Editorial Commentary

Pragmatic healthcare reform before the next pandemic

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Coronavirus disease 2019 (COVID-19) has laid bare the painful consequences of ignoring public health as a key pillar of ensuring economic, social, and community resilience. A gaping hole in US healthcare pre-COVID, during COVID, and almost assuredly after this pandemic will be the insurance coverage and affordability crisis facing millions of Americans, particularly in the context of rising inflationary pressures. More than 40% of Americans continue to be uninsured or underinsured, including minority populations and those already at elevated risk due to social determinants of health (1,2). Around half of Americans remain dependent on their employer for health coverage, a historical legacy of the post-World War II 1940s, when public policy created tax incentives for employers to offer health insurance in fear of inflation, with rapid inflation now a critical domestic economic and policy challenge. COVID-19 has also exposed how antiquated this system is to the needs of modern healthcare and responding to acute public health emergencies.

Failures in US healthcare coverage and affordability were a large concern for federal policymakers when COVID-19 arrived. Particularly, to address disruption caused by early pandemic unemployment and economic insecurity, the federal government stop gapped potential health insurance coverage losses by temporarily increasing subsidies for COBRA (program to continue insurance after leaving employment) and the Affordable Care Act marketplaces (a healthcare exchange created under the Affordable Care Act that offers healthcare plans to individuals, families, and small businesses in an effort to extend coverage to uninsured Americans), as well as locking in Medicaid enrollment for individuals and families even when no longer meeting program eligibility criteria (3). To date, health policy responses have largely focused on combatting COVID-19 and its impacts on the healthcare system rather than long-terms solutions for addressing inadequate insurance coverage. Failing to legislate on these systemic flaws misses the opportunity to improve the lives of millions of Americans and the additional bonus of creating a better equipped and more resilient healthcare system when the next pandemic arrives. Finding policy solutions requires evaluation of past and current health policy reform ideas best suited to achieve the aims of improving coverage, affordability, and controlling systemic costs without sacrificing care.

Prospects for federal reform and the relief of states

Markedly reducing the number of uninsured and underinsured Americans at the federal level has been an uphill legislative battle post- the Affordable Care Act (ACA). Even with a more sympathetic Biden Administration and Democratically controlled Congress, there is still great political division on national healthcare reform. Before the pandemic, inside the Democratic Caucus in both the House and Senate, views on healthcare reform differed from more moderate views of strengthening the existing ACA to more progressive stances calling for a restructuring of the healthcare system under a "Medicare-for-All" single-payer system (including a bill introduced by House Democrats on March 16, 2021, with 109 co-sponsors) (4). However, during COVID-19 the debate about health policy reform has been driven by acute challenges associated with the

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pandemic. Even if priorities were to change in the second half of 2022, with only a one vote margin in the Senate, Democrats need both unanimity and use of the reconciliation process (which is limited to budgetary matters) to avoid the 60-vote filibuster threshold, as Republicans have actually tried to unwind ACA government-funded healthcare reforms designed to expand access and coverage (5). The Biden Administration has left out the public option from its 2022 budget despite campaigning on the reform idea during the 2020 presidential campaign (6). The public option would create a government-run healthcare insurance option for Americans. Even more ominously, the introduced Build Back Better legislation that envisions substantive social and environmental policy reform, saw healthcare reform provisions whittled down to include only limited prescription drug negotiation authority for Medicare and increased subsidies to the ACA Exchanges in a less transformative legislative package known as The Inflation Reduction Act (7).

