cant savings that could be used to finance coverage expansions.

Especially after Covid and its economic impact, it will be critical to aid disabled and elderly people who need long-term services and supports, as well as their families. A Democratic-led government may be able to pass paid leave for people with an illness or caring for a family member, tax credits for caregiving expenses, reductions of waiting lists for Medicaid home- and community-based services, and new pilot programs to integrate social services with health care and home care. Substantial additional investments might be required in the home care, public health, and community health worker labor forces — investments that would be supported by a Biden administration.

An audio interview with Drs. Sherry Glied and Mark Pauly is available at NEJM.org

Just as President Barack Obama relied on incremental, practical changes to accomplish the most far-reaching and substantive reform of the U.S. health care system in 50 years, a Biden administration could take a variety of practical and efficient steps to ensure that an improved and less costly system serves all Americans.

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Health Policy after a Trump Election Victory

Mark V. Pauly, Ph.D.

The chances of a Republican presidential victory in the November election are unclear, but future changes in U.S. health policy depend even more on another unpredictable event: the U.S. Supreme Court decision on a constitutional challenge to the Affordable Care Act (ACA). If the ACA remains in effect, any changes in a second Trump administration are likely to be modest and to represent a continuation of efforts begun during President Donald Trump's first term. If the ACA is ruled unconstitutional, then regardless of who wins the election, far-reaching legislative changes will be required, possibly in a divided-government setting. Nevertheless, assuming that no Covid-related twist keeps the health care system from returning to its prepandemic status, the current administration's policy efforts provide a guide to what might happen after the Court rules — especially given that the Republican National Committee has not written a new platform.

Particularly since the Republican effort to repeal and replace the ACA failed, the Trump administration has used executive orders and administrative rule changes to shift health policy, even as it has continued to attack the ACA through the courts. The most politically prominent rule changes have tried to combine protection for high-risk people seeking individual insurance with changes aimed at allowing some low-risk purchasers to pay lower premiums for different kinds of plans than those required under the ACA. Obamacare's modified community rating was meant to protect people with preexisting conditions, but there is a trade-off between permitting some people with expensive medical conditions to obtain individual private coverage at moderate premiums and encouraging lower-risk people to buy coverage. Through rule changes, the administration has therefore created a patched-together system of short-term insurance policies and individual access to less-restricted group insurance plans, allowing consumers to avoid Obamacare's rating and coverage strictures. Such efforts to make an end run around

community rating (for example, using guaranteed renewability for short-term plans or state-based high-risk pools) while maintaining an option for high-risk people are likely to continue.

It's important to note that the fraction of the population that could be affected by either protection of high-risk people or the creation of a parallel insurance market to cater to lower-risk people is rather small, so the odds of benefiting from either are low. Most Americans who are or become high risk have guarantees of protection as long as they can continue receiving employment-based insurance coverage, individual insurance coverage, or Medicaid. Pre-ACA laws that remain in effect prohibit private insurers from singling out high-risk people for higher premiums if they continue their private group or individual coverage; the ACA coverage and rating rules matter only for people who become uninsured while ill and therefore are high risk. So although any high-risk person might theoretically have to seek unsubsidized individual insurance at community-rated ACA premiums, the proportion of the population running that risk in any one year is probably less than 2%, or fewer than 6 million people.

Similarly, currently low-risk people who might be induced by Obamacare's community rating to drop coverage (or move to bronze-level or catastrophic coverage), because the benefits they expect to receive in the near future are not worth high premiums, are a small fraction of all low-risk people — primarily young men and middle-aged women seeking individual insurance with incomes too high to qualify for premium subsidies.[1] Precise head counts are hard to find — we do know that about half a million people dropped unsubsidized individual coverage when the ACA's individual mandate disappeared and that about 3 million people (many of them not high risk) bought coverage on the ACA exchanges for the first time in 2019.[2]

Efforts to foster high-deductible health insurance plans, whether in the employment setting or as bronze or silver plans on the exchanges, will continue, as will the effort to increase price transparency for people with such insurance. The goal (so far not supported by evidence) is to persuade sick consumers to shop among competing health care providers for better deals and to provide incentives to avoid care when it won't produce a health improvement commensurate with its cost.

