACA, especially in Medicaid. The Centers for Medicaid and Medicare Services (CMS) could promote positive guidance on Section 1115 or 1332 waivers, specifically for those that expand coverage, strengthen or modernize eligibility and enrollment systems, improve quality or access, bolster provider networks, and reduce disparities and promote health equity. Another possible solution is establishing a Public Option, where those within the coverage gap between qualifying for subsidies on the Healthcare.gov Marketplace and Medicaid eligibility would be automatically enrolled into comparable coverage. With appropriate modifications to Medicaid and the Marketplace, the Public Option could be important for those 12 states that have yet to expand Medicaid.

A more fundamental change would be in ensuring universal coverage through a Medicare-for-All (M4A) approach. While universal coverage would drastically reduce uninsured rates, and thus the economic costs associated with indigent care, M4A's federalized structure would eliminate or drastically reduce the role of Medicaid in state public healthcare. A "best-of-both-worlds" option would be analogous to Medicaid expansion, wherein states would be required to submit approval for federal support for their own unique state-administered single-payer plans. In this "Medicaid-for-All", there could be options for states to innovate and be more responsive to local needs.

Promoting Health Equity Through Decarceration. As the COVID-19 pandemic has highlighted the fundamental inequality in our health systems, an area of particular concern is for those who are incarcerated. The Biden Administration has committed to achieving health equity for oppressed and marginalized groups. This commitment has been validated by early executive orders to eliminate discrimination in health coverage by gender identity, sexual orientation and pregnancy status, establishing the COVID-19 Health Equity Task Force, and ending contracts between the

Department of Justice and private prison companies. However, decarcerating America will be a profound process (National Academies, 2020).

Current options for the Biden Administration include investments in infrastructure to enroll those leaving the prison system into care and social services upon re-entry. Current options include provisions of the Re-entry Act (2019) that facilitate Medicaid enrollment prior to release. Additional areas of growth would be in guaranteeing jobs for those coming home. The harder, yet equally essential policies, include encouraging *divestment* from institutions antithetical to healthy communities. This could include incentives and mandates for states to sunset their prison systems. Many states have already begun reducing their institutional prison populations, and the federal government could facilitate deeper and more rapid processes. The savings from decommissioning corrections systems could be reinvested in community health programs that would actually make communities safer and healthier for future generations.

Caring for Caregivers. A pillar of the Biden campaign promises hinged on caring for caregivers. This included investing \$775 billion over 10 years in the caregiving workforce and promoting at-home treatment for the elderly. This would take the form of fiscal support and grant funding for workforce development as well as reducing barriers to access caregiving support. This could be a profound direction for the future of our country. An estimated 53 million adults provide unpaid care for a friend or family-member each year in the U.S. (AARP, National Alliance for Caregiving, 2020). By investing in this essential work, the US can be better prepared to care for its aging population.

A bolder step the Biden administration could take would be hiring caregivers directly as government employees, similar to the Public Works Administration under the New Deal. In recent decades, federal support has assumed the role of piggy bank rather than service provider. Instead of pumping money into the fractured systems that have led to current conditions, investing in federal support of our social infrastructure could position the US to bounce back from its decline as it did after the Great Depression.

Though the Biden administration has proposed policies that will have positive effects on insurance rates, access to healthcare, health equity and caregivers, there is still much room for improvement. The directions proposed here would expand on this direction and could leave a legacy of health for future generations.

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Policy Priorities for Health Information Technology

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In the current landscape of health information technology, we want to draw attention to the following policy topics for the Biden administration. First, as the COVID-19 pandemic expands the use of health information technology in care delivery, protecting the privacy of patients should be a priority. The patchwork of federal and state privacy laws leaves room for variation in how healthcare organizations set their privacy policy. The variation in privacy laws makes compliance challenging for organizations. Furthermore, the obscurity in privacy laws makes it difficult for consumers and patients to make informed decisions when interacting with healthcare organizations.

The 2009 HITECH Act from the Obama era provided significant financial incentives for healthcare providers to adopt health information technology. By 2015, nearly all non-federal acute care hospitals (96%) possessed certified electronic health records (EHR) technology. HITECH Act also strengthened regulations to protect patient privacy through the HIPAA Security Rules.

However, security failures that result in data breaches and ransomware attacks have been growing over the last decade and pose significant threats against healthcare organizations and patients. Despite regulatory efforts to protect patient data, health data breaches have been rising, with some breaches exposing millions of personal records (Donovan, 2018; Terhune, 2015). Ransomware attacks against US hospitals emerged in 2016, and they have disrupted critical health system operations and cost millions in ransom payments. For healthcare providers, these breaches and attacks may lead to care quality problems because resources are diverted away from patient care.

The current privacy laws that emphasize compliance and remedial action has not been effective at preventing breaches against healthcare organizations. The Biden administration should consider policy initiatives to standardize privacy laws across states, improve the security of healthcare organizations against cyberattacks, and give consumers and patients more control over what personal data is being shared with healthcare organizations and providers.

Second, as the wealth of healthcare data grows in electronic health records (EHR), the lack of electronic health information exchange (eHIE) between providers remains a significant cause of wasted healthcare utilization. Across the nation, from healthcare system to healthcare system, individuals' patient information remains siloed and corded off from each other. This increases wait times, places the burden of tracking complex healthcare data on the patient, and requires costly re-testing and re-imaging where prior records cannot be obtained in a timely manner (Office of the National Coordinator for Health Information Technology, 2019). These problems are not only costly, but also waste the time of the provider, associated staff, and, most importantly, the patient.

The plurality of standards and systems makes efforts to rectify the issue difficult to attempt without sound government intervention with appropriate regulation.

The HITECH Act sought to address some of the lack of eHIE through the EHR incentive programs (renamed Promoting Interoperability Programs in 2018) by promoting meaningful use, implemented over 3 stages. In the 10 years since the first implementation of the incentive program, the goals of meaningful use are still far from reach. Just over a half of office-based physicians are able to electronically find their patient's health information while only one-fourth to one-third of providers have been able to send or receive it. Emergency care notifications to primary care physicians are capable by one in five (Patel, et al., 2019). More of these kinds of health information exchanges should have been facilitated as part of Stage 2 goals, yet the majority of patient providers are yet to be able to do so. If patient health information remains siloed, then the potential gains in population health stay unrealized.

CMS has bolstered the movement towards Stage 2 with the 2015 edition of Certified EHR Technology, but yet to mandate its implementation for all providers in the Promoting Interoperability Program. EHR vendors, in turn, have less pressure to use non-proprietary standards that all major software and database implementations can understand. The Biden administration should encourage providers and EHR vendors to reach majority compliance with Stage 2 goals and move closer to actualizing the benefits of Stage 3 meaningful use.

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Public Health Practices for Pandemic Management in the Biden Administration: A Five Point Plan

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As of February 2021, the COVID-19 pandemic, has resulted in over 100 million cases worldwide and over 2 million deaths. In the United States alone, there are over 27 million cases and 450,000 deaths. The first known coronavirus case in the United States was announced on Jan. 21, 2020 near Seattle, Washington. As of early February 2021, the United States with approximately 331 million people represented just 4 percent of the world's population, accounted for approximately six times that proportion of COVID-19 cases worldwide, and U.S. COVID-19 related mortality contributing 20 percent of the world's pandemic mortality burden. The Biden Administration has a window of opportunity to improve the performance of the U.S. public health system to better respond to COVID-19 now, as well as future health challenges. Here is a list of five recommendations:

1. *Treat Global Public Health as a Common Good.* It is important to generate new plans and perspectives for managing this pandemic across geographical and cultural boundaries, with increased investments in public health infrastructure (currently at only 2-3% of total healthcare expenditures). This calls for redirecting and reconnecting our public health orientation to a global perspective to address a problem faced on a global battlefield. This requires new thinking toward health as a common good and becomes even more important as we anticipate future pandemics.

