Caring for the Uninsured

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SUMMARY. With a large uninsured population, the United States continues to depend heavily on health care safety net providers for ensuring access to essential services, in particular, vaccination services. The Consolidated Appropriations Act of 2021 provides modest funding to support health care for the uninsured, but the American Rescue Plan offered by the Biden administration promises both dramatic expansion as well as an approach to implementation that promotes equitable access to care.

Introduction
Chapter 14 in Volume I focused on the scope and underlying drivers of America’s uninsured problem along with the ways in which factors associated with being uninsured — being poor and being a member of a minority or immigrant population — also contribute to elevated risk severe illness or death from COVID-19 risk status and reduced access to health care. The Chapter also reviewed key programs and sources of funding to support COVID-related health services for the uninsured.

The number of uninsured remains seriously elevated, with the lack of health insurance disproportionately affecting families with incomes below twice the poverty line ($43,920 for a family of three in 2021) and racial and ethnic minority Americans. The vast majority live in working families and 86% are working-age adults (Berchick et al., 2019). Geographically, the highest proportions of uninsured people can be found in the southern and southwestern portions of the United States, and live in states that to date have not implemented the Affordable Care Act Medicaid expansion for low-income working-age adults. Extensive research documents that the uninsured are less likely to receive necessary health care and more likely to avoid care for reasons of unaffordability — serious problems at any time, especially so in the middle of a pandemic. Some 650,000 essential workers fall into the Medicaid coverage gap (Center on Budget and Policy Priorities, 2020) and 13% of essential workers — higher than the national average — are uninsured. (Kearney & Munana, 2020). Half the uninsured have no usual source of health care, compared to 12% who have public insurance and 1% with private coverage (Garfield et al., 2019).

This update reviews policy developments related to care for the uninsured since July 2020, with a special focus on access to immunization for the uninsured population, who, as a result of poverty and elevated health and social risks, also may be vulnerable to COVID-19 in its most severe form. This is also the population most likely to work in low wage physical jobs that involve extensive contact with others, including working with vulnerable populations such as residents of long-term care facilities and people in need of home and community care. Also among this group are inmates of jails and prisons, who are especially vulnerable to COVID-19 and who, especially in the case of jail inmates with short-term stays, run the risk of carrying the virus back to the communities where they reside.

Immunizing this population will depend heavily on accessible mass immunization centers. It will also depend on health care safety net providers that focus on medically vulnerable populations, specialize in removing barriers to health and social services, are located in or serve medically underserved communities, provide free and low-cost care, and are heavily dependent on public financing.

Vaccine administration is a reimbursable expense under the Provider Relief Fund’s Uninsured Program, which was established by the Trump administration in the spring 2020 using a small amount of direct health care funding allocated under a series of laws (Health Resources & Services Administration, 2021). However, the lion’s share of these funds went to the Provider Relief Fund whose purpose is to support provider revenue losses more generally. But the spring 2020 Coronavirus Preparedness and Response Act, the Families First Coronavirus Response Act, and the CARES Act did not focus on the cost of nationwide immunization — vaccines, their administration, and the costs of creating and strengthening accessible health care delivery systems capable of reaching all communities.

Overview of Recent Developments
Consolidated Appropriations Act of 2021 (H.R. 133).

Enacted during the final days of the Trump administration, this massive piece of legislation (which encompasses all federal appropriations funding for FY 2021) also provides approximately $900 billion in COVID-19 relief funding. With respect to COVID-related health care generally and vaccination in particular, the COVID-19 relief portion of the legislation contains the following provisions:

- A relatively small amount ($3 billion) for the Provider Relief Fund, though none of this money is specifically allocated to the Uninsured Program; along with broader standards for calculating revenue losses;
• $30 billion in federal funding to support the purchase and administration of vaccines and therapeutics, of which $8.85 billion is allocated to the Centers for Disease Control and Prevention for further distribution to states, localities and territories ($4.5 billion) and $300 million allocated to communities with populations that are at high risk and underserved, including racial and ethnic minority and rural communities.

• $22 billion to states for testing, tracing, and COVID-19 mitigation programs including $2.5 billion for targeted improvements to testing and contact tracing for underserved populations.

Beyond its COVID-specific provisions, the measure’s general fiscal year 2021 appropriations provisions include funding for ongoing support to federally supported health care safety net providers such as community health centers, Ryan White HIV/AIDS clinics, providers serving people with mental illness and addiction disorders and receiving support from the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, the legislation extends through FY 2023 the special Community Health Center Fund, which accounts for 70% of all federal community health center grant funding. Importantly, the act also eliminates a scheduled $4 billion reduction in federal funding during FY 2021 for hospitals serving a disproportionate percentage of low income patients and pushes off further DSH funding cuts that would have taken place in FY 2022 and 2023 (American Hospital Association, 2020). Together, these provisions lend some basic stabilization support to health care safety net providers.

