SOUNDING BOARD

Covid-19 — Implications for the Health Care System

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The novel coronavirus pandemic has spawned four intertwined health care crises that reveal and compound deep underlying problems in the health care system of the United States. In so doing, however, the pandemic points the way toward reforms that could improve our ability not only to cope with likely future epidemics but also to serve the basic health care needs of Americans.

THE CRISES AND THEIR ORIGINS

INSURANCE COVERAGE

The pandemic has significantly undermined health insurance coverage in the United States. A sudden surge in unemployment — exceeding 20 million workers[1] — has caused many Americans to lose employer-sponsored insurance. A recent Commonwealth Fund survey showed that 40% of respondents or their spouse or partner who lost a job or were furloughed had insurance through the job that was lost.[2] Although many will continue to get employer coverage or become eligible for Medicaid or marketplace plans, a substantial number will probably become uninsured.[3,4] Even workers who keep their jobs may find their coverage dropped or curtailed as financially strained employers cut costs. These developments will add to the 31 million persons who were uninsured and the more than 40 million estimated to be underinsured before the pandemic struck.[5,6]

This new crisis of coverage has at least two causes. The first is our continued reliance on employer-sponsored insurance to cover approximately half of Americans against the cost of illness. The second is failure to vigorously implement current law. By design, the Affordable Care Act (ACA) helps persons who lose employer-sponsored insurance by making subsidies available for the purchase of individual insurance in the ACA marketplaces, by expanding Medicaid eligibility, and by requiring that private insurance cover preexisting conditions and a basic package of benefits. However, although states with their own marketplaces have alerted the recently unemployed to their potential eligibility for subsidized plans,[7] the federal government has not engaged in a parallel effort. It has neither educated the newly unemployed about their immediate eligibility outside of open enrollment periods for subsidized insurance in the federally run ACA marketplaces nor opened special enrollment periods for those wishing to enroll even if they did not previously have coverage. Furthermore, 14 states have chosen not to expand Medicaid.

DEEP FINANCIAL LOSSES FOR PROVIDERS

For the first time since the Great Depression, crippling financial losses threaten the viability of substantial numbers of hospitals and office practices, especially those that were already financially vulnerable, including rural and safety-net providers and primary care practices.[8] The immediate cause of this unprecedented financial crisis is substantial, unexpected changes in demand for health services. On the one hand, a novel infectious illness has increased demand for specialized acute care that has overtaxed some hospitals and imposed unexpected costs on many more. On the other hand, precipitous declines in demand for routine services have reduced providers' revenue. Office-based practices had reductions of 60% in visit volumes in the first months of the crisis, and, by their own estimates, hospitals will lose an estimated $323.1 billion in 2020.[9,10] Employment in the health care system is down by more than 1 million jobs through May.[1]

Providers' vulnerability to these demand fluctuations raises a fundamental question about the way we currently pay for health care in the United States. Providers operate as businesses that charge for services in a predominantly fee-for-service marketplace. When the market for well-paid services collapses, so do health care providers.

This system has a number of adverse effects in normal times. It creates incentives to raise prices and push up volumes, shortages of poorly compensated services such as primary care and behavioral health, and an undersupply of services in less financially attractive poor and rural communities. But in the extreme circumstances of a pandemic, a new question arises: is health care an essential national resource that warrants secure financing beyond what the current fee-for-service system offers?

SUBSTANTIAL RACIAL AND ETHNIC DISPARITIES IN THE HEALTH CARE SYSTEM

Black persons constitute 13% of the U.S. population but account for 20% of Covid-19 cases and more than 22% of Covid-19 deaths, as of July 22, 2020. Hispanic persons, at 18% of the population, account for almost 33% of new cases nationwide.[11] Nearly 20% of U.S. counties are disproportionately Black, and these counties have accounted for more than half of Covid-19 cases and almost 60% of Covid-19 deaths nationally.[12]

These racial and ethnic disparities constitute a new crisis compounding the long-standing failure of our health system to care adequately for persons of color. The causes start with a system that disproportionately fails to insure persons of color for the cost of illness, a problem reduced but not eliminated by the ACA.[13] Lack of coverage causes less access to care, which results in a higher prevalence of and less-well-controlled chronic illness among persons of color. These illnesses leave them more vulnerable to the ravages of Covid-19.[14]

Another cause is that persons of color are more affected by nonmedical threats to health, including food and housing insecurity. They also tend to have jobs that are riskier during pandemics, such as providing care at home and long-term care facilities.[15] Once ill, persons of color are more likely to get care in safety-net facilities overwhelmed by surges in demand for acute care.

Disparities in access and health outcomes are entrenched features of the U.S. health care system.[16] They reflect a history of racism and discrimination that permeates society generally.

A CRISIS IN PUBLIC HEALTH

The United States has 4% of the world's population but, as of July 16, approximately 26% of its Covid-19 cases and 24% of its Covid-19 deaths.[17] These startling figures reflect a deep crisis in our public health system.