2. *Engage in Pandemic Population Health.* It is glaringly obvious that the United States is failing to meet the three core public health functions of surveillance, policy development, and assurance. The ramifications for public health leadership to ramp up our pandemic capabilities are abundantly clear. Pandemic planning and investment need to be substantially ramped up.

3. *Apply Early and Proactive Public Health Controls.* Early intervention is critical. Ten Asian countries (Indonesia, Japan, Malaysia, Myanmar, Philippines, Singapore, South Korea, Taiwan, Thailand, and Vietnam) better managed the pandemic than the U.S. in part because they started to manage COVID-19 in the early days of pandemic. Their measures (with number of countries noted parenthetically) included:

- Face Covering: Recommended (3); Required (5); No policy (2)
- Testing policy: Symptoms within Key Groups (3); Anyone with Symptoms (4); Open Public Testing (3)
- Contact Tracing: Limited (3); Comprehensive (7)

These practices were implemented throughout most of 2020 and helped control the spread of the COVID-19 infection, compared with the U.S. which experienced periods of exponential increase.

4. *Appoint A Federally Appointed Blue Ribbon Panel.* Public health governance should be front and center of public discourse now.

Americans have been aghast watching federal, state, and local authorities pointing fingers at each other as mismanagement of the pandemic mounted. Our decentralized and fragmented system that devolves authority to the local level has failed. Counties may have better understanding of local conditions but do not have the resources to properly manage pandemics. A clear and levelheaded analysis should be undertaken, perhaps by a federally appointed blue ribbon panel, to identify where comparative advantage lies in various public health functions. A continuing debate occurs about whether a centralized government approach is optimal to monitor pandemic activity or more localized government. Indeed, we need to establish those tasks best suited for management at the federal, state, and local levels, and provide statutory authority and resources to carry out these tasks.

5. *Optimizing Health and Economic Objectives.* There is another very important aspect of our response to the COVID pandemic that needs to be squarely addressed to better meet future pandemics. The uncomfortable and inevitable tradeoff between lives and livelihoods requires less squeamish and more rational deliberation. Of course, there are times when better management serves both improved health and greater economic output, but not always. The key concern here is willingness to include efficiency criteria in resource allocation and this requires placing a value on human life. The rest of the world is more willing than we to use cost-effectiveness or cost-utility analyses to allocate resources. Cost per quality-adjusted life year is commonly employed and even the WHO recognizes this approach. American public health and health agencies need reorientation, and part of this requires bringing in more health economists and others to assist in what are ultimately economic, and not just health decisions. More clarity and information in this regard will help establish when and how to use lockdowns more efficiently going forward.

For global application of effective public health policies to work better in combatting the COVID-19 pandemic, major policy initiatives and collaboration beyond any seen in recent history is essential.

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Value-Based Purchasing in Pharmaceutical Care

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The growth in value-based purchasing and reimbursement arrangements has grown significantly over the past decade-plus due to the regulatory framework and resources provided as part of the Affordable Care Act. Much of this growth has been concentrated among public payers, principally in the Medicare and Medicare Advantage programs, and has focused on the reorganization and payment for defined episodes of care and/or defined patient populations such as the chronically ill elderly population, towards the goal(s) outlined in the “Triple Aim” as described by Berwick and colleagues (Berwick, Nolan & Whittington, 2008).

Over the same period of time, the expansion of value-based purchasing and reimbursement systems specifically to the use of pharmaceuticals and the provision of pharmaceutical care has lagged behind other health care expenditure categories such as hospital care. According to the Centers for Medicare and Medicaid Services (CMS), value-based purchasing is defined as an arrangement or agreement between a pharmaceutical patent owner and payer that is intended to align pricing and/or payments to an observed or expected therapeutic or clinical value in a population which may include either of the following: (1) evidence-based measures, which substantially link the cost of a drug to existing evidence of the effectiveness or potential value for specific uses of that product, and/or (2) outcomes-based measures, which substantially link payment for the drug to that of the drug’s actual performance in a patient or a population, or a reduction in other medical expenses.

A cursory review of the CMS Innovation Center’s web page (innovation.cms.gov) suggests that there are currently 3-4 ongoing sponsored demonstration models out of more than 90 total that are specifically targeted towards pharmaceutical expenditures. Of these, only one such demonstration model, the Part D Enhanced Medication Therapy Management Model, has been operational long enough to have generated enough data to evaluate its success (or lack thereof) in improving health outcome(s) and/or reducing beneficiary/program costs, and none of the existing models specifically emphasizes value-based purchasing agreement(s), as defined by CMS, as a primary innovation strategy being employed by the model. There is also no systematic evidence that either Medicaid program(s) or commercial insurers have made any significant progress on a large enough scale over the past decade to move in the direction of implementing or otherwise incentivizing value-based purchasing agreements for pharmaceuticals among the populations they cover despite the substantial growth in expenditures and use of many high-cost and potentially marginal-value agents.

In the past year, CMS proposed a set of rules to address one of the most significant regulatory impediments to implementing value-based purchasing agreements for pharmaceuticals in the

Medicaid program (CMS, 2020). Such changes may have the effect of increasing the rate of adoption of such programs among state Medicaid programs in addition to the emerging interest among commercial and Medicare Advantage insurers in pursuing such agreements, especially in selected high-value/high-cost therapeutic areas such as heart disease and cancer.

As public and private payers begin to pursue such agreements more aggressively in the years ahead, there will be a substantial need for the collection and dissemination of real-world outcomes data pertinent to pharmaceutical use in covered populations to support the administration of such agreements and, more importantly, to demonstrate the value of pharmaceutical agents in the improvement of population health outcomes and/or the reduction in other medical expenses. Limited experience to date with such contracts suggests that there will be a relatively steep learning curve associated with their execution along with lingering questions about whether, or to what extent, such value-based contracting arrangements result in improved value for patients and payers alike, typically measured in terms of either/both improved clinical outcomes and/or incremental cost-effectiveness.

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LGBTQ Health Disparities during COVID-19: Exposing Potential Areas for Improvement Under the Biden Administration

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Over the past few decades, the amount of research on lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) health outcomes has grown significantly. Although early research mainly focused on HIV-positive men who have sex with men, current research on LGBTQ populations spans nearly every field of study. Nevertheless, there is much room for improvement. The COVID-19 pandemic highlights ways in which LGBTQ people remain particularly vulnerable to adverse health outcomes.

Throughout COVID-19, LGBTQ individuals have been more likely to work in highly laid-off industries, such as food service and retail. Approximately 40% of LGBTQ individuals work in service industries such as these, as opposed to only 22% of non-LGBTQ individuals (Whittington, Hadfield & Calderón, 2020). Disparities in health coverage have been further exacerbated for individuals who have lost their health insurance coverage along with their jobs. In 2018, 17% of LGBTQ adults did not have health insurance, compared to 12% of non-LGBTQ adults. This disparity was even worse for transgender adults and LGBTQ people of color, and has likely worsened as a result of the pandemic.