However, low expectations for major federal legislation should not be an excuse for states to sit on the sidelines when systemic healthcare issues beset their residents. States have vast powers to legislate and regulate healthcare within their borders. In fact, the pressure for states to improve their healthcare systems has been given further incentive due to the wide-ranging impacts and also localization of COVID-19 burden. Early on, COVID-19-related lockdowns, restrictions, and quarantine led to sharp state revenue declines and projections of serious fiscal crisis (8). While much of the state fiscal crisis did not materialize, states betting on large federal government subsidies and a resilient economy during and post a pandemic are taking a gamble. Increasing the risk, states have a tougher time borrowing money than the federal government which can rely on deficit spending, and many states have balanced budget amendments which will require them to cut state services to make-up for any looming losses in revenue. While having an emergency preparedness plan is no doubt essential for the next pandemic, implementing reforms that improve coverage or lower costs without sacrificing quality of care should be foundational. Doing so will create healthier populations with better relationships with their providers and health systems, and thus, less vulnerable to the worst consequences of disease and other phenomenon like medical misinformation.

Arguably the boldest solution to getting all state residents covered with affordable healthcare insurance is adopting a single-payer system with universal health coverage. In its most comprehensive form, such a system would take all of a state's residents on government programs and those on group and individual private insurance plans and transition them into a single government run program. However, states are unable to construct such a system without multiple federal waivers and changes to federal law, including addressing legal challenges associated with ERISA pre-emption (9). The cleanest and simplest way for single-payer advocates is likely via enacting Federal legislation, like the State-Based Universal Care Act, which creates a policy pathway to overcome the aforementioned statutory and regulatory barriers (10). However, historically, single-payer legislation (including state referendums) to create single-payer have been unsuccessful on both the state and Federal level (11). Assuming a policy pathway was created and legislation passed, it is equally unclear if and how long it would take for a single-payer system to manifest and how it would be challenged legally.

Waivers as a policy tool for post-pandemic healthcare reform

There are policy measures short of creating a single-payer system that can also achieve progress in making healthcare more affordable and accessible, as well as increasing coverage. Specifically, federal waivers (e.g., Medicare Section 402/222 waivers, Medicaid Section 1115 waivers, and ACA Section 1332 waivers) will be a key tool for states seeking to implement structural healthcare system reforms moving forward. Federal waivers allow for states to modify (within certain parameters) healthcare programs like Medicare, Medicaid, and the ACA Exchanges, while still retaining federal funding that accompany these programs (9). Trying to make significant structural modifications to Medicare, Medicaid, or the ACA Exchanges without getting federal government waiver approval risks having such modifications nullified by the federal government. While each waiver has its own distinct criteria for what type and how far reform can go, the approval or disapproval of waiver applications is still quite dependent on each presidential administration's interpretation of that criteria (9).

While President Biden himself has expressed skepticism towards federal single-payer, his administration is likely be more sympathetic towards state-based efforts to increase government healthcare coverage than the last one. As mentioned, his campaign platform centered around expanding affordable coverage by supporting creation of a Medicare public option. Additionally, President Biden

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appointed Health and Human Services Secretary (HHS), Xavier Becerra, who previously expressed support for federal and state-based single-payer, and thus, may be more inclined to approve progressive state-waiver attempts (12). Hence, those interested in more progressive reforms may have a better chance of getting waivers approved that expand and enhance coverage under the Biden administration, in contrast to the regulatory stance taken during the former Trump administration which placed greater focus on advancing waivers that coupled healthcare coverage with meeting set criteria (e.g., tying Medicaid eligibility to work requirements) and waivers that promoted government healthcare coverage more resembling commercial insurance (9,12).

Despite a more receptive administration to progressive healthcare reform, state healthcare reform should nevertheless be carefully crafted not to run afoul of federal waiver criteria. Three states for policymakers to monitor on this front are Colorado, Nevada, and Washington. Each of the states has passed legislation creating a public option-style plan, with Washington putting its first iteration of the public option into effect in 2021 (13). The public option-style plan creates a highly regulated private insurance plan or plans to compete against other private health insurance plans on the ACA Exchange, and in the case of Colorado and Washington, off-Exchange as well (off-Exchange plans are individual plans not sold on the ACA marketplace) (13). This design allows the state to impose a vast array of requirements on a commercial health plan that are usually only seen in Medicaid managed care (13). Some of the key aims of these three states include using the public-option style plan to control provider reimbursement, fill coverage gaps in counties without Exchange plans, and provide premium competition against regular health plans on the exchange (14). Additionally, Colorado and Washington are establishing a standardized benefit where public-option plans must provide certain services (e.g., primary care visits and generic prescription drugs) at either no cost or for a nominal copay, even if the policyholder has yet to meet their deductible (14). State policymakers should carefully examine these three state reforms, closely paying attention to the successes and failures of each model. Most fundamentally, policymakers should not lose sight that public option-style reforms allow states a vehicle to implement a variety of healthcare initiatives, and it is ultimately the wise or unwise policy decisions put into the public-option style plan or plans that will determine its success. Fortunately for observing states, the many commonalities but key variations in public-option style plans may help highlight the successes and failures of policy attributes of the respective reforms.