President Biden’s American Rescue Plan

President Biden’s American Rescue Plan provides for $1.9 trillion in new COVID-19 federal investments. Much of this funding is allocated to a variety of forms of individual financial relief for families, general relief to states, and funds to support school reopening, and other activities. However, a centerpiece of the plan is funding to support a robust national vaccination program, at an amount set at $160 billion in new funding for testing, immunization, and public health jobs. Among its most important features, the plan tackles the problem of health inequity head-on.

Immunizations. The plan proposes $20 billion for a national vaccine program, with funding to states, localities, territories, and Tribal governments to open up mass immunization centers, send mobile clinics into hard-to-serve areas in order to ensure that “all people in the United States — regardless of their immigration status — can access” immunizations free of charge and without cost sharing. The plan explicitly calls for actions that will reduce the “disparities in the pandemic at every step, from ensuring equitable distribution of vaccines and supplies to expanding health care services to underserved communities.”

Investment in community-based providers. To this end, and in addition to its $20 billion governmental investment, the plan calls for a direct and separate investment in community health centers, the nation’s largest primary care system for medically underserved communities as well as heightened investments in Tribal health care. (The plan does not specify a recommended amount.) Thus, the plan would supplement governmental funding with a direct infusion of funds into community-based providers located in the high-vulnerability communities and serving vulnerable populations, disproportionately insured.

Testing. The plan calls for $50 billion in a massive scale-up of testing capacity to ensure health safety in schools and facilities housing highly vulnerable populations including long-term care institutions and prisons and jails. With respect to long-term care institutions, the plan specifically references not only residents but also the “African-American and Latina women, who have borne the brunt of the pandemic [and who] are overrepresented among long-term care workers.” In the case of prisons and jails, the plan explicitly aims to protect not only prisoners but also one of the nation’s most extensively community-residing uninsured populations — the formerly incarcerated as they reenter their communities.

Expanding coverage for the uninsured. President Biden’s plan calls for reforms to the Affordable Care Act (ACA) Marketplace subsidy system that would broaden its protections against high-out-of-pocket premium costs for middle income families, by capping total premium costs at no more than 8.5% of income. This is a dramatic reduction in the potential financial exposure now faced by families with incomes that exceed the ACA’s original upper subsidy threshold of 400% of poverty ($104,800 for a family of four) (Kaiser Family Foundation, 2020). The plan also would increase the generosity of tax credit subsidies for those with low household incomes, the precise level of increase unspecified. The plan remains silent on relief for residents of the 14 states in which the Medicaid expansion is not in effect (Kaiser Family Foundation, 2020), either because expansion has not yet been implemented or because no expansion actions have occurred. In these 14 states, more than two million people, including more than 160,000 essential workers, would remain without a pathway to affordable insurance because their incomes fall below the lower threshold for Marketplace subsidies and they do not qualify for traditional Medicaid.

Presidential Executive Orders

Beyond the American Rescue Plan, the president has issued a series of executive orders aimed at ensuring rapid executive action in accordance with presidential direction. Among these orders are:

• Executive Order No. 13995: Ensuring an Equitable Pandemic Response and Recovery, which focuses on mitigating the “severe and pervasive” health and social inequities that have been “exposed and exacerbated” by COVID-19. This action is to be carried out through a task force consisting of key federal agencies and outside experts and charged with, among other matters, making recommendations regarding how COVID-19 relief fund agencies can ensure equity in funding distribution and conduct outreach to communities of color and other underserved populations.

• Executive Order No. 13997: Improving and Expanding Access to Care and Treatments for COVID-19 that, among
other matters, aims to improve health system capacity to support both patients and workers. Under this executive order, the secretary of Health and Human Services (HHS) must specifically, through the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), expand access to programs and services aimed at helping patients with long-term recovery needs. Specifically, this executive order directs HRSA to provide technical support to community health centers engaged in the COVID health care and long-term recovery effort. The order also calls for “equitable and effective distribution of therapeutics and bolster clinical care capacity where needed to support patient care” and overcoming barriers to “effective and equitable use of existing COVID-19 treatments. Specifically the order also calls for an evaluation of the COVID-19 Uninsured Program and requires HHS to “take any available steps to promote access to treatments and clinical care for those without adequate coverage, to support safety-net providers in delivering such treatments and clinical care, and to make the Program easy to use and accessible for patients and providers, with information about the Program widely disseminated.”

- **Executive Order No 13985:** Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. This global order, which transcends all federal policies, aims to advance equity and support for underserved communities by “[a]firmatively advancing equity, civil rights, racial justice, and equal opportunity” across government as a whole. Specifically the order directs the White House Domestic Policy Council to “coordinate efforts to embed equity principles, policies, and approaches across the Federal Government [through] efforts to remove systemic barriers to and provide equal access to opportunities and benefits, identify communities the Federal Government has underserved, and develop policies designed to advance equity for those communities.” Under this directive, the council is expected to conduct equity assessments across the federal government and develop, with the Office of Management and Budget director, methods for “allocating Federal resources in a manner that increases investment in underserved communities, as well as individuals from those communities.”