In addition to lacking health coverage, LGBTQ individuals are also less likely to see a physician when they need to, for a variety of reasons. First, compared to non-LGBTQ people, LGBTQ people are more likely to be unemployed or living in poverty, and thus unable to afford a hospital visit (Badgett, et al., 2019). Additionally, discrimination from healthcare providers, in the form of macro- and micro-aggressions, has led to distrust in the healthcare system among LGBTQ communities (Sabin, Riskind & Nosek, 2015). Finally, systemic discrimination, such as anti-transgender policies in public areas, have also prevented LGBTQ individuals from seeking care (Reisner et al., 2015). In the time of COVID-19, these barriers to accessing healthcare are more pertinent than ever, since delaying or avoiding care often leads to poorer health outcomes and more severe economic hardship.

LGBTQ individuals are also more prone to experience complications of COVID-19, since they are more likely than non-LGBTQ people to have chronic conditions such as asthma, cancer, and diabetes (Whittington, Hadfield & Calderón, 2020). The extremely high rates of smoking in LGBTQ populations are a particular concern during COVID-19 (Berger & Mooney-Somers, 2017). These factors have all been demonstrated to increase the risk of having serious complications of COVID-19. This pandemic has also exacerbated mental health outcomes

(Vindegaard & Benros, 2020). Prior to the pandemic, LGBTQ individuals were disproportionately impacted by adverse mental health outcomes such as PTSD, suicidality, depression, and anxiety (Whittington, Hadfield & Calderón, 2020). Increasing rates of depression and anxiety symptoms, as a result of social isolation and unemployment due to COVID-19, are likely to exacerbate the mental health burden among LGBTQ populations as well.

In December 2020, the Kaiser Family Foundation identified improving LGBTQ health research as one potential field of policy change under the Biden administration (Cox et al., 2020). The COVID-19 pandemic has highlighted many areas in which LGBTQ health can be improved, even after disease prevention measures are lifted, and life returns to relative normality. In addition to policy changes at the federal and state level, improvements at the interpersonal level are needed as well. From reversing regulations that allow discrimination based on sexual orientation and gender identity, to implementing cultural humility trainings for healthcare providers, there is still much that needs to be done in order to improve the health of LGBTQ individuals.

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Hospital Closure: The Invisible Hand of the Market or the Visible Hand of Management?

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In 2019, before the viral epidemic, U.S. hospitals faced a closure epidemic. Forty-seven hospitals, of which 19 were rural, closed in that year, twice or more the number that closed in any of the three previous years. Rural hospital closures get a lot of media attention, but non-rural hospital closure creates access problems too – because they tend to be in areas serving low-income, often minority populations (e.g. Mercy Hospital in Chicago, Hahnemann University Hospital in Philadelphia and Providence Hospital in Washington, DC). The country has lost roughly half of its major city hospitals since 1970, and the lower-income neighborhoods that relied on those hospitals is increasingly underserved. Access and health outcomes are affected by these urban closures, because residents cannot always gain timely access to the nearest remaining facilities.

Low occupancy and lack of state Medicaid expansion are often given as the reason for hospital closures and divestitures. Yet many of these hospitals have been around for decades, well before Medicaid expansion was even an option. Low occupancy does not just happen – it occurs when a hospital's facilities deteriorate and are not replaced, when it fails to keep up with needed information systems investments, when relationships with physicians deteriorate, and/ or institutional culture becomes uncaring. These relate to choices that health system managers make, influenced by but not determined by health policy.

One big change in the landscape that may be contributing to the record number of closures is the growing number of multi-hospital systems that are expanding their membership beyond their local community base. Increasingly, multi-hospital systems are buying hospitals or groups of hospitals to gain market share or expand to new markets, and later selling in order to “balance their portfolio” or pay off their debts. Loyalty to the local community or preserving access to care is not always a demonstrated consideration. Some sell the capital assets of an acquired hospital to a separate entity for tax purposes, and leave the operating assets under a mountain of debt, further jeopardizing its chances for survival.

While both investor-owned and large nonprofit health systems acquire and divest hospitals, the recent financial troubles of some of the larger investor-owned systems seem likely to have the effect of weakening some hospitals. Tenet's 2018 divestment of Hahnemann University Hospital resulted in its abrupt closure one year later by the purchaser. In the last couple of years, CHS, Verity, Quorum, and Curae Health all filed for bankruptcy and sold off dozens of hospitals. Many CHS hospitals were acquired in 2014 from financially-troubled HMA when it was being investigated for Medicare fraud and was subsequently liquidated. Between 2017 – 2019, CHS

itself had to sell over 50 community hospitals to reduce its onerous debt burden and improve its profitability. One 112-bed former CHS hospital, now called “Panola Medical Center” in Batesville, MS had three owners over two years.

Nonprofit systems are also divesting unwanted hospitals. Trinity, Ascension, University of Pittsburgh Medical Center, among others, have been in the news for seeking to divest or close hospitals, particularly those in low-income urban areas.

Are there aspects of financing or ownership intentions in multi-hospital system expansions that should be considered red flags for state or federal oversight of individual transactions? If the financing deal looks too rich or the acquisition price paid too high, or the deal involves a hospital serving a low-income population, should government intervene and/or set more stringent conditions and/or provide additional resources? Management turnover in these traded hospitals seems likely to have an effect on longer-term viability and may be contributing to the growing rate of hospital failure. This is not to say no hospital should close or be divested, but we may need rules to protect vulnerable institutions serving low-income populations. We need more ways to preserve these hospitals than allowing them to be acquired and then discarded by market-share hungry systems. Restrictions on purchasers, improved Medicaid rates or supplements, low-interest loans or grants for the specific hospital might all help, but would require vigilant oversight and accountability to work.

The Need for New Initiatives with HIPAA Given Advancing Technologies

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The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. In 2003, the first of its eleven parts, the Privacy Rule, was implemented. Six months later, the Transactions and Code Sets Rule was introduced. The next year, 2004, saw the Standard Unique Identifier for Employers Rule implemented. This was followed in 2005, by the Security Rule. Five months later, the Claims Attachment Standards Rule was introduced. Having all these rules out, in 2006, the Enforcement Rule was introduced to establish how the Government would enforce the parts of HIPAA. A year later in 2007, the Standard Unique Healthcare Provider Identifier Rule, also known as the National Provider Identifier (NPI) number, was introduced. Year after year, new HIPAA Rules were introduced and then a small break came until 2009 when the Health Information Technology for Economic and Clinical Health Act, (HITECH) was passed which increased the fines for HIPAA violations. Along with HITECH in 2009, was the Breach Notification Rule which mandated that depending on how large the breach was, various groups needed to be notified. Lastly in 2013, the Omnibus Rule was passed which, 10 years later, strengthened the Privacy Rule and introduced the Genetic Information Nondiscrimination Act (GINA). As genetics use became more mainstream, GINA was implemented to stop insurers from using genetic information to price insurance policies.

