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What Does a Post-Pandemic Presidency Mean for Medicare?

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The ongoing COVID-19 pandemic has impacted the lives of all Americans, but the virus has disproportionately affected Medicare beneficiaries, including people 65 years and older and younger beneficiaries with serious disabilities. The Centers for Disease Control and Prevention has found that older adults and those with underlying medical conditions are most susceptible to severe illness, hospitalization, and mortality (Centers for Disease Control and Prevention, 2020). As of April 2020, about 4 out of every 5 COVID-19–related deaths in the United States have been among those aged 65 and older, despite this age group representing less than a third of laboratory-confirmed cases (Patient Access Network Foundation, 2020). Measures taken to slow transmission of the virus may have also created new challenges for beneficiaries, by increasing social isolation and decreasing access to care. The Centers for Medicare and Medicaid Services (CMS) have relaxed many rules in an attempt to combat these challenges, but questions remain about the long-term implications for beneficiaries. As the presidential election draws near, a post-COVID-19 presidency will have to grapple with the ramifications of the pandemic, including the consequences for Medicare beneficiaries.

Financial Strain on Beneficiaries and the Medicare Hospital Insurance Trust Fund

Perhaps the most pressing issue for the next administration is the financial challenges created by COVID-19. Prior to the pandemic, the Medicare Hospital Insurance trust fund,

out of which beneficiaries' hospital bills are paid, was projected to be insolvent by 2026. The pandemic is expected to further shorten the life of the trust fund, because the economic recession resulting from the pandemic is projected to sharply reduce the taxes flowing into the Medicare trust fund. Additionally, the recession has caused a sizeable share (16%) of people 65 and older to become unemployed, with 1.2 million losing their jobs in March alone (United States Bureau of Labor Statistics, 2020). Despite some financial protections for Medicare beneficiaries, the high level of job losses and the economic downturn could place an undue financial burden on enrollees for everyday medical expenses, let alone a COVID-19–related hospitalization. Finding ways to reduce costs for both the federal government and beneficiaries will be essential to preserving the program for future generations of beneficiaries. The pandemic, however, has caused more than financial hardships for beneficiaries.

COVID-19 Has Amplified Challenges for Medicare Beneficiaries

Social Isolation

The COVID-19 pandemic has amplified many previous concerns for Medicare beneficiaries, from social isolation to access to care (Blumenthal et al., 2020; Lewis et al., 2020). Community lockdowns and stay-at-home orders were implemented to interrupt the spread of the coronavirus, but they have also severed social links within communities. This has contributed to both social isolation, defined as a lack of meaningful social contact with others, and loneliness,

defined as the subjective feeling of being isolated ([The National Academies of Sciences, Engineering, and Medicine, 2020](#)). Medicare beneficiaries, who have the highest risk of contracting COVID-19, were also most likely to report high rates of social isolation before the pandemic: as many as 43% of adults over 60 report feeling lonely, and 24% of adults aged 65 and older are considered socially isolated ([The National Academies of Sciences, Engineering, and Medicine, 2020](#)). Adults with underlying chronic conditions or physical or cognitive limitations, representing two-thirds of Medicare beneficiaries, are twice as likely to report feeling isolated than adults without these health concerns, leaving people with a difficult choice between avoiding potential COVID-19 infection or suffering the health consequences of loneliness ([Lewis et al., 2020](#); [Lochner et al., 2013](#)).

Social isolation and loneliness are associated with significant negative impacts on mental and physical health, including heart disease, stroke, depression, cancer, and dementia. Loneliness increases the risk of early death by 26%—the equivalent of smoking 15 cigarettes per day—and adds an additional \$6.7 billion in federal spending every year ([Flowers et al., 2017](#); [Lewis et al., 2020](#)). The COVID-19 pandemic compounds these issues by increasing the risk of isolation and the subsequent mental and physical health concerns. It also creates logistical challenges for beneficiaries trying to see a physician, receive home health care, or seek other care.

