An Introduction to *2025 and Beyond*

Looming Health Policy Challenges

Lanhee J. Chen, Tom Church, and Daniel L. Heil

The US healthcare system remains too expensive and overly cumbersome for many patients. Costs continue to rise while millions of Americans have poor access to high-quality healthcare. None of these facts should come as a surprise. Despite countless reform efforts, the dual challenges of high costs and sometimes limited access remain a stubborn fact of our nation's healthcare system.

But there are new reasons for optimism.

Recent technological developments in the healthcare space, such as telehealth and machine-learning applications, offer new paths for improvement. The COVID-19 pandemic provided important lessons regarding the efficacy—or lack thereof—of current healthcare policies. And, most importantly, sunsetting policies and looming deadlines in 2025 and beyond mean federal policymakers will soon have no choice but to act.

The incoming Trump administration, new Congress, and state lawmakers have a unique opportunity to improve our healthcare system for the American people. Past chances to improve the system have been missed. How can we make this time different?

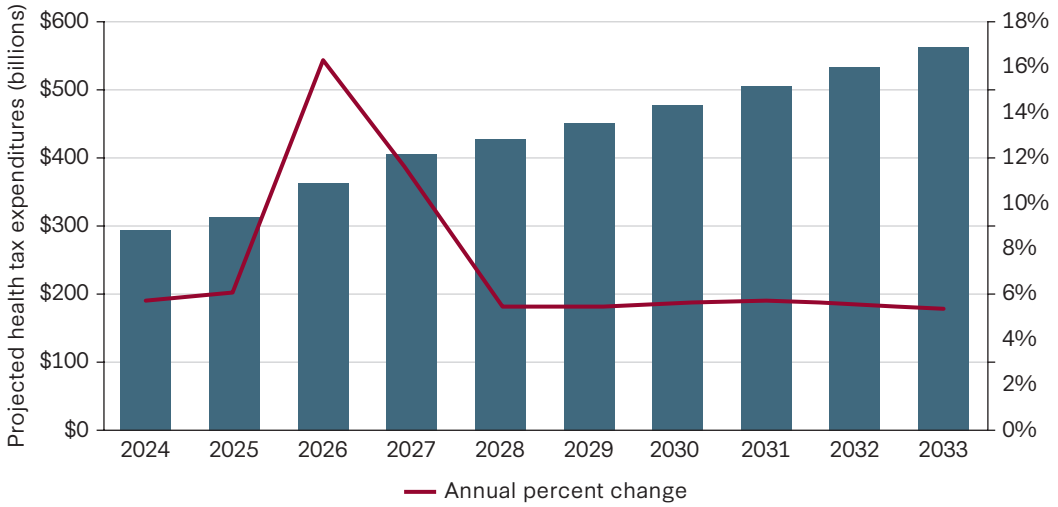
Lawmakers need ideas today to seize tomorrow's policy opportunities. The Hoover Institution's Healthcare Policy Working Group's essay series, *2025 and Beyond*, aims to do just that. Over the next several months, we will identify some of the most pressing health policy challenges facing our country and offer ideas to address them.

We begin by focusing on several critical healthcare decisions that await federal action. Prompted by statutory deadlines and looming fiscal crises, Congress will face unavoidable decisions over the future of Medicare, health-related tax policy provisions, and coverage subsidies for low-income Americans originally created by the Affordable Care Act (ACA). Meanwhile, the Trump administration will be tasked with implementing the Inflation Reduction Act's (IRA) new drug-pricing rules. And state policymakers will likewise be forced to confront changes in individual insurance and state Medicaid plans.

TAX REFORM AND THE EXPIRATION OF THE TCJA

Health policy and tax policy are inextricably linked. From the tax preference for employer-sponsored insurance to tax deductions for medical expenses, the federal tax code affects how

FIGURE 1 Health-related tax expenditures (in billions)



Source: Data are from Department of the Treasury (2024).