But since 2013, very little has changed with HIPAA, yet the healthcare field has changed dramatically, especially in the area of information technology. Given this, several new initiatives should be undertaken with HIPAA. First, as of now, only places that conduct one of the eleven HIPAA transactions, as stated in the Transactions and Code Sets Rule, are governed by HIPAA. The most prominent of these eleven is electronically billing for services; thus, if a facility is cash only or free, they are not under HIPAA despite collecting patient health information (PHI). These places are not under the PHI protections of the Privacy and Security Rules and thus PHI could be in a compromising situation. Second, with the advent of telemedicine, especially during this pandemic, HIPAA must include greater security protections when conducting live patient visits. Telemedicine visits clearly contain more PHI, such as the patient's facial image, the full dialogue between the patient and provider, than the medical record, whether it be paper or electronic, and thus the protections should be more. Third, since 2013, social media platforms have escalated in number and usage. From TikTok to Instagram to Facebook, these unregulated platforms can contain PHI as patients use them to convey their medical information. Providers also find them to be a part of everyday use, but refrain from formally using them with patients as they are not under the HIPAA Security Rule. By updating the HIPAA Security Rule and the social media platforms

security features, patients and providers can have another way to communicate. Fourth, wearable devices that collect PHI, such as FitBits and smart watches, are not under HIPAA as the wearable belongs to the wearer; i.e. the patient. But where does that data go? Who sees that data? How are the data transferred? All questions that an updated HIPAA can have answers to. Fifth, artificial intelligence in health is not the future, but the present; thus, HIPAA must concurrently be in the present alongside it. Are artificial intelligence computer programs that analyze patient data considered business associates under HIPAA? Not as HIPAA is presently written for in 1996 artificial intelligence uses in healthcare were very different and minimal than they are now.

As HIPAA enters its silver anniversary, new initiatives to protect patient health information from all sources, including the latest information technology, are needed. In this way, the healthcare industry can continue to be inventive and innovative in delivering high quality care.

Using the Community Health Needs Assessment to Inform Healthcare Policy

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The Affordable Care Act (ACA) provided coverage to 21 million Americans. Importantly there were other legislative drivers included in this important reformation including community-centered strategies to promote improved access to physical and behavioral health, accountability among health care providers claiming non-profit status, and promotion of health behaviors by making healthy nutrition and physical activity more accessible. There remains a need for more health care providers to fully address the issue of access to care. Equally important is a need to more fully engage people through improved literacy about their health and health care utilization, promotion of health care provider communication strategies that return a voice to patients.

Using the Community Health Needs Assessment (CHNA), now required for many health systems, to identify unmet health needs among vulnerable populations is critical to improving health outcomes for those with serious chronic health conditions. While the need for healthcare systems to invest in community health should be considered in developing policies and services, addressing how individuals perceive health, access, and affordability should also inform these policies. Health happens in the community in a hierarchical manner—people live in their communities within families and households. They are influenced by what happens in their living environment. Recognizing this paradigm, developing health policies that give a “voice” to patients and providers in the community can inform how resources are allocated and distributed, particularly in underserved communities.

Using CHNA's conducted by nonprofit systems in a more meaningful way can shape interventions, programs, and services that reflect the unmet needs of the community by engaging directly with patients and providers to address the circumstances and exposures that influence everyday health. Healthcare happens in provider settings. These settings are located in the community. Patients and providers interact (or not) in ways that influence health and wellbeing. Access includes not only the physical location but also the ability to pay for care, communication, trust, and flexibility of the provider setting around the structural issues within the community—for example, hours open for primary care or openness of providers to adapt to the cultural conditions of daily living amongst community members. In communities that experience health inequity and disparities, policies that focus on reallocating resources that directly address the root causes of disparities; cost, access, trust, communication, and literacy should be considered. In

order to achieve the goal of a healthy community, it is time to take a moment to consider the important precept of population health—returning the voice to people living in communities. Outcomes occur in relation to the interaction between health and health care. Outcomes may be used to map the inequities of a health care system that is not responsive to its community. Positive outcomes will occur through a renewed emphasis on healthcare policies that address health inequality and inequity.

Is Universal Health Coverage an Option?

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In the past decades, there have been significant gains in life expectancy in the US and around the world. The global life expectancy gain that we have been observing since 1900 has been a miracle that has never happened in the history of humankind, going from an average global life expectancy of 31 in the year 1900 to 72 in 2020. Life expectancy in the US was on the stable increase up to a few years ago and is now decreasing or remaining stable due to issues like opioid epidemic, obesity, and COVID-19. There is profound disparity in life expectancy between countries and regions, with dramatic geographic variations in life expectancy in the US, where life expectancy in West Virginia averages at about 74 years of age vs. Hawaii and California with around 82 years of life expectancy expected at birth. Similarly, according to CDC data from 2018, there is a large racial variation in life expectancy in the US, with African American population life expectancy of 75 years of age compared to European American population life with expectancy of 78.7.

On the day he took office, President Biden signed an executive order establishing a government-wide initiative to address racial inequity and systemic racism in federal policies, laws, and programs. What would this move mean for ending the health disparities in the US and what initiative should be taken by the new administration to end the disproportionate burden of morbidity and mortality in the minority groups?

Research studies conducted in the US and globally implicated many explanatory factors in life expectancy disparities such as per capita income, smoking, obesity, education, healthcare expenditure, access to safe water, physician ratio, nutritional outcomes, geographical status, and urbanization (Mackenbach, et al., 2019). The factor that we also want to point out as a contributing factor to global life expectancy gains is the universal health coverage (UHC). UHC is broadly defined as service which ensures broad population access to at least basic but comprehensive promotive, preventive, curative and rehabilitative health services and has been receiving growing attention (Ranabhat, et al., 2018). In fact, all 10 countries with the highest life expectancy around the world have some sort of universal health coverage, typically covering all of the preventive services, maternal and infant health services, immunizations, etc. We would like to argue that one of the biggest healthcare priorities for the new administration would be new initiatives to bring the country closer to providing the UHC to all of the population.

Any step that could bring our country closer to UHC is better than doing nothing. “Medicare for all” idea considered many different plans, and such discussions should be continued. Providing UHC is not cheap, however we would like to argue that providing some of the preventive services free of charge to all is a good start. Free maternity services that could target the disproportionate mortality of African American women dying due to pregnancy complications could be a great

start. While the Department of Defense budget has been increasing each year in the US, budget dedicated to public health has been decreasing or remaining the same for decades. With COVID-19 vaccine development and distribution, US government demonstrated it is possible to do a uniform centralized public health intervention in a very short time frame. The recommendation is to use these experiences and translate them into other public health services in the US. Fragmented, complex, expensive, and inconsistent medical coverage was associated with inability to adequately control the outbreak of COVID-19 in the US in 2020. We would like to argue that 2021 should be the year of change and transition towards better and equitable healthcare in the US.

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Thoughts on a New Administration's Place in Time

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Back in March 2010, at the time the Affordable Care Act (ACA) was signed into law by President Barack Obama, many of us involved in creating the ACA knew that it was not affordable enough. Senators and House members, staff, Obama Administration officials, and outside experts all recognized that improving the affordability of subsidized private coverage was essential. A decade ago, one of my key conclusions was that “(a)ffordability for new exchange enrollees will be a key test...” (McDonough, 2011).

We had time to fix it. The new coverage for middle and lower income Americans would not start until January 2014. Every major law, from Social Security to Medicare on down, required fixing and improving. We could not fix it during the remainder of 2010 because members were too spooked by the Tea Party conservative resurgence. The House switched to Republican control in January 2011, and Republicans realized that opposing “Obamacare” could be a long-term and politically beneficial gift that would keep on giving. For the remainder of the decade, the window of opportunity remained closed to progressive enhancements, however justified.

On January 20 2021, the window of opportunity began to reopen with Democrats in control of the White House, Senate, and House of Representatives, albeit with razor-thin margins in both chambers. Improving and expanding affordability of ACA coverage became a cornerstone of candidate Joe Biden’s campaign, improving the affordability of premiums and cost sharing for current eligible, and expanding subsidies for middle income households making more than 400 percent of the federal poverty level.