Put simply, that system failed to quickly identify and control the spread of the novel coronavirus. The United States did not make testing widely available early in the pandemic, was late to impose physical-distancing guidelines, and has still not implemented either as widely as needed.[18] National guidance on managing the pandemic has been inconsistent and delayed. Many states have now abandoned stringent physical-distancing guidelines without careful attention to public health measures needed to prevent resurgence.

Although inadequate leadership and excessive partisanship have played a role in these shortcomings, other factors are also in play. Public health is a quintessentially governmental function, undertaken collectively for the public good at the national, state, and local levels. In part because of many Americans' distrust of government, public health functions have historically been underresourced.[19] The trained personnel who are needed for contact tracing — a traditional public health function long applied to such age-old afflictions as tuberculosis and sexually transmitted disease — are now scarce. Tellingly, there is no national public health information system — electronic or otherwise — that enables authorities to identify regional variation in the demand for, and supply of, resources critical to managing Covid-19. Without such information, authorities have no way to direct vital resources from areas of surplus to areas of undersupply. It is no exaggeration to say that the United States currently lacks a functioning national system for responding to pandemics.

RESPONSES TO THE CRISES

OPPORTUNITIES FOR FEDERAL POLICY REFORM

National trauma can change national psychology and create opportunities for major reform. Whether the novel coronavirus will do so remains un-

certain, but even if it does not, the pandemic may open the way to meaningful incremental changes that are normally difficult for our highly divided and partisan political institutions to accomplish. Major reforms may prove most feasible in the area of public health, where recent events have made deficiencies so obvious.

We focus here on policy solutions at the federal level, both for reasons of space and because the pandemic has illustrated the critical role that federal leadership — and its absence — play in our health care system. The changes that are envisioned will naturally require additional federal outlays. The amounts are difficult to predict because some, such as reforms envisioned in provider payment, may actually generate savings over the middle-to-long term by reducing the costs of health care. Expenses might be defrayed by adopting other cost-reducing policies, such as modifications in how Medicare pays for pharmaceuticals. However, it is also possible that paying for these reforms — and for the other major federal programs adopted to combat pandemic-induced economic dislocations — may require reversing some of the tax reductions enacted in 2017.

INSURANCE COVERAGE

The United States has fiercely debated for nearly a century whether and how to protect Americans against the cost of illness.[20,21] That debate has generated steady incremental progress that most recently, through the ACA, reduced the numbers of uninsured Americans to a historic low of 28.6 million in 2015.[22] Will a sudden increase in uninsured Americans create the political will to expand coverage again?

If it does, proponents of expanded coverage have multiple policy options to choose from, ranging from a government-financed single-payer system such as Medicare for All to reforms that build on current law.[23] One of several arguments for a single-payer system is that it would unlink employment and health insurance. If recent events have soured Americans and their employers on employer-sponsored insurance, a transition to an increasingly public insurance system may become more politically appealing.

It seems equally or more likely, however, that our national preference for incrementalism would favor reforms that preserve employer-sponsored insurance while compensating for its flaws. This has the considerable advantage of keeping the full costs of insuring Americans — a projected $34 trillion over a period of 10 years — off the federal budget at a time of already sobering federal deficits.[24] In this vein, building on and fully enforcing existing ACA authorities could ensure virtually universal health coverage.[24] A first step might be to have the federal government absorb the full costs of expanding Medicaid, thus encouraging resistant states to take this step. Another reform might include extending and enhancing subsidies for ACA marketplace coverage. Still another possibility is a public option available to people with employer plans. The achievement of universal coverage under this incremental approach will also require a strong individual mandate or autoenrollment mechanism.[24]

SECURING THE FINANCES OF OUR HEALTH CARE SYSTEM

Just a few months ago, health care providers in the United States seemed, if anything, overcompensated. Even now, many of the nation's most wealthy and prestigious health care institutions and practices can probably absorb and survive the immediate losses inflicted by Covid-19.[25]

However, the pandemic also shows that some hospitals and health professionals are far too vulnerable under current financial arrangements, and the failure of these providers could leave major gaps in critical health care services. This raises obvious questions about whether the United States needs a financing system that preserves essential health services in the face of market disruption.

Part of the solution might be to adopt payment models that sever the link between compensation and the volume of services provided. The most promising as a way to assure more secure funding for the health care industry is capitation, in which a provider organization receives prospective, monthly payments for providing all necessary care to groups of patients. Medicare Advantage plans already operate under this system.

There are many variations on this theme, including capitation for selected services (e.g., primary or specialty care) or a combination of capitation with fee for service for certain types of care (e.g., preventive services) that might otherwise be undersupplied or are particularly valuable. For hospitals, a capitation equivalent might

be a prospective annual budget for providing all necessary hospital services to patients in particular geographic areas.

There is no perfect approach to compensating providers. One advantage of full or partial capitation and prospective budgeting is that they offer hospitals and health professionals a predictable stream of revenue that is unlinked from the volume of services provided. Capitation would have protected many providers against the sharp short-term losses they are sustaining as a result of Covid-19, reduced the need for immediate federal subsidies (now totaling hundreds of billions of dollars), and provided time to consider their amount and distribution with more care. Upfront, global payments also offer providers the flexibility to innovate. For example, they could substitute virtual care for in-person care without worrying about how telemedicine is compensated under fee-for-service rules.