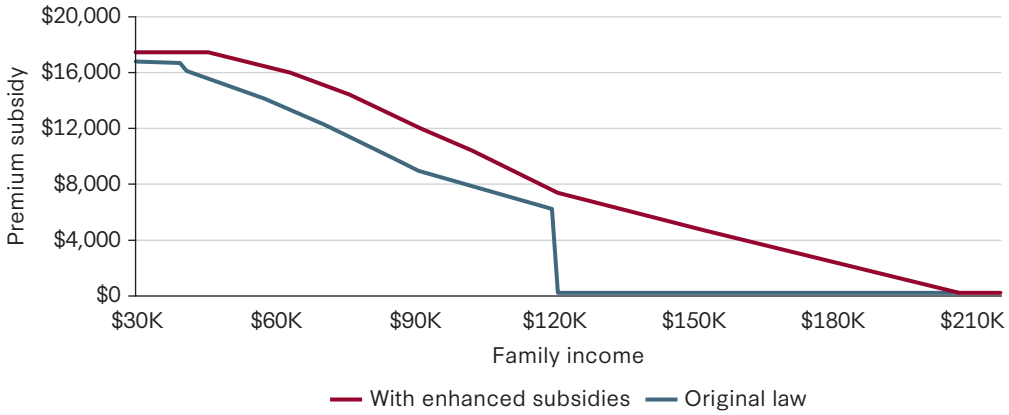
much we pay for healthcare. Changes to the tax code—even ones that are seemingly far removed from healthcare—may have significant ramifications for healthcare costs and spending. Tax rate hikes increase tax subsidies (so-called tax expenditures) for employer-sponsored insurance (ESI) and contributions to health savings accounts (HSAs). Similarly, increases in the standard deduction reduce the value of the itemized deduction for medical expenses.

Year-to-year tax changes are typically small, merely reflecting inflation adjustments in various tax provisions. The next Congress, however, will face substantial changes in the US tax code. Individual provisions in the Tax Cuts and Jobs Act of 2017 (TCJA) will expire at the end of 2025. If lawmakers fail to enact new legislation, then the tax code will largely revert to its pre-TCJA status. As shown in figure 1, the expiration of the TCJA will have significant effects on health-related tax expenditures.

The Treasury Department estimates that between 2025 and 2026, health-related tax expenditures will rise by over $51 billion, an increase of 16 percent. The largest change will come from income tax expenditures for the ESI tax exclusion, which will rise by $43.4 billion—nearly three times the increase from 2024 to 2025.[1] Similarly, the TCJA's expiration will result in a large decrease in the standard deduction—meaning millions more taxpayers will benefit from the deductibility of medical expenses. The Treasury Department estimates that from 2025 to 2026 tax expenditures for itemizing medical expenses will rise by $5 billion, about a 37 percent increase.

These projections assume that Congress will allow the TCJA to expire. That is possible but unlikely. Tax reform legislation will be a high priority in 2025, offering Congress a unique opportunity to rethink the interplay between tax policy and healthcare. This could include liberalizing HSA rules to enhance take-up or expanding deductions for out-of-pocket health expenditures during a time when cost-of-living issues have been front and center for many Americans. It could also include clarifying rules surrounding the ability of states or individuals to use direct primary care agreements to fill in gaps in their health coverage.

FIGURE 2 Estimated ACA subsidy for family of four before and after ARPA



Notes: Authors' calculations. We assume a family of four where parents are forty years old and children are under age fifteen. We use the average for the benchmark premiums from health policy research organization KFF (Average Marketplace Premiums by Metal Tier, 2023) for forty-year-olds ($5,472) and calculate children's premiums using the Department of Health and Human Services' (HHS) community rating age curves.

Using tax reform as a vehicle for reforming the health system may be controversial, but there is precedent. The TCJA, for example, eliminated the ACA's individual mandate penalty. Similarly, the Tax Relief and Health Care Act of 2006, which primarily extended temporary tax code provisions, included several measures liberalizing the use of health savings accounts.