Other Biden health reform promises will face tough sledding, especially winning the creation of a so-called “public option” insurance choice within Medicare or the exchanges, and likely the same trouble for lowering the age of Medicare eligibility to 60. This is because Democrats lack 60 votes in the Senate to overcome filibusters, and also lack the votes to repeal that mechanism, even if they wanted to do so.

The affordability changes can be achieved as part of a “budget reconciliation” package that requires only 51 votes (50 Senators plus Vice President Kamala Harris). It’s one of the few significant ACA reforms that have a realistic chance of happening this year, and could be the most significant health reform achievement of President Biden’s first year in office. It’s a reasonable bet from the vantage point of early February. If passed, it will address one of the largest and most important pain points afflicting Americans in need of more affordable coverage options.

A year ago, as I write in February, many progressives were thrilled at the prospect of a Bernie Sanders presidency and the ultimate battle to achieve a Medicare for All single payer health plan for all Americans. Today, it's hard to see a window for it in this decade.

To make sense of this, I prepared a single chart to illustrate the history of attempts to achieve full or partial progress toward universal health care in the United States.

President	Year of Win/Loss	White House Party	Cong. Control Senate/House	Policy Ambition	Win/Loss
Harry Truman	1950	D	D/D	Comprehensive	Loss
Lyndon Johnson	1965	D	D/D	Incremental	Win
Richard Nixon	1974	R	D/D	Comprehensive	Loss
Bill Clinton	1994	D	D/D	Comprehensive	Loss
Bill Clinton (CHIP)	1997	D	R/R	Incremental	Win
Barak Obama	2010	D	D/D	Incremental	Win

I hope readers can discern the pattern in the two columns to the right. Over 70 years of health policy we can see that comprehensive all-or-nothing reform loses, and incremental expansion wins. It's not a prediction for the future, and it's a lesson, disappointing for many, for future reform and reformers.

When it comes to health system changes, Americans exhibit the classic “loss aversion” dynamic of behavioral economics. Americans fear hypothetical losses far more than they appreciate hypothetical gains – which is precisely why President Obama had such a tough road in 2010, and also why President Trump had such a tough road in 2017 when he attempted near-complete repeal.

Love it or hate it, this is how it has gone down in the U.S. since 1950. If the COVID-19 Pandemic and Recession can't shake loose this pattern, it's hard to image what else could. Democrats need to prove that they can hold onto the Washington D.C. Trifecta (simultaneous control of White House, Senate, and House) for more than two years. Bill Clinton and Barack Obama could not. And the stakes are so much higher now.

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Health Care Policy Priorities for 2021 and Beyond

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The Biden Administration faces unprecedented health care challenges in the coming weeks and months. From our perspective, the most important keys to the future are making health insurance coverage more affordable and accessible.

President Biden campaigned on a health care plan that will build up the existing infrastructure created via the Affordable Care Act of 2010 (ACA). Attitudes toward the ACA are more favorable than unfavorable, with favorability reaching near peak levels in December 2020. The majority of Republican voters would like to overturn it, but keep some of the central provisions.

President Biden is moving forward on several fronts, including strategies from the former President's playbook like issuing executive orders, encouraging Congressional action, and invoking the Congressional Review Act. Biden is using executive actions to eliminate what he terms "bad policy" of the prior administration. Executive orders have opened up the ACA health care marketplace exchange enrollment period to expand coverage availability for the millions who have lost employment and thereby their health insurance in the COVID-19 pandemic. He has enhanced this with fully funding navigators to help enrollees find the best plan, and should actively fund the marketing and awareness of the open enrollment period. Administrative burdens should be alleviated, including the requirement to attest to income every twelve months. These barriers cause families to lose needed insurance coverage due to administrative obstacles, and could be increased to attestations every three years.

Biden's strategy is also to work in a bipartisan fashion with the Congress. It is time to drop the politics, fight the Coronavirus, and improve our health care system. The 50 Senators that align with Democrats and the 50 that align with the Republican party create a precarious, narrow Democratic control in the Senate. Vice President Harris will serve as the determining vote on any 50/50 vote decisions.

Lastly, similar to President Trump, Biden should consider invoking the Congressional Review Act of 1996. Biden can revoke some of the Trump administration's more controversial rules, including the Final Rule issued in December 2020 on grandfathered health plans. The rule allows higher consumer cost-sharing by insurers, increasing the out-of-pocket costs faced by unwitting patients.

The Health Care Affordability Act of 2021 should be a top, bipartisan priority to make the premiums for coverage available on the Exchanges more affordable (Underwood, 2021). In addition, Biden campaigned on capping the share of income that subsidized households would pay

for their health insurance at 8.5%. Biden should go bolder and reduce this cap to 7%. The Biden administration should bolster federal subsidies for the private insurance companies providing coverage on the Exchanges, so they can in turn reduce the out-of-pocket expenditures for low-income enrollees. This support extends beyond premiums to cover high deductibles, high copayments, and high coinsurance enrollees face at the point of care. Making health care more affordable and accessible will help alleviate racial and ethnic disparities in access to care.

Biden should use incentives to encourage the 12 states that have not expanded their state Medicaid program under the ACA to do so with a full federal match, similar to the one granted to states that expanded their Medicaid programs in the early years of ACA implementation.

The Bipartisan-Bicameral Omnibus COVID Relief bill overwhelmingly passed the Senate and the House in December 2020. Among many provisions, this bill eliminates surprise billing, meaning consumers will not face unexpectedly high bills for receiving care from out-of-network providers. The Biden administration should continue these bipartisan efforts.

The Biden administration should carefully examine and consider keeping some of the Trump administration's actions on health care prices. The executive orders on hospital price transparency, requiring hospitals and eventually insurers to post their negotiated charges, brings a price transparency to health care that could help consumers shop for health care services. Lowering prescription drug prices should also be an area of focus for the Biden administration. Trump's 2020 executive order, Lowering Drug Prices by Putting America First, is limited in its reach because it loosely defines the medications it aims to impact as "certain high-cost prescription drugs" and drugs with "insufficient competition." It is imperative to clarify these terms, allow opportunity for public input, and determine a method of enforcement to keep prices affordable for all individuals.

Community Health Centers expanded under the ACA provide vital care to millions of Americans. This infrastructure should be used, rather than hospitals, to roll out a sustained vaccine distribution system. Pharmacies and grocery stores should also quickly be mobilized, with creativity around the types of providers who inoculate the population.

As the Biden administration presses forward with ensuring affordable access to health care to all those living in the United States, it should of course be balanced with all of the social determinants of health that lead to healthier populations. A health-in-all-policies approach should ensure access to affordable housing, clean air and water, affordable child care, food security, and education.

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Reform of Health Policy and Availability of Services for the Severely Mentally Ill

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The large and rapidly growing number of seriously mentally ill (SMI) individuals living on the streets and in jails and prisons in the United States is an unaddressed humanitarian health crisis at home. Approximately 5% of our population experiences severe mental illness, but these individuals are disproportionately represented in our unhoused and prison populations. What amounts to an abysmal lack of effective care and treatment available to this group of Americans contributes to frequent use of emergency rooms as well as 911 calls resulting in violent and sometimes fatal clashes with law enforcement. The general public also pays the price in wasted healthcare tax dollars more effectively spent on prevention, as well as unsanitary compromised streets and public areas. Three important steps are recommended to address the tragedies that are playing out daily due to this pressing need for policy reform.