Access to Care

Soon after the beginning of the pandemic, hospitals and providers ceased elective procedures and barred patients from in-person visits to mitigate risk and prepare for a wave of COVID-19 infections. Consequently, the use of in-person health care dropped drastically, with in-person ambulatory care visits decreasing 63% by early April of 2020 for people 65 years and older ([Mehrotra et al., 2020](#)).

The reduction in use of home health care is one example of declines in health care services as a result of measures to slow the spread of COVID-19, and exemplifies the tough choices beneficiaries have had to make about receiving ongoing health care. Since March of 2020, the vast majority of home health providers have reported declining use of services by beneficiaries ([Holly, 2020](#)). On the one hand, receiving home health care increases beneficiaries' risk of contracting the virus, but on the other hand, not receiving home health care puts beneficiaries at risk of not receiving appropriate care for underlying chronic conditions, leaving beneficiaries who need home health care with a difficult decision and no perfect options.

Response from the Federal Government

In response to the pandemic, wide-ranging legislative and regulatory changes have been made, resulting

in unprecedented flexibilities for Medicare providers. Specifically, telehealth utilization and capabilities have rapidly expanded, and many coverage rules have been waived or not enforced by policymakers in order to ensure beneficiaries retain access to some health care without increasing the risk of COVID-19 infection. It has created a new opportunity to deploy previously limited telehealth services on a wide, national scale. Prior to the pandemic, traditional Medicare covered telehealth services only at designated, primarily rural health-care facilities under specific circumstances ([LaRosa, 2020](#)). The notion behind telehealth coverage was to provide access to care for beneficiaries in rural areas when a suitable provider was not otherwise accessible. Telehealth could thus only be accessed at health-care facilities, such as outpatient clinics, to minimize fraud and misuse of the services. Consequently, it was mostly used for mental health care in rural areas.

Regulatory and legislative action by policymakers, specifically the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, greatly increased telehealth access by temporarily lifting nearly all restrictions on telehealth coverage under traditional Medicare. This included restrictions on rurality and site of care, allowing all beneficiaries, in both rural and urban areas, to use telehealth from their own homes ([LaRosa, 2020](#)). The CARES Act also removed the requirement for face-to-face video interactions, which allowed beneficiaries to access care through the telephone. The rule change addressed some concerns about access and knowledge of technology, and increased health care access for low-income enrollees. CMS also expanded the range of services covered under telehealth, including home health care, and permitted providers to waive cost sharing for telehealth visits and bill Medicare for telehealth services at in-person rates without a prior established relationship with the beneficiary ([LaRosa, 2020](#)). Combined, these rules give all Medicare beneficiaries, especially low-income and vulnerable beneficiaries without smartphones or other technology, access to care without exposing them to the risk of infection.

Consequently, telehealth utilization has greatly increased: from 90,000 uses in the entire year of 2016 to 1.3 million during the second week of April in 2020. For beneficiaries in traditional Medicare, utilization rose 11,718% ([Pifer, 2020](#)). There are concerns and questions, however, about telehealth's efficacy and its impact on Medicare beneficiaries' long-term health outcomes. While some studies have shown telehealth's promise, the impact of telehealth on clinical outcomes and health care costs remains uncertain ([Hersh, 2001](#)). The pandemic, however, has created an unintended national telehealth demonstration that will allow policymakers to assess the impact of telehealth on both beneficiaries' health and federal spending, enabling the development of more effective policies in the future.

While the expansion of telehealth services helps to address the challenges beneficiaries have faced from social isolation and stay-at-home orders, many beneficiaries encounter difficulties accessing telehealth options. Just over half of adults aged 65 and older did not have broadband service and 42% did not own a cellphone in 2017, and almost two-thirds of technology newcomers report they would need assistance to operate new programs (Rainie, 2017). Furthermore, social distancing measures make it tough for beneficiaries to receive assistance from more technology-savvy friends, family, or community members. This digital divide disproportionately impacts low-income recipients and older people of color, and gives telehealth the potential to increase disparities in the short term (Yoon et al., 2018). In response to concerns about access, the Federal Communications Commission appropriated \$200 million as part of the CARES Act to expand access to telehealth. The program fully funds provider's technological needs, including purchasing telecommunications, information services, and connected devices for their patients (Federal Communications Commission, 2020). This move may alleviate some issues beneficiaries may have accessing telehealth services, and sets up a telehealth framework that could decrease disparities in the long term.