EXPIRATION OF "TEMPORARY ACA" SUBSIDIES IN 2026

Shortly after President Joe Biden entered office, Congress enacted the $1.9 trillion American Rescue Plan Act of 2021 (ARPA). Among ARPA's provisions was a temporary expansion of the ACA's premium subsidies. The ACA subsidizes recipients' premiums in the individual market. The size of the subsidy depends on an individual's benchmark premium—equal to the second-lowest-cost plan available that will on average pay for 70 percent of the individual's covered medical expenses—and the individual's family income. Under the original law, individuals with incomes below 138 percent of the federal poverty line (FPL) were required to contribute 2 percent of their income. This rose to over 9.5 percent of one's income for individuals with family incomes from 300 to 400 percent of the FPL. Individuals with incomes above 400 percent of the FPL were ineligible for subsidies. ARPA reduced the required contributions amount for all recipients and removed the 400 percent threshold. As shown in figure 2, ACA subsidies are now more generous and are potentially available to individuals with annual incomes above $200,000.

These expansions were due to expire at the end of 2022, but the Inflation Reduction Act of 2022 extended the "temporary" measure through 2025. Without a further extension, the Congressional Budget Office (CBO) expects 5.6 million fewer individuals will receive premium subsidies in 2026 than in 2025. Most of these individuals, however, are expected to secure coverage elsewhere (e.g., unsubsidized insurance plans or ESI plans).[2] Even absent an extension, the CBO expects the nationwide uninsured rate to rise by only 0.8 percentage points from 2025 to 2026. Policymakers should be wary of a permanent extension of these subsidies. The Biden administration, which favored this, acknowledged that the extension would increase 2026–2034 federal deficits by $273 billion,

amounting to a 37 percent increase in ACA premium subsidies.[3]

Rather than merely extend subsidies that were enacted in the depths of the pandemic, the new Congress in 2025 will have the opportunity to consider thoughtful reforms that will balance the need for fiscal restraint with ensuring adequate coverage for low-income Americans. As noted, individuals with incomes well above the US median income are eligible for the expanded subsidies. Lawmakers could instead opt for reforms that better target individuals in need while also improving the quality of the ACA's individual plans for all recipients.

RISING MEDICARE SPENDING

Medicare spending continues to outpace economic growth. In 2000, the program's expenditures totaled 2.2 percent of GDP. That figure rose to 3.7 percent in 2023. Without reforms, the CBO expects Medicare expenditures to exceed 5 percent of GDP by 2034.[4] In that year, Medicare will consume twice as many resources as the entire defense budget. Even this ominous projection, however, is likely to underestimate future Medicare spending. The projection assumes Medicare payments to hospitals and providers will grow much more slowly than the rates paid by commercial providers. Actuaries for the program warn that "without fundamental change in the current delivery system," these assumptions will "probably not be viable indefinitely" and consequently actual premiums are likely to exceed current projections, "possibly by considerable amounts."[5]

While in the near term policymakers may be willing to finance rising Medicare spending through borrowing or shifting other resources to the program, they will not be able to avoid making hard choices in the Medicare program entirely.

Among other pressing issues, policymakers must soon address scheduled cuts to Medicare physician reimbursement rates, the implementation of the IRA's drug-pricing negotiation rules, and the expiration of temporary telehealth provisions. Each solution must focus on improving incentives for patients, doctors, and insurers while still restricting the rapid expansion of spending.

MEDICARE PHYSICIAN CUTS

In 1997, Congress attempted to restrain Medicare spending by enacting the sustainable growth rate (SGR), which capped the growth in Medicare's physician fee schedule (MPFS).[6] The caps quickly became a political disaster. From 2003 to 2015, Congress regularly overrode the SGR's scheduled cuts with temporary "doc fix" legislation. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) aimed to fix this system. It scrapped the SGR, replacing it with new scheduled updates for the MPFS as well as new incentive-based payment methods.

MACRA called for payments to rise by 0.5 percent per year from 2015 to 2019 with rates remaining flat between 2020 and 2025. In 2021, Congress began to again override scheduled fee cuts, raising payments by 3.75 percent in 2021, 3 percent in 2022, 2.5 percent in 2023, and 1.25 percent in 2024.[7] While 2024 payments were higher than called for under MACRA, physicians still faced a year-over-year reduction in payments of 3.37 percent.[8] In March 2024, under pressure from doctors, Congress agreed to halve that cut—increasing the fee schedule by 1.68 percent—for the remainder of the year.[9] Consequently, the fee schedule is now 2.93 percent higher than scheduled.

