# Exploring the Health Care System

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Michael Vetter, Assistant Director, Council on Health Care Economics and Policy
The Heller School for Social Policy and Management, Brandeis University

Michael Doonan, PhD, Schneider Institute for Health Policy, Director, Council on Health Care Economics and Policy
The Heller School for Social Policy and Management, Brandeis University

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## Opening Night: Mollyann Brodie, Executive Vice President & Chief Operating Officer Executive Director, Public Opinion and Survey Research, KFF

The opening night's speaker, Mollyann Brodie of KFF, provided a deep dive into preliminary pre- and post-election polling data from the 2024 election. Voters viewed the race as a referendum on the current state of the economy, health care, social issues and was a "change election" that favored Donald Trump over Kamala Harris.

While the economy was primary, health care affordability and health care costs were also on voters' minds. Medicare and Medicaid remained popular with voters, as were initiatives that drive down cost. Biden's efforts in these areas, however, were largely unrecognized. Only 40% of voters knew of the Biden administration's $35 insulin cap legislation. Even fewer were aware of the Medicare drug negotiation plan and the savings it is projected to yield. Among those noting that economic anxiety was the primary concern facing the country, 54% favored Trump over Harris. However, regardless of deep political divisions and increasing tribalism, the Accountable Care Act and associated Medicaid expansion remains overwhelmingly popular even in red states like Alabama and Kansas, indicating an appetite for government involvement in health care cost regulation.

Ballot initiatives in support of abortion rights passed in 8 out of 10 states that Trump carried. The issue did energize key democratic voters enough to pass the initiatives, but not enough to overcome the electoral advantage Trump had among irregular voters.

Now that the election is over concern over impacts to popular social programs supporting Americans' access to health care have increased. It is possible that actions taken by the new administration may have palpable consequences to the everyday voter, turning favor back to Democrats on this issue as the midterms approach.

## SESSION 1: MEDICAID INNOVATION

**MODERATOR**
**Hemi Tewarson, JD, MPH,**
Executive Director, National Academy for State Health Policy (NASHP)

**PANEL**
**Robin Rudowitz,** Vice President and director of the Program on Medicaid and the Uninsured, KFF
**Amanda Lothrop,** Chief Operating Officer, New York Medicaid
**Nate Checketts,** Deputy Director, Utah Department of Health and Human Services

The Medicaid panel stressed that states have a common goal of improving the Medicaid program, including across expansion states. States have taken different steps towards that goal. Survey work from KFF showed that state governments have attempted to expand services, such as behavioral health access, but that financial constraints remain a persistent issue. While a few state governments have increased hospital rates and others have established spending benchmark targets, high costs, inflation and workforce issues continue to challenge the system. Specific state-level initiatives were outlined to show the breadth of strategies to address these challenges.

The state of New York has implemented two models to make their state Medicaid program more efficient and cost-effective. The first is a 10-year initiative to increase access to and importance of primary care to shift towards a value-based model. Differing tiers help to determine levels of appropriate risk to assume based on population health needs. The second model is Advancing All-Payer Equity Approaches and Development (AHEAD) which was designed to improve population health and health equity. Similarly, this model increases the push to engage in primary care services and forces hospitals to be more intentional about their spending by providing them with a flat payment every two weeks.

The goal is to alleviate preventative care burden from hospitals by shifting that care to more cost effective primary and acute care. Medicaid officials are mindful, however, that these changes may result in a general shift towards home and community-based services, also funded by Medicaid. Undergirding both models is an attempt to engage in holistic care that compensates for demographic changes, health related social needs, and shifts in general population health (i.e., increases in prevalence in chronic conditions).

Medicaid officials in Utah offered an alternative approach to Medicaid innovation. The state's program covers roughly 10% of its population and has seen significant increases over the past few years. Specifically, the state has been conducting work in jails and prisons where incarcerated persons are suspended from the program upon entering. This population tends to have higher usage and has benefited over time with use of case managers to coordinate prisoner care prior to release to ensure proper health care access.

Historically low Medicaid payment to hospitals remains a concern and limits access to care. CMS has provided supplemental payments to hospitals that is some instances have risen as high as private

reimbursement rates. Government oversight and involvement, as well as quality metrics, can aid in controlling spending, but a lot still depends on accountability and proper management of population health.

Across the country, Medicaid enrollment has slowed post-Covid, with 72.5 million beneficiaries covered compared to 90 million. Americans remain largely in favor of Medicaid and the services it offers, such as long term supports and services, maternal health, and child health. Moving forward, addressing the tension created at the federal level for potential changes to Medicaid funding and policy will continue to fall to state programs.