For the nonpoor population, the administration has sought to weaken rules about what care plans must and must not cover, allowing individuals to choose short-term coverage with little restriction. The administration has also put in place a new kind of "individual coverage": health reimbursement arrangements (HRAs) that allow employers to make tax-shielded contributions for employees to use in the individual insurance market. Such HRAs represent an attempt to reduce the perceived compulsion and coverage discontinuity that employer-based group insurance imposes on workers (albeit at a higher administrative cost for customized coverage). Among Republicans, there is a general trend in sentiment away from legislating provisions in insurance policies (in private insurance or in Medicare Advantage alternatives), except for federal proposals to deal with plans that put enrollees at risk for surprise out-of-network bills.

One insurance issue on which there will be little movement in a Republican administration is coverage for low-income people who are not now enrolled in or eligible for Medicaid. There will not be support for compelling the remaining 12 states to expand Medicaid or for the federal government to pay for reduced cost sharing for low-income people with exchange coverage.

Apart from insurance coverage, the Trump administration has focused some attention on prescription drug prices and spending. The volatility of pricing and use in this market means that spending on some specific drugs can rise or fall substantially, and some large increases have provided a political target. A series of executive orders issued last year aimed to push prices down.[3] One of them has been effective — an agreement with insulin makers to rein in prices (perhaps fostered as much by the imminent approval of a generic substitute for the most expensive form as by political jawboning). Provisions to link prices for infused Medicare Part B drugs to prices paid in European countries or to make it easier for Americans to buy drugs at lower prices in Canada have been held up by legal issues but would probably be pursued in a new Trump administration. A recent promise to provide drug discount cards to Medicare beneficiaries also lacks details on funding sources.

The evidence that any of these efforts will produce meaningful

savings in drug insurance premiums or average out-of-pocket costs, however, is absent, as is evidence to assuage the fear that "cutting drug firms' profits" might discourage efforts to discover and bring to market highly effective new drugs.

If the ACA remains in force, the efforts described above will continue. Their overall effect so far has been small, and I would expect it to remain so into the foreseeable future — affecting only slivers of the population (high-risk, nonpoor, uninsured people and buyers of specific drugs). Major changes affecting large swaths of the population will require legislation that would be unlikely to pass unless it was necessitated by the overturning of the ACA.

In that event, the administration's most likely core strategy would be an effort to turn back much health policy to the states, with changes in the federal role limited largely to block-grant financing for Medicaid and exchanges. The House Republican Study Group has outlined an Obamacare replacement incorporating such an approach.[4] States would then pursue their own solutions to challenges such as creating high-risk pools, covering any remaining uninsured people, controlling medical spending, and improving health outcomes. The overall strategy would be to accept that no uniform Republican plan can (or even should) work at the federal level, nor is it politically feasible, so perhaps the states can do better.

Whatever the outcome of the Court case, the one sure feature of health policy under either a second Trump administration or a Biden administration is that for some time to come, its fundamental structure will rest on Medicaid, Medicare, and the ACA exchanges. Employment-based group insurance will remain, as will the Obamacare platform of means-based premiums for means-tested individual insurance coverage. Republicans will oppose a public option, fearing that it will be favored by government bureaucrats. The great bulk of private insurance provided through employment and often supplied by self-insured employers rather than insurance companies will remain largely unchanged.

Disclosure forms provided by the author are available at NEJM.org.

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Covid-19 and the Mandate to Redefine Preventive Care

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As the U.S. health care system defines the new normal for ambulatory care in the Covid-19 era, it needs a new approach to providing routine preventive care for adults. Concerns about contagion, competing demands, and shortages of personal protective equipment may limit preventive care visits — most commonly the "routine annual exam" and the Medicare Annual Wellness Visit. But given that routine physical examinations have been shown to have limited clinical value, we believe health care organizations should take this opportunity to advance alternative systems for promoting evidence-based prevention.[1,2] Failure to do so will sustain or worsen the long-standing disparities in health that have been underscored by the pandemic.

Before Covid-19, many primary care clinicians believed that annual exams did not optimally make use of their skills. The visit often became an exercise in checking off regulatory boxes, performing a head-to-toe physical exam for which there is no evidence of benefit, and ordering "routine" lab tests, many of which also lack supporting evidence. Yet many clinicians value these exams as a time for establishing or maintaining relationships with patients and reviewing the results of and