To begin, current laws don't adequately address the medical inability of a person experiencing psychosis to understand their need for care. Many of those suffering from Schizophrenia, for instance, were high functioning individuals prior to the onset of illness, but once a severe break occurs are most often medically unable to understand their incapacity, and therefore to seek or consent to care. No one would think to allow their mother or father experiencing Alzheimer's to live on the streets just because they didn't know they were sick. At the same time, we let exactly that happen to many of our adult sons and daughters who are experiencing SMI. Current consent requirements and the Health Insurance Portability and Accountability Act prevent family members from accessing care for their incapacitated loved ones or even from advocating for them. This is especially tragic because Schizophrenia and other types of severe mental illness are treatable, and early intervention has been shown to be especially effective. The first most important action, therefore, would be to craft policy that allows family members to collaborate with healthcare organizations to facilitate mandated care for those who are suffering in this manner. Current laws that require individuals to be a clear and present danger to themselves or others both miss the early treatment window and create a standard often not reached until it is too late.

Next, even for individuals "lucky" enough to be found to meet the required legal standard thereby triggering legal access to care, the dismantling of the acute mental healthcare system in the 1950's and 1960's means there is a dire shortage of beds and care available. While no one advocates returning to the documented abuses in mental hospitals that led to the widespread closures, a dearth of replacements has quite literally put those displaced patients on the streets and into the prison system. The second required action then is to take steps to rebuild an appropriately financed acute mental care inpatient, step-down, and outpatient system that supports the number of patients requiring care.

A third urgently needed action is to establish emergency mental health teams that can respond to mental health emergencies in lieu of police. This innovation, as demonstrated successfully in a program in Eugene Oregon, has been shown to substantially improve outcomes, as these teams have been highly successful in deescalating crisis situations, avoiding death and injuries, identifying need for treatment, and bridging access to care. Families need to be able to call for help without fearing their affected family member will be further traumatized or even killed at the hands of those from whom they are seeking help.

The pressing need for these recommended reforms represents important opportunities to significantly impact the lives of many, not just the sick, but also their families and the public at large. Simply stated, people with SMI should not be left to suffer and die on the streets and in prisons as well as in altercations with the public and with police. The ramifications of our failure to adequately address this travesty is visible to all. The economic incentives are also substantial as we know that dollars spent on prevention are significantly more efficient than waiting to treat disease. Addressing this pressing and widespread public health crisis must be a priority to the new administration and to all those that work for the improved health and welfare of our population.

For-Profits Are ... For Profit

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One of President Biden's clearest messages has been of unity and Americans working together. In that spirit, the answers to some of our country's worse healthcare problems – rising healthcare costs, structural racism leading to health inequities, an ongoing pandemic – won't (shouldn't?!) be solved with the ideologies strictly from one political party or the other.

Most Republicans believe in the power of the competitive market as do I. The laws of supply and demand make sense. Competitive markets and private ownership often go hand-in-hand as they are both features of capitalism, another typical Republican belief. Most Democrats believe that healthcare is a right as do I. When you live in a country as rich and powerful as the United States, it is easy to think its citizens should be taken care of. The problem is that when you apply the ideas of capitalism to healthcare, it fails for economic reasons such as information asymmetry, barriers to entry, limited suppliers, and differentiated services as well as moral reasons such as the idea of businesses profiting because someone is sick or injured. These market failures exacerbate the health inequities of Americans. How do we merge these two seemingly mutually exclusive beliefs of capitalism and healthcare being a right? How can President Biden move forward with health policies that unite the country while solving some of our healthcare problems?

The answer doesn't lie in sweeping reforms that are strictly right or left but rather a middle ground. The power of the free market should be applied to healthcare when it makes sense – concierge medicine immediately comes to mind. Also, some outpatient services, especially if these are offered as an alternative to more invasive, expensive care to patients who have chronic conditions. People with a chronic disease or injury have time to do research and make more informed decisions about their care. They should be able to more easily distinguish if the care is working for them. There are less barriers to entry and more suppliers as well for outpatient services – think of starting a nutritional clinic or physical therapy office as opposed to starting a hospital. These services are more aligned with the necessary conditions for a competitive market. At the same time, the healthcare market should be regulated when it needs to be – hospitals immediately come to mind this time.

Hospitals fail the conditions for a competitive market. There is information asymmetry between patients and physicians, especially if patients are there for an acute injury or disease. There are barriers to entry in the form of certificates of need and large capital costs. There are limited suppliers, particularly in rural areas. Patients cannot often differentiate between services. If someone was in a car crash and went to the nearest hospital, how would they know the care given to them in a different hospital?

Despite this, for-profit hospitals gained market share in a (somewhat ironic) attempt to lower rising healthcare costs. The thought was private, for-profit hospitals would be run more efficiently, lowering costs. This does appear true in some ways. However, for-profit hospitals are...for profit. Woolhandler and Himmelstein (2004) sum it up best, “investor-owned hospitals are profit maximizers, not cost minimizers.” Any extra savings for-profit hospitals may have in efficiency are not passed on to the patients but rather consumed as profit. Additionally, research unequivocally demonstrates charges are higher at for-profit hospitals.

For decades, researchers have warned of the problems of having for-profit hospitals yet they continue to grow. In the United States, 15% of hospitals were for-profit in 1999 and 25% in 2018 (Kaiser Family Foundation, 2021). This is adding to an already problematic, continuous increase in healthcare spending. One possible priority for President Biden and his health policy team is to consider hospital ownership in the United States and its impact on healthcare spending. I am not suggesting socialist healthcare – nor capitalist – but rather a step-by-step approach to regulation for some of our country’s healthcare problems based on sound economic theory and research.

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Rebalancing Investments to Strengthen Public Health

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In 2019, the U.S. spent over \$3.8 trillion - or \$11,582 per person - on health (Centers for Medicare and Medicaid Services, 2021). As in prior years, almost all of this investment funded healthcare services for individual patients. A mere 2.6 percent – less than \$300 per person – supported the efforts of local, state, and federal public health agencies to protect and promote population health, with a fraction of this allotted to sustaining foundational public health infrastructure and programs.

The disparate emphasis on treating individuals in acute care systems is broadly acknowledged as both sub-optimal and wasteful. Studies have shown that a substantial proportion of our nation's investment in healthcare services for individuals is wasted while public health agencies are chronically underfunded. Analysis by Shrank and colleagues (2019) affirmed previous research that wasteful spending accounted for approximately 25% of total U.S. healthcare expenditures, or approximately \$950 billion in 2019 and almost \$2,900 per capita. This eclipsed the Fiscal 2020 U.S. defense budget by over \$200 billion. Disheartening are the large sums attributed to poorly provided, unnecessary, or overpriced care.

Public health agencies, on the other hand, often have insufficient resources to provide the basic public health infrastructure and programs needed to ensure the health of their communities. As a nation, we have come to accept the chronic underfunding of our public health system despite growing evidence that investing in public health makes both clinical and economic sense. Available evidence has shown that for many programs and activities, increased public health spending can result in measurable improvements in the health of individuals and their communities. Moreover, such spending often has a positive return on investment, suggesting that investments in public health can be highly-cost saving.

A recent study by Mamaril and colleagues (2018) estimated that, on average, public health agencies need an additional \$35 per person to fully fund foundational public health infrastructure and programs. At the national level, this estimate translates into an additional investment need of \$11.5 billion. When compared to the \$950 billion estimate of wasteful spending in healthcare, increasing funding for core public health services by \$11.5 billion would require reallocating a mere 1.2 percent of the amount of resources currently considered wasteful spending in healthcare delivery.