## SESSION 2:
## THE IMPACTS OF PRIVATE EQUITY IN THE U.S.: MICRO AND MACRO PERSPECTIVES

**MODERATOR**
**Zirui Song, MD, PhD,** Associate Professor of Health Care Policy and Medicine, Harvard Medical School and Massachusetts General Hospital

**PANEL**
**Yashaswini Singh, PhD,** Assistant Professor, Brown University
**Mary Bugbee, MA,** Research and Campaign Director, Private Equity Stakeholder Project

To many, the growth of private equity (PE) in the U.S. health care system is of increasing concern. Often the fast-paced nature of PE acquisition and exit of hospitals and physician practices raises issues related to quality of care, workforce retention, and patient experience. The average timeframe from acquisition to sale is typically between 3 and 7 years, and during that time the goal is to double or triple the value of the acquired entity. Today, hundreds of hospitals and thousands of practices have been acquired by PE firms.

To reach investment goals, PE acquisitions have often involved staffing cuts in hospitals and nursing homes, along with substitution of higher-cost physician labor for lower-cost clinicians on the margin in physician practices. This has affected the quality of patient care and experience, as evidenced by increased prevalence of hospital infections, nursing home deaths, and patient satisfaction. Other changes after PE acquisition has included elimination of less profitable service lines, selection of more profitable patients, and transfers of sicker patients to other hospitals.

There is currently a rapid rise in physicians working for PE- or corporate-owned health entities. Physicians enter willingly but studies have demonstrated a high turnover rate for these participating clinicians. The nature of PE-owned hospitals and facilities necessitates rapid growth, sale, and reacquisition for maximum value extraction. There is concern that this cycle will result in less competition as entities increase in size, increasing overall cost to the consumer and federal and private payers. Moreover, the rapid growth in this sector has outpaced viable reporting and oversight efforts.

Policy recommendations put forth include increased antitrust regulation, an increase in transparency throughout the acquisition process, potential requirement of ownership to assume more accountability for care and health outcomes, and regulation of use of debt to finance purchases. Currently, the narrative that PE firms are stepping in to save financially struggling hospitals or facilities is not consistent with the evidence, which instead shows that, on average, PE firms acquire financially more healthy facilities, which can take on new debt and still produce returns. The evidence base on PE in health care continues to grow.

## SESSION 3: AI AND TECHNOLOGY IN THE HEALTH SYSTEM

**MODERATOR**
**Micky Tripathi, PhD, MPP,** Assistant Secretary for Technology Policy,
Chief Artificial Intelligence Officer (Acting), U.S. Department of Health and Human Services

**PANEL**
**Seth Hain,** Senior Vice President of R&D, Epic
**Meghan M. Dierks, MD,** Chief Data Officer, Komodo
**Bernardo Bizzo, MD, PhD,** Senior Director, Mass General Brigham AI

The growth of artificial intelligence (AI) in health care has brought excitement about possibilities and concerns over regulations stifling innovation. The impact on total health care cost is also uncertain. This tension, between responsible use and regulation, has forced a shift from public investment towards private for AI. While regulation can stymie innovation, lack of significant regulation can also inhibit growth.

AI's use in healthcare is increasing in most areas such as surgery, electronic health record use, and billing. Despite its ubiquity, the data it relies on is critical and there is a level of quality that must be maintained to ensure AI's reliable and viability. It is likely that in the coming years, however, that clinicians and health professionals will rely heavily on AI tools to work collaboratively to improve patient care.

Historically, AI depended on logic-based modeling but as its underlying functions become more advanced generative AI has more to offer. Use of AI will require human collaboration and significant safeguards to ensure efficient and proper use. Specialized training for providers and staff will be essential to successful integration. It will also require a cost structure to consider value, and a safety infrastructure. It is the challenge of an advanced and iterative system that relies on human involvement and constant feedback to increase quality of performance.

## SESSION 4: REPRODUCTIVE HEALTH IN A POST-ROE SYSTEM

**MODERATOR**
**Renée Landers, JD,** Professor of Law and Faculty Director, Health and Biomedical Law Concentration and Master of Science in Law, Life Sciences Program, Suffolk University

**PANEL**
**Caitlin Gustafson, MD** President, Idaho Coalition for Safe Healthcare Foundation
**Amirala S. Pasha, DO, JD,** Assistant Professor of Medicine, Mayo Clinic
**Christine Neuhoff,** Senior Vice President and Chief Legal Officer, St. Luke's Health System

The reversal of *Roe v. Wade* eliminated constitutional protection for abortion and returned authority to regulate the issue to the states. In many cases, the reversal of what had been established law has allowed states with dormant abortion policies and "trigger" laws to implement restrictive regulations automatically.