The temporary fixes by Congress, however, mean doctors will now face steeper cuts in 2025. Without larger reforms, a return to annual "doc fixes" seems likely. Avoiding this future will require rethinking Medicare's payment system.

This could include overhauling Medicare's Merit-based Incentive Payment System (MIPS) or enhancing Medicare Advantage to further reduce Medicare's reliance on its fee-for-service payment system.

MEDICARE'S PRESCRIPTION DRUG-PRICING RULES

The Inflation Reduction Act of 2022 (IRA) included several measures to constrain prescription costs for Medicare beneficiaries. The growth in Medicare drug prices was capped at the rate of inflation, and out-of-pocket spending for Medicare prescription drug recipients was capped at lower levels. Perhaps most importantly, the IRA requires the Centers for Medicare and Medicaid Services (CMS) to directly negotiate the price of select single-source drugs in Medicare Parts B and D. The first ten Part D drugs to face the negotiations have been selected and their negotiated prices were announced in September 2024. In 2025, fifteen additional Part D drugs will be selected for 2027 prices, followed by fifteen drugs from either Part B or Part D in 2028, and twenty drugs in subsequent years.

Concerns over the effect of the rules on future drug development abound. After the first set of drug prices was announced, CBO (2024) found that the average negotiated price reduction was only 22 percent, far below the original projection of 50 percent.[10] Regardless, the negotiations may reduce incentives for drugmakers to develop new drugs. It may also give drugmakers incentives to alter their pricing and production decisions for existing drugs to avoid being selected. The result could mean reduced access to lifesaving drugs for Medicare recipients.

While the Biden administration has already commenced rulemaking, the new Trump administration will face several decisions over the trajectory of the regulations, including future rounds of price negotiations. Congress will likewise be confronted with addressing various unintended consequences of the law. The Trump administration should carefully consider how any new rules might affect both the development pipeline for innovative drugs and the timely entry of generic competitors once patent and exclusivity periods expire.

THE FUTURE OF TELEHEALTH

The Department of Health and Human Services (HHS) provided numerous waivers for care delivered by telehealth to increase access during the COVID-19 pandemic for Medicare recipients. Some were made permanent; others are set to expire at the end of the 2024 calendar year. The permanent changes focus mainly on removing restrictions for telehealth visits regarding behavioral or mental health care. In addition, rural emergency hospitals (REHs) are now allowed to serve as originating sites for telehealth.

The temporary changes that are set to expire on December 31, 2024, include:

- Expanding the allowable type of care that can be provided via telehealth to nonbehavioral or nonmental care
- Allowing Medicare patients to receive telehealth services in their homes
- Removing geographic restrictions for all originating sites
- Eliminating the requirement that behavioral or mental telehealth services must begin with an initial in-person visit
- Allowing all eligible Medicare providers to provide telehealth services[11]

Permanently expanding the waivers has the clear benefit of expanding access for covered services. Research has found that expanded telehealth authority mainly benefited those in rural areas,

individuals who lived close to state lines, and patients receiving primary care or mental health treatment.[12]

A recent review of the literature on the benefits of telehealth did not find negative impacts on clinical outcomes or increased healthcare costs. Among the benefits identified, no-shows to appointments dropped (11.7 percent to 2.5 percent), rural patients showed higher completion rates of prescribed care routines, and emergency room visits fell when access to telehealth appointments grew.[13]

Permanently extending these changes offers Congress a relatively low-cost way to deliver higher-quality care to Medicare recipients. The reforms likely shouldn't stop with the Medicare program. Congress and the next administration will have opportunities to expand telehealth services to populations beyond Medicare recipients.

CONCLUSION

The US healthcare system continues to deliver high-quality care, but it is far from perfect. Issues of cost and access are a persistent concern to American families and government budgets. But opportunities for reform are plentiful. The forthcoming essays in Hoover's *2025 and Beyond* series will offer policymakers a road map to seize these opportunities.

NOTES

1. Department of the Treasury, *Tax Expenditures*, 2024, https://home.treasury.gov/system/files/131/Tax-Expenditures-FY2025.pdf.

