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Perspective

Covid-19 and the Need for Health Care Reform

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The Covid-19 pandemic has brought into sharp focus the need for health care reforms that promote universal access to affordable care. Although all aspects of U.S. health care will face incredible challenges in the coming months, the patchwork way we govern and pay for health care is unraveling in this time of crisis, leaving millions of people vulnerable and requiring swift, coordinated political action to ensure access to affordable care.

About half of Americans receive health coverage through their employer, and with record numbers filing for unemployment insurance, millions find themselves without health insurance in the midst of the largest pandemic in a century. Even those who maintain insurance coverage may find care unaffordable.

Before the pandemic, research showed that more than half of Americans with employer-sponsored health insurance had delayed or postponed recommended treatment for themselves or a family member in the previous year because of cost.[1] The loss of jobs, income, and health insurance associated with the pandemic will greatly exacerbate existing health care cost challenges for all Americans. For instance, in a recent poll, 68% of adults said the out-of-pocket costs they might have to pay would be very or somewhat important to their decision to seek care if they had symptoms of Covid-19.[2] Failure to receive testing and treatment because of cost harms everyone by prolonging the pandemic, increasing its morbidity and mortality, and exacerbating its economic impact.

To address myriad issues raised by Covid-19, Congress has passed two significant pieces of legislation, with more likely to come. The Families First Coronavirus Response Act (FFCRA) requires all private insurers, Medicare, Medicare Advantage, and Medicaid to cover Covid-19 testing and eliminate all cost sharing (copayments, deductibles, and coinsurance payments) associated with testing services during the public health emergency. It also appropriated $1 billion for the Public Health and Social Services Emergency Fund to cover testing for uninsured individuals under state Medicaid plans. Although the FFCRA assists with testing costs, patients remain vulnerable to cost-sharing expenses associated with treatment (such as hospitalization) until they reach their yearly out-of-pocket maximum, which can exceed $8,000 for an individual and $16,000 for a family.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, a $2.2 trillion pandemic-relief bill, requires all private plans to cover Covid-19 testing and future

vaccines, but it stops short of eliminating cost sharing for Covid-19 treatment. Nonetheless, many private insurers, including Humana, Cigna, UnitedHealth Group, and Blue Cross Blue Shield, have agreed to waive cost-sharing payments for plan members treated for Covid-19. The CARES Act appropriated $100 billion for hospitals and health care providers, which Health and Human Services Secretary Alex Azar later conditioned on providers' agreement not to bill insured patients more than their in-network cost-sharing amounts and not to bill uninsured patients at all for Covid-19 treatment. The federal government will reimburse providers at Medicare rates for treating uninsured patients. The CARES Act also provided substantial tax credits, emergency grants, and loans to help businesses keep employees on the payroll or on furlough through June 2020, while extending and increasing unemployment benefits for those who lost their jobs.

Though these laws provide critical assistance, additional policies are needed to ensure that Americans can continue to access affordable care as the crisis continues. First, I believe policymakers should freeze people's insurance status as of April 1, 2020, to keep as many people as possible in their existing plans and with their current providers. People who had employer-sponsored insurance or an Affordable Care Act (ACA) marketplace plan as of that date should be able to remain on that plan through the end of the public health emergency, even if they lose their jobs or cannot pay their premiums. As an initial step in this direction, several states have instituted grace periods on insurance-premium payments for all policies.[3] For example, the Ohio Department of Insurance ordered all insurers to offer employers a 60-day grace period for premium payments, enabling them to retain employees and their health benefits for an extended period.[4] Premium payments could be paused, subsidized, or paid directly by federal disaster-relief funds.

Second, policymakers should secure coverage for people who have already lost their jobs by expanding access to ACA marketplace plans and Medicaid. Eleven states and the District of Columbia have opened new open enrollment periods for their state ACA marketplaces to encourage enrollment.[3] Despite President Donald Trump's announcement that he would not open enrollment in the 38 states with ACA plans hosted on the federal marketplace, people who have lost their jobs within the past 60 days or who expect to lose their job in the next 60 days can apply to enroll in an ACA marketplace plan during a special enrollment period (just as one can after a life event such as marriage or the birth of a child).

In response to the pandemic, nearly all states have received Section 1135 Medicaid waivers to meet the needs of their most vulnerable residents.[3] Many states sought such waivers to eliminate Covid-19–related cost sharing, facilitate provider and participant enrollment, and waive preauthorization requirements for Covid-19–related services during the declared public health emergency. In addition, many states (including Iowa, which already applied for and received a Medicaid waiver to be allowed to maintain its enrollment) will pause disenrollment to receive a higher federal matching rate established by the FFCRA. Finally, no state is currently enforcing work requirements for maintaining Medicaid eligibility.

Given the size and scope of the pandemic, state or federal government officials could also implement something similar to the Disaster Relief Medicaid program (DRM), a temporary public health insurance program created in New York after the 9/11 terrorist attacks.[5] The DRM allowed nearly 350,000 New Yorkers to quickly and easily obtain access to Medicaid benefits by raising eligibility thresholds, excluding asset tests, and using short-form applications. The program provided New Yorkers with 4 months of emergency Medicaid coverage during the most critical time of the crisis, and then helped them transition to other coverage. A similar emergency program could raise eligibility thresholds beyond Medicaid expansion levels and increase federal matching funds to help cover people who lost their jobs or remain uninsured during the pandemic.

Third, state and federal officials should continue addressing out-of-pocket expenses, such as cost sharing and surprise medical billing. Lawmakers can follow Massachusetts, New Mexico, and Washington, D.C., by eliminating cost sharing for Covid-19–related treatment. Hospital and provider reimbursement shortages can be covered by CARES Act appropriations.

Covid-19 also creates unique affordability challenges related to surprise medical billing, which can occur when a patient receives treatment from an out-of-network physician at an in-network facility. Staffing shortages and triage protocols make it more likely that patients will be sent to out-of-network facilities or be seen

by out-of-network providers when they cannot check providers' network status. Furthermore, provider shortages may require providers to fill in care gaps for many conditions, not just Covid-19, expanding the potential for out-of-network care and surprise bills during this time. Though more than half the states offer some surprise-billing protections, policymakers should eliminate bills from out-of-network providers that exceed in-network cost-sharing limits for any medical treatment received during the public health emergency.

While states should continue leading the way on Covid-19 policies, comprehensive protections demand federal intervention. The Employee Retirement Income Security Act of 1974 (ERISA) prohibits state laws governing health insurance from applying to self-insured employer plans, typically offered by large employers such as Apple, Intuit, and Microsoft. As a result, current state surprise-billing protections, cost-sharing prohibitions, and coverage mandates will not apply to nearly 60% of Americans with employer-sponsored health insurance (nearly 30% of the population). ERISA thus leaves millions of people unprotected by state health care reforms. Absent a federal response, states can avoid some ERISA entanglements by directly prohibiting providers from charging cost-sharing rates for Covid-19 treatment and from surprise billing, but historically this approach has been politically infeasible. Perhaps Covid-19 provides the necessary impetus for change.

Never before has the interdependence of all our health, finances, and social fabric been so starkly visible. Never before has the need for health care reforms that ensure universal access to affordable care for all Americans been more apparent. Our policies on health and health care, both during this pandemic and in the future, should reflect this reality, and we should not let the lessons of this crisis pass us by.

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

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