Payment models such as capitation would not completely stabilize the financing of vital health care services. If volumes and associated costs to providers are consistently lower than expected, payers will insist on reduced capitation levels when existing agreements end. However, providers will have more time to plan for and adapt to such reductions than they have had in the early months of the pandemic. If reduced prepayments nevertheless threaten the availability of critical services, additional public policies may be necessary to subsidize providers whose losses might jeopardize the health of communities. All capitated payment models should include measures of quality and efficiency to ensure that health professionals and institutions do not undersupply services and that compensation is proportional to the value provided.

Another part of the financing puzzle is guaranteeing that essential services that were undersupported in fee-for-service markets before the pandemic are adequate in the future. This will mean public policies to shore up primary care services, behavioral health care, safety-net providers, and rural health care services. The pandemic has shown the limitations of insufficiently planned markets in caring for Americans, both in normal times and in emergencies.

RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Clear inequities in the effect of the pandemic on communities of color shine a light on systemic racism in health care. The health system cannot solve this problem by itself. Social determinants of health that partially explain the heightened vulnerability of persons of color to the novel coronavirus originate outside health care — in differential access to education, employment, housing, and justice.

Nevertheless, the pandemic refocuses attention on how the health care system can ameliorate health inequities. Universal coverage would improve access to primary and preventive care services, which in turn could reduce the prevalence and severity of chronic illnesses that exacerbate the health effects of disasters of all types. Although expanded health coverage under the ACA reduced the uninsured rate across all groups, racial and ethnic minorities saw the biggest gains in coverage and access to care.[26]

Greater support for safety-net facilities and small community providers, including inner-city and rural hospitals and community health centers, could also improve access to basic and advanced services for populations of color. These providers also would need support to transition to value-based care.

The education and licensing of health professionals could be required to include anti-bias training. In addition, all health care organizations could be required to compare the quality of care for patients of different races and ethnic groups and report these data to local and national health authorities as a condition for eligibility for Medicare and Medicaid funding. Reporting is the starting point for coming to terms with inequity in our health system.

A ROBUST PUBLIC HEALTH CAPACITY

The novel coronavirus is unlikely to be the last pandemic we face.[27] To control Covid-19 and prevent unnecessary suffering and economic damage from future pandemics, the United States will need to improve its capacity for collective action to protect the public's health.

This starts with building the ability of state and local public health authorities to implement basic disease-control measures, such as testing, contact tracing, and isolation of affected persons. Because states often lack the means to create these capabilities, federal support and guidance would be required. And because microbes do not respect state boundaries, containing infection depends on cross-state coordination. Only the federal government can reliably lead such interstate collaboration.

The federal government currently lacks all the authorities needed to play this role effectively. This leadership vacuum leaves the country unprepared to mount an effective, unified response to emerging infectious threats. Of all the problems highlighted by Covid-19, creating federal leadership capacity may be the most challenging. Some Americans simply have an aversion to centralized power of any kind. And an increase in the federal role would potentially shift the balance of power between Washington and state governments.

Nevertheless, it is hard to imagine an effective approach to containing pandemics that doesn't involve national direction. As long as one state or region continues to harbor infection, the nation as a whole remains at risk.

New federal legislation is necessary to clarify and bolster the ability of the federal government to intervene decisively and rapidly, and especially to require states and localities to implement critical health measures that are currently the responsibility of states but are vital to the health and welfare of persons in other states. This legislation would have several aims. First, it would enable the federal government to establish a national public health information system that provides real-time data on disease prevalence and incidence of illness as well as on the availability of critical resources to treat affected patients. This system should connect state and local health departments with one another and with private health care providers and require the participation of private health care facilities, laboratories, and manufacturers to give a complete picture of available resources. Second, it would allow the federal government to expend federal funds, without prior congressional approval, on emergency responses, including the development and distribution of new diagnostic tests, new therapeutic approaches, and new vaccines and the hiring and training of personnel needed to track and contain epidemics at the local level. Third, it would let the federal government require states to adopt measures needed to contain the spread of infections. In particular, legislation could facilitate the use by the federal government of its constitutional powers to regulate interstate commerce by forcing states that did not comply with critical infection-control measures to cease participation in interstate travel and commercial activities. Fourth, it would allow the federal government to regulate the distribution of new vaccines and antimicrobial agents. Fifth, it would grant the federal government emergency powers to require states to allow licensed health professionals to participate in cross-state telehealth. The use of some of these authorities could be conditional on a presidential declaration of a public health emergency and could be time limited unless extended by Congress.

CONCLUSIONS

The Covid-19 pandemic recalls once more the old truism attributed to Winston Churchill: one should never let a crisis go to waste. We may now have the opportunity to reform a flawed health care system that made the novel coronavirus far more damaging in the United States than it had to be.

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From the Commonwealth Fund, New York.

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