Of course, shifting dollars currently spent on wasteful healthcare services to fund public health activities is challenging. Even wasteful services represent revenue, profits, and livelihoods in the

medical-industrial complex and under predominantly fee-for-service reimbursement, healthcare providers have little incentive to reduce services that provide no or only limited value to patients.

To achieve a meaningful shift in our health investment portfolio, the Biden Administration and Congress must challenge fundamental assumptions supporting the current status of healthcare delivery and continue to aggressively implement value-based reimbursement models that embrace both upside and downside risk for healthcare providers. Combined with a simultaneous rebalancing of investment that includes strategic funding of public health capabilities, sustainable partnerships and integrative approaches that place populations and communities at the center can be deployed to truly “move the needle” on health.

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Policy Priorities for the Intellectual and Developmental Disabilities Community

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People with disabilities across the lifespan face considerable barriers to living a healthy life. Remarkable progress has been made since the 1970s in advancing the rights and well-being of people with disabilities (including the closure of our largest institutions, passage of the Americans with Disabilities Act, and Employment First policies), yet systemic disparities in access, care, and outcomes remain, making full community inclusion elusive. The Biden administration has an opportunity to address these obstacles through strategic investments in community-based services, including the critical yet fragile direct support workforce.

Addressing institutional bias in Medicaid long-term services and supports (LTSS) should be a top priority for the new administration. Of the 17.4 million children and adults with disabilities and older adults who rely on Medicaid, approximately 5 million receive LTSS, which includes support with daily tasks such as eating, bathing, dressing, transportation, and managing medications (Thach & Wiener, 2018). LTSS can be delivered in institutional settings or through home and community-based services (HCBS). An overwhelming majority of people prefer to have control over where and how they live, and over the past 30 years, Medicaid LTSS dollars have increasingly gone toward HCBS, supporting meaningful community inclusion. HCBS are typically less expensive than institutional care, so increasing access to HCBS could allow the Medicaid program to serve more people without increasing costs. And community living is increasingly the expectation, not the exception; more than 700,000 people are on an HCBS waiver waiting list (MACPAC, 2020). HCBS is an optional benefit in the Medicaid program, however, and states can design their own offerings and set eligibility criteria. This split in optional and mandatory benefits for Medicaid LTSS creates a bias toward placement in institutions (nursing and intermediate care facilities) and can therefore limit choice in housing.

This institutional bias is costly. Across populations, including older people, adults with physical disabilities, and people with intellectual and developmental disabilities (IDD), Medicaid pays nearly three times as much for each person served in institutional settings as it does for each person served in the community. Redirecting more resources to home and community-based services is cost-effective, and, more importantly, has the potential to improve the quality of life for those receiving services. People living in homes and communities of their choice report significantly better outcomes than those living in institutions, a fact reinforced by the disproportionate number of COVID-19 fatalities in nursing homes and other congregate settings.

Another dire situation the administration should address is the shamefully low wages paid to professional caregivers. The quality of life for millions of individuals with disabilities, including

health outcomes, is contingent upon the stability of a well-trained, professional direct support workforce. John F. Kennedy, Jr. wrote “Quality is defined at the point of interaction between the staff member and the individual with a developmental disability.” In the IDD community, professional caregivers are known as direct support professionals (DSPs), and their responsibilities go well beyond caregiving. In addition to supporting activities of daily living, they take people to appointments with various health care and specialty providers and often play important roles in communicating with medical professionals about health-related observations and records. DSPs are integral to supporting overall wellbeing and prevention of costly acute care by identifying emerging signs and symptoms of illness or disease, encouraging healthy lifestyles, fostering connections to caring family and friends, and monitoring changes in health status. Importantly, DSPs support people with disabilities in finding and keeping jobs and working toward their personal career goals. They get people socially connected to and support their participation in recreation activities, education, cultural events, spiritual activities and civic functions. DSPs are interdisciplinary professionals and their job duties are diverse and ever-changing, based on each individual’s needs and abilities.

Yet direct support professionals, a lynchpin of effective home and community-based services, earn an average of \$12 per hour. Many work two or three jobs to make ends meet, leading to frequent burnout and a turnover rate above 50%. (The annual cost of staff turnover is \$2.3 billion.) The U.S. Department of Labor subsumes DSPs under three primary Standard Occupational Classifications: personal care assistant, home health aide, and nursing assistant. In 2015, there were nearly 4.5 million direct support workers in these three occupational categories, which are among the top five fastest-growing occupations in the United States. Given the range and variation of job titles assigned to DSPs, they may be uncounted or undercounted by the current BLS classification.

The Biden administration can make a tremendous difference in the lives of millions of people with disabilities, and their families and communities, by prioritizing home and community-based services, removing the bias for institutional placement, and recognizing the essential status of DSPs through a standard occupational classification tied to wages commensurate with job responsibilities. Investing in caregiving systems produces twice as many jobs per dollar invested than physical infrastructure investment, research shows. The return on investment in human capital will include better health and quality of life outcomes and a sustainable, direct support workforce. Now is the time to take the bold steps to make this happen.

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Achieving Educational Equity Through Investment in School Health Services

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Health is a prerequisite to learning. Children in good health have fewer absences, earn better grades, and graduate at higher rates. Despite this well-known fact, there is limited integration of health improvement strategies in the broader national goal to achieve educational equity. Millions of children in the United States experience chronic health conditions and limited access to health care, and schools have historically served as a safety net for these populations of youth. As the Biden Administration takes office, there is a need and basis for more meaningful integration of health and education in schools, and a precedent for federal investment in school health services that the administration can expand.

Title I, Part A of the Elementary and Secondary Education Act (ESEA), as amended by the Every Student Succeeds Act (ESSA) (2016) provides financial assistance to local educational agencies serving a significant proportion of children from low-income families to ensure that all students meet the academic standards set by states. Title I is the nation's largest federal assistance program for schools, and allowable expenditures under Title I include subsidizing the provision of health care as well as preventive and mental health interventions. Given their effectiveness and impact, we highly recommend the Biden administration allocate funds to increase the number of school-based health centers (SBHCs) operating in Title I schools. Strategically located in underserved neighborhoods, SBHCs are medical clinics established in schools to provide physical and mental health care and preventive services to vulnerable youth. Extensive research indicates that a positive relationship exists between SBHCs and children's health outcomes, and emerging data suggest SBHCs are also associated with improved academic outcomes. Currently linked to over 10,000 public schools and serving 15% of the nation's school-age children, increased funding for SBHCs will help address the growing need for expansion of children's health care nationwide.

In addition to targeted funding for SBHCs through Title I, the Biden Administration is encouraged to expand the allowable use of funds for Full-Service Community Schools Program grantees to include costs associated with establishing an SBHC. Authorized through the Community Support for School Success subpart (Title IV, Part F, Subpart 2) of the ESEA as amended by the ESSA, the Full-Service Community Schools Program provides funds to start and scale community schools. Community schools are a place-based school improvement model wherein public schools partner with local organizations to deliver education, social, and health services to students and

the community. Although they vary by local context, four pillars guide most community schools: (1) integrated student support, (2) enriched learning time and opportunities, (3) family and community engagement, and (4) collaborative leadership. To a great extent, there is overlap between the populations that community schools and SBHCs seek to serve. In fact, the Coalition for Community Schools states that a school cannot be a community school without an SBHC and/or school health providers. In alignment with their stated priorities regarding education and health care, the Biden Administration can ensure that Full Service Community Schools grantees are allowed to use funds for the start-up costs for SBHCs.