**Recommendations for Action**

The first year of the federal response to the pandemic offers unequivocal lessons regarding care for the uninsured. Most clearly, the past year has shown us the extent to which the United States simply has failed to use readily available tools to ensure that — at least during a public health emergency and the recovery period that follows — all Americans are insured, that essential health services are available in medically underserved communities, and that methods are in place for ensuring that emergency resources can move quickly into the highest risk communities and be put to work.

On the eve of the pandemic, more than 30 million people lacked health insurance, and health care safety net providers already were struggling with chronic underfunding. Despite the existence of a nationwide federal health insurance marketplace that offers a ready means for supporting such a system, the nation lacked any policy that would enable uninsured people to immediately enroll in subsidized Marketplace plans. Despite the fact that safety net providers are readily identifiable through the federal funding mechanisms that provide ongoing support (such as Medicaid hospital disproportionate share hospital (DSH) payments, the Indian Health Service, grants to community health centers and other community-based safety net providers, and grant programs supporting state and local public health agencies), the nation still lacks any emergency relief fund that can be rapidly deployed to infuse resources into these providers to support expanded sites, services, and workforce. It is not that the United States lacks the knowledge regarding where to send support or even the mechanisms to move that support rapidly; it is that we have not used this knowledge or these mechanisms.

In the longer term, however, the nation needs a strategy for ensuring that in future public health emergencies — whether local, regional, or nationwide — Americans do not find themselves without resources to ensure equitable access to care. The legal mechanism for declaring a public health emergency exists in federal law, of course, and where health care is concerned, this mechanism authorizes the HHS secretary to make certain changes in federal Medicare policy and to authorize similar modest changes in state Medicaid operations. But in a nation that lacks universal health insurance, the ability to trigger emergency coverage becomes paramount. Moreover, fundamental equity considerations dictate that in times of emergency, additional, direct funding be rapidly deployed to providers serving populations and communities facing elevated risks along with serious health care shortages. The pandemic has demonstrated the essential nature of a fallback public health emergency insurance mechanism coupled with rapid deployment of additional, direct resources into medically underserved communities and populations.
Recommendations for Action

**Federal government:**

- Congress should revise existing federal emergency laws to provide for automatic emergency funding to specifically identified health care safety net providers for testing, treatment (including vaccines and their administration), and recovery care. At a minimum, such identified providers should include federally-funded community health centers and “look-alike community health centers” designated as such for purposes of Medicare and Medicaid “federally qualified health center” payments, “deemed” DSH hospitals, Title X family planning providers, the Indian Health Service, rural hospitals designated as critical access hospitals, rural health clinics, state and local health agencies, and other providers designated by the HHS secretary as essential providers during public health emergencies.

- Congress should create a universal insurance coverage mechanism to ensure access to coverage during a declared public health emergency. Such an emergency coverage mechanism should be open to any person who lacks health insurance covering testing, treatment (including immunization), and post-emergency recovery services. Coverage should encompass both treatment for conditions caused by the emergency, as well as underlying conditions exacerbated by the emergency or that could delay or complicate recovery. The establishment of a national exchange system makes this type of emergency insurance feasible through the use of a special enrollment period linked to public health emergencies. This is essentially the model that the Biden administration is now effectively testing on a limited scale under Executive Order 14009. However, that executive order can make affordable insurance available only to people who qualify for subsidized coverage under ACA rules (those with incomes between 100% and 400% of the federal poverty level (between $21,960 and about $88,000 for a family of three in 2021), since the president lacks the power to expand the subsidy system to all Americans without an act of Congress.

- In order to relieve the extraordinary financial pressures states face during public health emergencies, Congress should establish a special emergency-related increase in the Medicaid “federal medical assistance (FMAP)” formula that would increase all state FMAP rates to 90% for all program costs for the duration of the emergency and recovery period.

- The Biden administration should develop model demonstration programs under Medicaid and the Children’s Health Insurance Program that permit states to extend Medicaid to all uninsured low income residents and that waive normal budget neutrality principles for the duration of the emergency and recovery periods.

**State governments:**

- Governors and state legislatures should devote additional resources to support uncompensated care costs through direct grants and should accompany such direct funding with a temporary upward adjustment to Medicaid provider payments.

- Governors and state legislatures should make readiness grants available to help safety net providers immediately begin the process of adapting to operating in emergency conditions, including resources to help providers locate, secure, and expand into additional operating sites and expanded hours, bring on additional staff, and secure needed equipment and supplies. These emergency response grants should also support activities such as contact tracing, outreach and patient support services, and temporary housing and living supports for staff, and housing support for homeless patients and people too sick to return to their residences.

- Governors and state legislatures should establish mechanisms that will immediately expand support to state and local health agencies to rapidly deploy supplemental public health professionals to develop and implement emergency response plans and provide technical support to local health care efforts.
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References


