Full Coverage of COVID-19–related Care Was Necessary, but Do Other Pulmonary Patients Deserve Any Less?

Adam W. Gaffney

Cambridge Health Alliance, Cambridge, Massachusetts; and Harvard Medical School, Harvard University, Boston, Massachusetts

In March 2020, as coronavirus disease (COVID-19) began its first deadly surge in the United States, policy-makers grasped that the nation's wide gaps in health coverage would undercut our pandemic response.

Containment of outbreaks requires testing and isolation, efforts that will be derailed if those with symptoms avoid care because of costs. Hence, a provision of the March 2020 Families First Coronavirus Response Act eliminated out-of-pocket costs for much severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing.

However, the cost of treatment dwarfs that of testing. Hospitalization for COVID-19 pneumonia might impose costs of thousands or tens of thousands of dollars, or more, on the uninsured or underinsured. At the pandemic's outset, an estimated 18 million Americans at increased risk of severe COVID-19 due to advanced age or comorbidities were inadequately insured (1). In April 2020, about 1 in 10 Americans said they would avoid seeking care because of costs if they believed they had COVID-19 (2). To address such concerns, the Coronavirus Aid, Relief, and Economic Security Act, passed that month, provided funds to cover COVID-19 treatment for the uninsured. Meanwhile, some private insurers waived copays and deductibles for such care.

Finally, the federal government fully subsidized the cost of COVID-19 vaccination for all. It has even warned providers not to charge out-of-pocket fees for any services related to vaccine administration.

Such measures fell short of full protection. For instance, the complexity of our billing and coding system left some patients with inappropriate bills for coronavirus testing (3). Some uninsured patients hospitalized with COVID-19 fell through the regulatory cracks and were sent large bills (4). A portion of those avoiding vaccination cited fear of costs as the reason, which was likely due to previous adverse experiences (5). Private insurers, meanwhile, have ended the copay/deductible waivers.

With more than 600,000 dead from COVID-19, the United States' overall response to the outbreak must be judged a failure. Still, it is probable that these COVID-19–specific coverage expansion measures made an important difference, even if they were insufficient. Although we lack data on their effects on outcomes, many previous studies have found that cost barriers deter all types of care, even for emergencies (6). Without an expansion of coverage for COVID-19–related care, it is probable that many more may have avoided testing and potentially infected others, faced ruinous hospital bills during a period of widespread job loss, or even succumbed to COVID-19 because of delays in seeking medical attention or vaccination.

Yet that raises an important, if uncomfortable, question. If such cost-related adverse outcomes seem unacceptable, indeed abhorrent, for patients with COVID-19, why are they considered acceptable for our patients with other lung diseases?

A growing body of evidence has shed light on the inadequacy of coverage for patients with respiratory illness. In 2018, 24.2% of those with asthma and 28.2% of those with chronic obstructive pulmonary disease (COPD) were inadequately insured (i.e., uninsured, or insured but unable to afford the costs of medical care or prescription drugs) (7). Stark racial and economic disparities in access to care magnify the greater burden of chronic respiratory disease experienced by disadvantaged populations (8), a pattern also seen with COVID-19 (1, 9).

Inadequate access to care can lead to worse outcomes for such patients. Higher medication cost-sharing is associated with a greater likelihood of hospitalizations among older children with asthma (10). A province-wide increase in prescription drug cost-sharing in British Columbia led to more COPD and asthma admissions (11). A cross-sectional analysis of national survey data by my colleagues and I found greater foregone care and cost-related nonadherence to prescription drugs—and more hospitalizations—among individuals with COPD and high deductibles relative to those with no or low deductibles (12).

And for the critically ill, intensive care unit (ICU) treatment can translate into critically high medical bills. Estimated out-of-pocket costs over the last year of life for patients who use the ICU shortly before death amount to $26,993 for the uninsured and $10,022 for the privately insured (13).

Some may argue that enhanced coverage specifically for COVID-19-related care—but not other conditions—is justified given the contagious nature of the illness. When a

(Received in original form June 8, 2021; accepted in final form August 11, 2021.

Correspondence and requests for reprints should be addressed to Adam W. Gaffney, M.D., Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02138. E-mail: agaffney@challiance.org.

Ann Am Thorac Soc Vol 19, No 1, pp 1–2, Jan 2022

DOI: 10.1513/AnnalsATS.202106-683VP
Internet address: www.atsjournals.org

patient avoids COVID-19 testing or vaccination, in other words, it is not just that individual, but also their communities, that are endangered.