Finally, the Biden Administration must follow through with its pledge to double the number of counselors, social workers, psychologists, and nurses in schools to address national shortages. Professional standards recommend that schools maintain a ratio of one counselor and one social worker per 250 students, and at least one psychologist and one nurse for every 500 students and 750 students, respectively. However, data show that up to 90% of students in the United States are in public schools that do not meet these recommendations. There are several investments to recruit and retain school-based health providers that the White House should consider. Programs to attract and retain school-based health providers such as the School-Based Mental Health Services Grant need substantially more funding. Preserving and expanding the National Health Services Corps and Public Service Loan Forgiveness Program would also increase the country's ability to attract a skilled workforce to work in regions around the country experiencing provider shortages. Expanding the allowable use of funds under the Student Success and Academic Enrichment Grant (Title IV, Part A) to include school-based health providers would give schools the flexibility to meaningfully invest in a complement of qualified staff to effectively attend to the needs of all students in a community.

Research shows that academic performance is an indicator and outcome of a child's lifelong health status. The "Biden Plan for Educators, Students, and Our Future" signals the new administration's commitment to addressing educational inequity. This article's recommendations offer purposeful, evidence-based actions and investments the Biden Administration can pursue to elevate the critical role of health in children's learning and realize its vision of equality for all in education.

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Health Care Policy Priorities: Be Bold

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Most people agree that the US health care system is in urgent need of repair. We spend too much, we get too little, and we get massively different amounts depending on our income, employment status, race, gender identity, location, and disease state. These are not new problems, so it is reasonable to ask why we, in arguably one of the highest income and most powerful nations, haven't successfully addressed them. Applying the words of Ichiro Kawachi (2005) to a narrow domestic view, our failure must either be because we do not know, we do not care, or we misunderstand the cause of the problem so we cannot find an effective solution.

Most of us knew about the holes in our health care system before the COVID-19 pandemic, but the events of the past 12+ months can leave no doubt. The holes are large, consequential, and old. Thus, the "we don't know" explanation can be ruled out. That leaves us with "we don't care," and "we misunderstand the cause." I think these fit better, and offer some guidance for the new Administration as to a path –albeit not an easy one - toward a health care system in which we spend something closer to the right amount based on the value we receive, and in which disparities across the factors listed above are greatly reduced.

Our health care outcomes, like all the others of importance, are determined through the interaction of four forces: power, politics, policy, and payment. Over the past 50 years, a coalition of the wealthy and big business leaders, outraged by the impact of President Johnson's Great Society programs, has used each of these forces to change public discourse, public expectations, and the rules of the game to exacerbate inequality and prevent meaningful social change. An almost religious belief in market forces as superior to government action has re-shaped even solidly public programs like Medicare and Medicaid. But many years of research tells us that markets favor the better resourced, the better educated, the better connected – the very characteristics that often do not describe the populations most in need of public assistance. Research also tells us that prosperity does not require inequality, in fact just the reverse is true (Brennan, 2016).

If the Biden Administration is to make serious inroads into solving the health care problems that face this nation, it must go beyond the obvious steps of improving Affordable Care Act exchanges, lowering drug prices, eliminating surprise bills, and seeking coverage of at least essential health care benefits for everyone. It must even go beyond current modest attempts at addressing things like affordable housing and access to healthy food and transportation, which, while important, are only ways to make our current economic structure more bearable for those at the bottom. These are consequences of the problem; addressing them only treats the symptoms. The real problem is an economic and political structure that heavily favors a small segment of the population at the top of the income and wealth hierarchy at the expense of the rest of society.

History tells us that disasters create inflection points: windows through which opportunity lies. The stark reality of continuing white supremacy and conspiracy thinking combined with a global pandemic creates such an inflection point. I believe the majority of Americans have come to understand how very interdependent we are regardless of our income, our employment status, our race, our gender identity, our location, or our disease state. I think we are ready to use the altered balance of power faced by the new Administration and a changed political climate to make significant changes to the policies and payment systems that not only determine the outcomes of our health care system, but the success of our democracy as well.

So be bold, Mr. President. Seek the big changes we really need: eliminate policies that discriminate against subpopulations; secure voting rights for all citizens; create appropriate regulation and oversight of businesses to assure they operate in the public interest; implement a tax structure that reduces gross inequality and supports a stable safety net; and yes, assure access to health care for all. Reach for the stars, Mr. President, and if you fall short, perhaps you can grab some meaningful incremental change on the way down.

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Healthcare Policy and Health Equity

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With its many forms and interpretations, racism has infected every aspect of American life somehow, whether it be biological, institutional, or systemic. America was built on the backs of slaves, whose descendants are still encountering its reverberations. Racism is pervasive and a notable contributor to many health disparities among African Americans compared to white Americans. Contemporarily, Americans encounter progeny racism, from implicit biases and discrimination to noted micro-aggressions in the healthcare system. The consequences of that mistrust and lack of equity within the healthcare system are apparent in Covid-19 outcomes related to African Americans (Lancet Diabetes & Endocrinology, 2020). Therefore, the Biden administration's healthcare policy priority should focus on health equity, particularly the concept relates to African Americans and their myriad of experiences with racism-related traumas, and the complicity with racism in healthcare systems should be denounced.

Racism and discrimination are part of our country's thread and, according to Prather and colleagues (2018), African American health has been compromised throughout history due to discriminatory healthcare practices. Historically, African Americans have been experimented on for the benefit of science, from sexual and reproductive health to the use of Hela cells without familial consent, the integrity of black bodies and their autonomy has been compromised (Prather et al., 2018). As of 2020, African Americans are among the most at risk for contracting Covid-19 and experiencing the worst outcomes related to the virus (Lancet Diabetes & Endocrinology, 2020). These adverse health outcomes are likely related to health disparities that African Americans are predisposed to because of systemic racism and other social determinants of health (Prather et al., 2018). Covid-19 has exposed healthcare systems' fragility, illuminated the lack of equitable access for healthcare among vulnerable populations, and amplified health inequalities (Lancet Diabetes & Endocrinology, 2020).

Establishing trust and ensuring healthcare leaders aware of systemic racism and aware of their own implicit biases when interacting with African Americans may promote continuity of equity related to African Americans across all healthcare systems. Biden's term should continue to spread awareness and recognition that racism is a social determinant of health and should promote equity. The covid-19 vaccine and access to the vaccine among the most vulnerable populations are examples of how the promotion of equity could profoundly affect African Americans' health outcomes. As of 2020, the Ten Essentials of Public Health, a framework for the inner workings of public health and related topics, has been updated to reflect health equity as the centralized focal concept (CDC, 2020). The Biden administration should be at the forefront of this public health shift and bring equity to fruition. Biden's administration must focus on evaluating current systems

and inherent racism within them, being actively anti-racist and not complicit in racist ideology, assuring that equity is a priority in policy creation, funding culturally relevant programming with community leaders, and providing continuous training to healthcare professionals (Baciu et al., 2017, Ford et al., 2019; Prather et al., 2018). To achieve equity, we must become one America. This America can be achieved by justice and police reform, ending mass incarceration, education reform, economic inclusion, healthcare reform, and a genuine and equitable partnership. Continuity in his administration's efforts and substantial, profound commitment to changing healthcare's face (and ideals) should be his primary goal.

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