2. Congressional Budget Office (CBO), "Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections," June 2024, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

3. See page 143 of White House, *Budget of the US Government, Fiscal Year 2025*, https://www.whitehouse.gov/wp-content/uploads/2024/03/budget_fy2025.pdf.

4. Historical expenditure data are from the 2023 Medicare trustees report, https://www.cms.gov/oact/tr/2023; projections are from CBO, "Health Insurance and Its Federal Subsidies."

5. See page 13 in John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," March 31, 2023, Department of Health and Human Services, Centers for Medicare and Medicaid Services, https://www.cms.gov/files/document/illustrative-alternative-scenario-2023.pdf.

6. The Balanced Budget Act of 1997 (Pub. L. No. 105-33).

7. Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260, Division N, Title 1, Section 101); Protecting Medicare and American Farmers from Sequester Cuts Act of 2022 (Pub. L. No. 117-71, Section 3); Consolidated Appropriations Act of 2023 (Pub. L. No. 11-322, Section 4112).

8. These scheduled cuts in part reflect budget-neutral changes that increased Medicare payments for office and outpatient E&M (evaluation and management) visits. For a discussion, see page 104 in MedPAC, "Medicare Payment Policy," March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

9. Consolidated Appropriations Act of 2024 (Pub. L. No. 118-42, Division G, Title 1, Subtitle C, Section 305).

10. Congressional Budget Office, "Alternative Approaches to Reducing Prescription Drug Prices," October 2024, https://www.cbo.gov/system/files/2024-10/58793-rx-drug-prices.pdf.

11. Department of Health and Human Services, "Telehealth Policy Changes After the COVID-19 Public Health Emergency," https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency.

12. Ateev Mehrotra, Haiden A. Huskamp, Alok Nimgaonkar, Krisda H. Chaiyachati, Eric Bressman, and Barak Richman, "Receipt of Out-of-State Telemedicine Visits Among Medicare Beneficiaries During the COVID-19 Pandemic," *JAMA Health Forum* 3, no. 9 (2022), https://pubmed.ncbi.nlm.nih.gov/36218938/.

13. Juan J. Andino, Nicholas W. Eyrich, and Richard J. Boxer, "Overview of Telehealth in the United States Since the COVID-19 Public Health Emergency: A Narrative Review," *mHealth* 9 (2023), https://mhealth.amegroups.org/article/view/115704/html.

30 29 28 27 26 25 24 7 6 5 4 3 2 1

ABOUT THE AUTHORS

LANHEE J. CHEN

Lanhee J. Chen, PhD, is the David and Diane Steffy Fellow in American Public Policy Studies and cochair of the Healthcare Policy Working Group at the Hoover Institution. He is also a lecturer and the director of Domestic Policy Studies in the Public Policy Program at Stanford University. He has advised four presidential campaigns and served as a member of the Social Security Advisory Board and as a senior official at the US Department of Health and Human Services.

DANIEL L. HEIL

Daniel L. Heil is a policy fellow at the Hoover Institution whose work focuses on the federal budget, healthcare, tax policy, and antipoverty programs. Heil served as Florida governor Jeb Bush's economic policy adviser, counseling him on these issues, during the 2016 presidential campaign. He holds a master's degree in public policy from Pepperdine University.

TOM CHURCH

Tom Church is a policy fellow at the Hoover Institution whose work focuses on healthcare policy, entitlement reform, income inequality, poverty, and the federal budget. He holds a master's degree in public policy with honors from Pepperdine University.

About the Healthcare Policy Working Group

Hoover's Healthcare Policy Working Group develops and promotes innovative market-based health policy proposals that are capable of both reducing costs and expanding access to healthcare. The policy proposals include reforms to introduce competitive forces across the sector and improve consumer-directed healthcare. The working group collaborates with healthcare experts and other stakeholders to identify actionable policies that will improve America's healthcare system.

For more information about this Hoover Institution initiative, visit us online at hoover.org/research-teams/healthcare-policy-working-group.

Hoover Institution, Stanford University
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

Hoover Institution in Washington
1399 New York Avenue NW, Suite 500
Washington, DC 20005
202-760-3200

HOOVER INSTITUTION