Importantly, Colorado, Nevada, and Washington each have authorized in legislation and are planning on filing ACA Section 1332 Waivers with the federal government (13). The main purpose of the waivers will be to achieve what is known as pass-through funding. ACA Section 1332 allows the federal government to "pass through" the money that it would have spent on Exchange premium tax credits, cost-sharing reductions, and small employer tax credits to the state (15). Since each of these public option-style plans aims to level and reduce Exchange premiums, if approved, states may find themselves with federal dollars that can be used to further boost affordability on their Exchanges or advance other healthcare initiatives to expand coverage and affordability (13,14). A more comprehensive Section 1332 Waiver may not be needed, as these public-option style plans do not make significant structural changes to the Exchange, like collapsing it into a larger program as single-payer would require (16). State policymakers should monitor closely the waiver approval process to gain insight for the possibilities of their own reform.

States should also consider healthcare reform measures that focus on controlling overall healthcare system costs while incentivizing improved care, such as the approved Vermont's All-Payer Model Accountable Care Organization Model (17). Importantly, implementation of Vermont's All-Payer Model ACO relies on a Section 1115A Medicare Waiver and Medicaid Section 1115 Waiver (17). The Medicare waiver was accomplished by aligning the All-Payer Model closely to an existing Medicare quality payment program, which incentivizes creation of ACOs under the ACA that can reduce costs or improve care (17). Medicaid, which has a history of experimenting with different financial delivery models, also approved the All-Payer program to allow Medicaid provider payments to comport with this model (17). While not necessarily expanding beneficiaries or changing benefit mandates, Vermont's All-Payer ACO Model has a large influence on how providers and health care organizations are reimbursed and how they deliver care through cost and quality benchmarks. Even though Vermont's reform approach is voluntary, by including private non-governmental insurers into the mix, the target is for 70% of Vermont's residents to be part of the program by 2022 (17). Further, a 2019 study found that the program has saved the state and federal government millions of dollars as well as successfully curbing Vermont's healthcare spending growth rate and placing it well below the national average (18).

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Conclusions

Ensuring accessible and affordable healthcare coverage for all Americans should be a baseline requirement for patching up the US healthcare system and a key factor in preparing and mitigating for the next inevitable public health crisis. Leveraging federal waivers is a crucial policy tool for reform-minded states to exercise while the national debate around healthcare reform remains unresolved, particularly in the context of being more responsive to state-specific challenges and their respective political climates and constituent needs. When attempting these approaches, states should examine existing and proposed models (such as those in Colorado, Nevada, Washington, and Vermont) that can be used to expand affordable coverage or control state healthcare costs as test cases for their own future healthcare policy reform. Additionally, states should be mindful that a change in presidential administrations may change their policy options if they are utilizing federal waivers and strongly consider pursuing waivers that have a precedent or at least relation to previously approved waivers. Ideally, states should not prioritize cost-controls over providing accessible healthcare, nor should they forget about costs altogether. Rather, states should seek healthcare reforms that in their totality achieve the "Triple Aim" of reducing costs, improving quality, and expanding access. Pragmatic healthcare reform efforts are needed now to prepare us for a post-COVID-19 era. Healthcare reforms that create healthy populations, lessen human suffering, create stronger communities, and provide more resilience to the economy in good times and especially during public health crises are urgently needed.

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