In the wake of *Roe*'s reversal, the maternal mortality rate has increased. In Idaho, out of 42 hospitals, 3 no longer offer obstetrics. Additionally, in any state with an abortion ban mothers are three times more likely to die during pregnancy, childbirth, or shortly thereafter. In addition, such states also experience an increase in infant mortality rates of ~30%. Even though the Emergency Medical Treatment and Labor Act requires that emergency departments provide stabilizing treatment to protect the life or health of pregnant person experiencing a medical emergency, Idaho's aggressive anti-abortion laws have introduced the threat of criminal prosecution for practitioners who are delivering emergency medical care to prevent severe health consequences .

These developments create a significant threat to the OB/GYN workforce both in Idaho and in other states. In Idaho alone 22% of practicing women's health physicians have left the state. Training programs in restrictive states have seen a decrease in applications to OB/GYN residency programs. Conversely, those states that permit abortions are facing unprecedented demand for limited training opportunities from applicants and trainees from restrictive states. The long-term results of this situation are twofold: a dramatic decline in the number of providers who can perform this work and an increase in pregnancy-related complications.

## SESSION 5: SHIFTS IN LONG-TERM CARE FINANCING AND INFORMAL CAREGIVING

**MODERATOR**
**David C. Grabowski, PhD,** Professor, Harvard Medical School

**PANEL**
**Jennifer Wolff, PhD,**
Eugene & Mildred Lipitz Professor, Johns Hopkins University
**Laura M. Keohane, PhD,**
Associate Professor, Health Policy, Vanderbilt University School of Medicine

Demographic changes will lead to a major increase in the need for robust long-term care (LTC) supports. Despite this growing need, the U.S. ranks low on LTC spending despite Medicaid providing 61% of funding. The LTC system is disjointed, in high demand, and heavily reliant on unpaid caregiving. Medicare does not cover LTC with very few exceptions and LTC insurance is not widespread or an affordable option for most people.

The U.S. health system has created a tiered system wherein the lowest and highest income individuals access different LTC supports. Medicaid requires a certain income threshold before services can be accessed and often those with assets must "spend down" to gain LTC coverage. Paying for nursing home care or home health aide support out-of-pocket is expensive and even those in higher income brackets can struggle to maintain the level of care required for quality health outcomes.

The result is that family and other unpaid caregivers provide the majority of support to those in need of LTC services. This care can occur throughout the life course. The reliance on family caregivers contributes to the healthcare system and results in significant cost savings with both positive and negative effects for caregivers themselves. Over the past few years, there has been an acknowledgement of the importance of caregiving in the U.S. and some initiatives have been implemented to better incorporate them into their care recipient's care team. One example is providing caregivers access to patient portals and patient's electronic health record.

Among those dual-eligible individuals, beneficiaries who qualify for both Medicare and Medicaid, there is a significant cost associated with the needs of this population. Roughly 5% of Medicaid enrollees – those who use LTC -- are responsible for 30% of all Medicaid spending. With the rise of home and community-based services (HCBS), there is significant demand for LTC workers. HCBS suffers from long waiting lists and underfunding despite its popularity, due in part to the low wages and high turnover rates among LTC workers.

The disjointed and often complicated nature of the LTC system in the U.S. creates unnecessary barriers to access and care. Addressing and acknowledging the complexities and consequential repercussions requires a hard look at the inequitable system currently in place.

Recognition of unpaid caregiving in the U.S. has increased with federal initiatives like the Recognize, Assist, Include, Support, & Engage (RAISE) Act in 2022. This program directs state and private-sector

actors to begin strategizing and implementing supports for caregivers. In the long-term care space, there is general acknowledgement among the medical establishment and policymakers alike that aging in the community via supports like HCBS are preferable to beneficiaries. Attempts to direct resources to these services are on-going.