Yet the same could be said of other respiratory infections, including common seasonal viral infections like influenza that are typically associated with tens of thousands of deaths a year. The consequences of noninfectious lung diseases also extend beyond patients themselves. When one member of a family accrues unpayable medical debt because of an ICU stay for acute respiratory distress syndrome, the family goes bankrupt together. Deaths of any cause can leave children without parents and parents without children or can traumatize whole communities.

Of course, the delivery of high-quality care to each patient is a worthy goal in its own right. Yet a lack of coverage, and inadequate coverage, make that nigh impossible. The implicit idea underlying the expansion of coverage for COVID-19–related care was that first-dollar universal coverage would help us fight this disease. Yet this principle is valid not just for COVID-19 but also for all of the illnesses that cause substantial morbidity, financial ruin, and death.

We cannot undo the destruction wrought by this pandemic, but we can learn from it. Among other things, it has made the case for national health insurance—for transforming our healthcare system to ensure full health coverage for every patient—all the stronger. ■

Author disclosures are available with the text of this article at www.atsjournals.org.

References

1 Gaffney AW, Hawks L, Bor DH, Woolhandler S, Himmelstein DU, McCormick D. 18.2 Million individuals at increased risk of severe COVID-19 illness are un- or underinsured. *J Gen Intern Med* 2020;35:2487–2489.

2 Witters D. In U.S., 14% with likely COVID-19 to avoid care due to cost. Washington, DC: Gallup; 2020 [created 2020 Apr 28; accessed 2020 Apr 28]. Available from: https://news.gallup.com/poll/309224/avoid-care-likely-covid-due-cost.aspx.

3 Kliff S. Coronavirus tests are supposed to be free: the surprise bills come anyway. New York, NY: New York Times: 2020 [created 2020 Sep 9; accessed 2021 Jun 7]. Available from: https://www.nytimes.com/2020/09/09/upshot/coronavirus-surprise-test-fees.html.

4 Goodnough A. Trump program to cover uninsured COVID-19 patients falls short of promise. New York, NY: New York Times: 2020 [created 2020 Aug 29; accessed 2021 Jun 7]. Available from: https://www.nytimes.com/2020/08/29/health/Covid-obamacare-uninsured.html.

5 Kliff S. The COVID vaccine is free, but not everyone believes that. New York, NY: New York Times: 2021 [created 2021 Jun 1; accessed 2021 Jun 7]. Available from: https://www.nytimes.com/2021/06/01/upshot/covid-vaccine-hesitancy-cost.html.

6 Chou S-C, Hong AS, Weiner SG, Wharam JF. Impact of high-deductible health plans on emergency department patients with nonspecific chest pain and their subsequent care. *Circulation* 2021;144:336–349.

7 Gaffney AW, Hawks L, Bor D, White AC, Woolhandler S, McCormick D, *et al.* National trends and disparities in health care access and coverage among adults with asthma and COPD: 1997–2018. *Chest* 2021;159:2173–2182.

8 Gaffney AW, Himmelstein DU, Christiani DC, Woolhandler S. Socioeconomic inequality in respiratory health in the US from 1959 to 2018. *JAMA Intern Med* 2021;181:968–976.

9 Wadhera RK, Wadhera P, Gaba P, Figueroa JF, Joynt Maddox KE, Yeh RW, *et al.* Variation in COVID-19 hospitalizations and deaths across New York City boroughs. *JAMA* 2020;323:2192–2195.

10 Karaca-Mandic P, Jena AB, Joyce GF, Goldman DP. Out-of-pocket medication costs and use of medications and health care services among children with asthma. *JAMA* 2012;307:1284–1291.

11 Dormuth CR, Maclure M, Glynn RJ, Neumann P, Brookhart AM, Schneeweiss S. Emergency hospital admissions after income-based deductibles and prescription copayments in older users of inhaled medications. *Clin Ther* 2008;30:1038–1050.

12 Gaffney A, White A, Hawks L, Himmelstein D, Woolhandler S, Christiani DC, *et al.* High-deductible health plans and healthcare access, use, and financial strain in those with COPD. *Ann Am Thorac Soc* 2020;17:49–56.

13 Khandelwal N, White L, Curtis JR, Coe NB. Health insurance and out-of-pocket costs in the last year of life among decedents utilizing the ICU. *Crit Care Med* 2019;47:749–756.