Insuring the Population During National Emergencies Leveraging Both Medicaid and the Marketplace

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See also Erwin et al., p. 540, and the Fixing US Health Policy section, pp. 620–657.

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No event in modern history has brought the US health system's flaws into sharp relief like the COVID-19 pandemic. Whether the focus is on insurance coverage, public health, or health disparities, the novel coronavirus is forcing the United States to confront a remarkable set of problems.[1] Given the fierce urgency of these challenges, we do not have years to solve these problems or implement promising solutions.

CURRENT EFFORTS TO EXPAND COVERAGE

The consequences of the pandemic should encourage policymakers to pursue—as an initial step—reforms that expand access to health insurance during national emergencies. The Families First Coronavirus Response Act (FFCRA) takes a very modest step toward this aim through the creation of a fully federally funded state option for coverage of COVID-19 testing for the uninsured. The Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, passed by the House of Representatives in mid-May, would carry this reform further by expanding coverage to include treatment of COVID-19 as well as health conditions that complicate treatment and recovery.

Existing US national policy currently includes a modest but important law that creates health care flexibilities during declared emergencies. Section 1135 of the Social Security Act[2] authorizes the US Department of Health and Human Services (HHS) secretary to waive numerous provisions of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) during an emergency to improve the flow of insurance resources and reduce barriers to care. Under section 1135, the HHS secretary can relax program compliance rules, ease requirements that participating providers must satisfy (including in-state licensure requirements), expand the range of covered services in health care settings, and use strategies such as telehealth. During the current pandemic, the presidential administration has used these powers to expand Medicare and has encouraged states to adopt parallel Medicaid and CHIP reforms.[3]

EXPANDING MEDICAID MITIGATES EMERGENCIES

As important as these flexibilities are, they do not provide coverage. As Louisiana's secretary of health, one of the authors oversaw the development and implementation of Medicaid expansion in Louisiana. Louisiana's 2016 Medicaid expansion through the Patient Protection and Affordable Care Act (ACA) played a critical role in providing health care during the pandemic.[4] In the four years since adoption, the state's decision to fundamentally redesign Medicaid has reduced its uninsured population by more than half, with more than 500 000 people gaining coverage by 2018. Expansion has enabled Louisiana to become a national leader in testing, its contact tracing program is robust, and ensuring equity in access to care and health system performance has been formalized as a pandemic priority.

USING THE AFFORDABLE CARE ACT

The COVID-19 emergency has coincided with national recognition of the achievements and limitations of the ACA, now in its 10th year. Even before the

pandemic, a chief limitation was the unaffordability of health care: one third of those who visit the health insurance marketplace do not buy coverage,[5] and millions remain uninsured because they live in a state refusing to expand Medicaid (a problem created by the Supreme Court's 2012 decision, not by the ACA) and have income that is too low to qualify for marketplace subsidies.[6] Although the FFCRA and the HEROES Act are a beginning to interim reforms to strengthen insurance, a holistic response is imperative, one that addresses public health emergencies more broadly, not one illness or event at a time.

OPTIONS FOR EMERGENCY INSURANCE REFORM

Lawmakers have two basic options where emergency insurance reform is concerned. The first strategy is to use Medicaid, which over decades has become the nation's largest public health first responder. For example, Louisiana employed Medicaid in the wake of Hurricane Katrina to provide emergency uninsured coverage under a Medicaid expansion operating under the authority of section 1115, a special federal experimental statute. A Medicaid strategy could provide full federal funding for coverage, without cost sharing, for preventive, diagnostic, treatment, and recovery care and to treat preexisting conditions that could be complicated by the public health emergency. Medicaid coverage, as was done under the FFCRA, could be designed to remain in place throughout the emergency, without a lapse in coverage. Consistent with Supreme Court principles, emergency Medicaid would be designed to operate as a state option. Whether full federal funding would be sufficient to ensure state adoption is unclear; indeed, to date 13 states have resisted the ACA expansion despite enhanced funding. To promote state participation, the emergency option could be combined with incentives, such as supplemental grants, to participating states to help offset emergency-related health needs such as emergency housing assistance and nutrition.

A second option would be to establish a federally administered program operated through state health insurance marketplaces. Under this approach, the federal government would fully subsidize the purchase of qualified health plans operating under special emergency coverage rules that waive cost sharing for covered services. To ensure enrollment, the marketplaces would remain open throughout the emergency in recognition of continually changing employment and family circumstances triggering the need for public coverage. Unlike Medicaid, which allows people to enroll at any time, the marketplace is open for only a few weeks annually, and access is otherwise limited to designated special enrollment periods. Residents of states that opt not to adopt the special Medicaid emergency program would have access to emergency marketplace qualified health plans.

CONCLUSIONS

Infectious diseases such as COVID-19 remind us that the health of every individual is inextricably linked to the health of the community, and the health of the community is the foundation of a healthy economy. Among the system failings revealed by COVID-19, the lack of health insurance is, in many ways, the easiest to fix. The ACA has given us two highly useful pathways—one through Medicaid, the other through the marketplace. Medicaid has the benefit of being less costly than commercial insurance, and states are highly experienced health insurance managers, as evidenced by the speed with which they implemented the ACA Medicaid expansion. A national system, by contrast, offers the benefit of uniformity, although the cost likely would be somewhat higher because commercial insurers pay at a higher rate. Either approach (or the two combined) could work, and there is reason to believe such approaches may be adopted by the Biden administration.

Mitigating the COVID-19 pandemic is the top health priority of the Biden administration, and using existing options in Medicaid waivers and the marketplace has been expressed as a part of this strategy. As was stated in the Biden–Sanders Unity Task Force Recommendations, a key plank in the Democratic policy platform will be using innovation waivers to enable innovation in coverage expansion. Given this commitment and the overwhelming need, the options we have presented may be implemented in the near future. All the nation needs to do is select one and start moving. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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