## SESSION 6:
## ACCESS, COST-SAVINGS, AND VALUE: THE STATE OF PHARMACEUTICALS IN THE U.S.

**MODERATOR**
**Aaron S. Kesselheim, MD, JD, MPH,**
Professor of Medicine, Brigham and Women's Hospital/Harvard Medical School

**PANEL**
**Steven Pearson, MD, MSc,** Special Advisor, Institute for Clinical and Economic Review
**Anna Kaltenboeck, MA, MBA,** Practice Director, ATI Advisory
**Ge Bai, PhD, CPA,** Professor of Accounting at Johns Hopkins Carey Business School and Professor of Health Policy & Management, Johns Hopkins Bloomberg School of Public Health

This panel highlighted the challenge of aligning value and affordability of available drugs for consumers. Using the new Medicare negotiation legislation as an example, organizations like the Institute for Clinical and Economic Review (ICER) directly address the tension between transparency and the cost of drugs with access and affordability. Balancing issues such as clinical effectiveness and value, federal officials have the option to either adopt a “recipe” or a “blender” approach. The former uses a detailed approach specifying exactly how the various elements of evidence and other information are used to determined a maximum fair price. In contrast, a “blender” approach only identifies the elements of evidence that were considered without detailing whether some elements were more important than others, or whether there was any quantitative approach taken to synthesizing information. In the first public description of the overall approach, the Biden administration adhered to a “blender” approach, leaving the most flexibility for the program going forward, but also frustrating the drug industry and many analysts who were left unclear about how the process of determining a maximum fair price really works.

Key to Medicare drug pricing negotiations are the pharmacy benefit managers (PBMs) who have significant impacts on supply, cost, and access. PBMs are key and manage negotiations, often serving as critical players in Medicare pricing. Given their influence in this space PBMs can adversely affect pricing because of their concentration and growing influenced in the market.

GLP-1 drugs, like Wegovy, have shined a light on the influence of PBMs and attempts at regulation of these entities. One federal-level policy solution is to evaluate and enforce on issues of drug pricing and value to the consumer. Coverage of these drugs also impacts the private sector as well. GLP-1s were in one case found to increase cost to employers due to the effectiveness and widespread use of the drug, resulting in unexpected outcomes resulting from weight loss and associated activities. One solution that

was suggested was direct-to-employer contract negotiations which eliminates the need for PBMs and acts as a circumvention of the current system.

Pricing regulation and enforcement remain as persistent problem. There is little political appetite for these types of solutions among manufacturers but strong evidence for benefit to the consumer to keep costs low and access high. Further complicating the issue is consumer non-compliance to drug regimens, impacting both value and cost. Given the current political climate, the long-term impact of the Inflation Reduction Act remains in question, as does meaningful political action on stronger regulation and transparency of these negotiation processes.

## SESSION 7: IMPACTS TO THE HEALTHCARE SYSTEM POST-ELECTION

**MODERATOR**
**Michael Doonan, PhD**
The Heller School for Social Policy and Management, Brandeis University

**PANEL**
**Dean Rosen,** Partner, Mehlman Consulting
**Chris Jennings**, President and Founder, Jennings Policy Strategies

The discussion focused on what might happen in health care and policy under the new Trump administration. The panel began with moderator concerns about the system of government and whether safeguards against concentrated power in the executive will hold. The new administration and Congress will try to find money to pay for tax cuts and could lead to significant cuts in Medicaid and the Affordable Care Act (ACA) subsidies. It will be important for the public to understand the implications of these cuts and the new administration's policies on healthcare.

Panelists were asked about potential changes to Medicaid and the Affordable Care Act under the new administration. The administration can use executive orders, administrative action such as revised rulemaking, the budget process and passing legislation to accomplish their priorities. The need for a more unified approach to healthcare programs, rather than viewing them as "us versus them" based on who passed them, was highlighted as an area of growth. General concerns were raised about the new department for government efficiency and the appointment of Robert Kennedy as the Secretary of HHS, the potential impact of Kennedy's appointment on the Food and Drug Administration (FDA) and the National Institutes of Health (NIH), and the impacts to the public health infrastructure in the country. These issues should emphasize a nonpartisan approach to policy analysis being mindful of the potential for abuse of power.

It was suggested that the Senate's role in advising and consenting on appointments is crucial and that most Republican Senators may resist any attempt to bypass this process.

Discussion turned to the potential impact of the Trump administration on reproductive health, particularly regarding the regulation of medications and enforcement activities. It was mentioned that

the election wasn't about deep cuts in entitlements, but rather about the economy and addressing issues like immigration and inflation.

Speakers asserted that hospitals and blue states activism will be necessary to avoid major cuts the Medicaid program. Under the first Trump administration there wasn't enough votes to repeal the ACA and this still may be the case. However they were able to use administrative procedures and waiver to forward their priorities. While gridlock is likely there may be some opportunities for bipartisan support for new initiatives, like physician payment reform under Medicare and the potential for bipartisan support on issues like prior authorization and billing issues.