Post-Pandemic Future

The upcoming presidential election places the next administration, whether new or returning, in charge of shaping post-pandemic America. The decisions that will need to be made could permanently alter how Medicare beneficiaries experience care, affect the amount of fraud and abuse in the Medicare program, and ameliorate or worsen the insolvency of the Medicare Hospital Insurance trust fund.

Telehealth

The Medicare program has been modernized in a short time frame as a result of beneficiaries' needs and circumstances during the pandemic. Most changes, however, will automatically revert to the rules prior to the pandemic when the federal state of emergency is officially lifted. As beneficiaries are adapting to new circumstances, questions have started to arise about the possibility of extending new rules or making them permanent. Seema Verma, Administrator of CMS, has indicated her willingness to examine proposals to make expanded telehealth access a permanent feature for Medicare enrollees; however, challenges exist for both beneficiaries and providers (Ross, 2020). A recent survey found that older adults were less receptive to telehealth: nearly a third of adults aged 55 and older said they would never consider telehealth (SYKES, 2020). However, COVID-19 may reshape these perceptions, as nearly three-quarters said they would consider using telehealth for COVID-19 screening (Siwicki, 2020).

The expansion of telehealth in a post-pandemic world could create positive health care experiences for many beneficiaries, but rolling back regulations and loosening coverage rules could also have negative impacts.

Fraud and Abuse

One possible negative outcome from relaxing coverage rules is the potential for more fraud and abuse, which the coverage restrictions were originally meant to address. For example, during the pandemic, fraudsters have been offering beneficiaries COVID-19 tests in return for personal information that is used to wrongfully bill federal health programs. If the claim is denied, Medicare beneficiaries are responsible for the cost. Large-scale telehealth fraud can and does take place, as can abuse on a smaller scale. Any permanent extension of telehealth would have to address the ease of digital fraud and abuse for beneficiaries, and balance the merits of regulation rollbacks with increasing access to care.

Telehealth Parity

The question of telehealth parity is also a new frontier for a post-pandemic presidency. CMS has allowed providers to bill for telehealth services at the same rate as in-person visits during the pandemic (Centers for Medicare and Medicaid Services, 2020). Some have requested that telehealth parity be made permanent, but many questions remain about a sustainable, fair model of pricing. Further study is needed to determine to what extent telehealth provides the same quality of care as an in-person visit. For certain services, such as mental health, telehealth may offer a similar or enhanced experience, while other services may require an in-person examination that telehealth cannot replace. Furthermore, not all telehealth visits offer the same experience, and it is unclear whether audio-only visits should be treated differently than visits with both audio and visual, among other differences. Payment models will also have to be considered. Telehealth may offer more cost savings for value-based models over fee-for-service models; in the latter, telehealth could increase utilization and spending if it is used as a prelude to rather than a substitute for an in-person visit.

As the incoming administration grapples with these issues, the impending insolvency of the Medicare Part A trust fund will also be part of the discussions. The economic fallout from the pandemic may shorten the lifespan of the Medicare trust fund even further, but a careful, judicious expansion of telehealth might also offer one element of the solution. If the pitfalls of technological access, payment, and abuse are addressed, telehealth could improve social isolation, increase access to health care, and contribute to aggregate cost savings for both patients and providers. The COVID-19 pandemic has had a disproportionate

impact on Medicare beneficiaries' lives, from higher mortality rates to increased social isolation and limited access to care. Finding a middle ground between competing efforts to restrain infections while meeting basic needs for socialization and health care has proven to be a delicate balance. It has also presented an opportunity to change and expand how Medicare beneficiaries receive care, and the new administration will have a chance to shape the future of Medicare into a more accessible, resilient, and sustainable model of health care.

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Conflict of Interest

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