## SESSION 8: MEDICARE AND MEDICARE ADVANTAGE: KEY POLICY ISSUES

**MODERATOR**
**Cheryl Damberg,** Director, RAND Center of Excellence on Health System Performance, RAND

**PANEL**
**Michael E. Chernew, PhD**
Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School
**Jennifer L. Kowalski, MS,** Vice President, Public Policy Institute, Elevance Health
**J. Michael McWilliams, MD, PhD,**
Warren Alpert Professor of Health Care Policy, Harvard Medical School
**Brent Carson, MBA,** Chief Revenue Cycle Officer, University Hospitals, Cleveland, Ohio

Older adults in the U.S. are shifting rapidly to Medicare Advantage (MA) from Traditional fee-for-service Medicare (TM). Currently enrollment has crossed 54% and is expected to grow. While not designed to become the majority option the program has grown due to lower costs, additional benefits and program flexibility. MA faces several challenges including concerns of overpayments, questions about quality of care, and the complexity of beneficiaries having numerous plan options. The Medicare panel suggested that if policymakers cut payments to MA, plans would have to consider reducing benefits. MA's popularity makes these options politically challenging. Policymakers are also interested in increasing oversight and better understanding healthcare utilization among MA enrollees. Conversely, legislators could consider capping MA plan payments at traditional Medicare costs, with an add-on payment to MA to continue to cover some supplemental benefits, which beneficiaries are choosing MA for.

Among the reasons that MA is popular among Medicare beneficiaries are the supplemental benefits offered by MA plans which are not available to those enrolled in Traditional Medicare. These benefits can include benefits for dental, vision, hearing, transportation, meals, and other health-related services designed to address social needs. Supplemental benefits are shown to alleviate financial burden for beneficiaries, in some cases freeing up resources to pay for copays or other needs. They have also had positive impacts on health care utilization like preventive services (e.g., annual wellness visits) and management of chronic conditions. Moreover, increased enrollment inMA has noticeably slowed the total growth of Medicare spending over time.

. Traditional Medicare, absent a Medigap plan or other supplemental coverage, generally has greater out-of-pocket expenses  of the two options but can be made more competitive by matching some of the benefits that MA offers. MA, conversely, suffers from an abundance of available plans, which can make it difficult for beneficiaries to compare their options. Beneficiaries often do not shop around and tend to choose suboptimal plans, from an economic perspective. MA plans, unlike TM, use managed care tools such as prior authorization, which lead to higher denial rates particularly for low-value services compared to TM.

TM could be made more competitive by increasing the accuracy in diagnostic coding, which would mitigate issues with MA risk adjustment stemming from "coding intensity" in MA vs. TM. That is, MA, in general, has higher coding accuracy and often shows higher acuity of its enrollees vs. TM beneficiaries as a result.

Examples of competing performance of MA and TM was provided for a university hospital in Cleveland, Ohio. Comparable to similarly sized systems in the U.S., 40% of the system's patients are Medicare MA/TM beneficiaries. After Covid, there was an 8% increase in the health system's costs and 2-3% increase in reimbursements. In this specific case, hospitals in this system were being paid less by MA than TM as a result of denials and downgrades They also witnessed a shift from MA to TM by their patient population and it was suggested that this was partially due to a lack of infrastructure for those on MA plans. Additionally, this hospital system saw a dramatic increase in prior authorizations and overall denials. Despite these MA plans being reported to CMS for non-compliance, issues persist. However, incentive payments from population health-based initiatives and value-based care implementation have improved performance.

## CONCLUSION

The 2025 conference touched on significant issues facing the U.S. healthcare system and the potential impacts the incoming administration would have. While topics like Medicare, Medicaid, reproductive health, and the workforce remain prescient, new and complex challenges continue to arise and be addressed by our esteemed colleagues in the field. Newer emerging topics such as private equity and artificial intelligence were covered, providing attendees with helpful primers to understand these important issues and insight into their impacts on healthcare quality, cost, and delivery. While speculation on the downstream effects of the new administration were provided, the panelists remained stalwart in their efforts to clearly present challenges and evidence-based solutions for researchers, policymakers, and clinicians alike.

**NOTE: All the speaker's comments and recommendations expressed in this material are theirs only and do not necessarily reflect the views of the organizations and institutions they work for.**