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COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability

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The COVID-19 pandemic and economic downturn prompted widespread expectations of severe declines in health insurance coverage, as people lost their jobs and saw their incomes plunge. But the federal government swiftly enacted relief legislation and took other policy actions that stabilized health insurance coverage, increased affordability, and mitigated adverse impacts on health care access and equity during the public health emergency. These actions point the way to additional policy changes that would build upon the help provided in this crisis by expanding access to stable, affordable coverage.

The wave of expected health coverage losses would have hit at the worst possible time. The health impacts of the pandemic have been devastating: over 950,000 lives lost and approximately 80 million documented illnesses as of March 2022, disproportionately borne by people with low incomes and people of color. Coverage losses would have exacerbated declines in health care access directly caused by the pandemic, hindered people's ability to seek testing and treatment for COVID-19, and raised economic burdens for people who were already struggling.

But the federal government implemented policies that proved highly successful in preventing coverage loss, improving access to critical services, increasing continuity of coverage, and making coverage more affordable when people needed it most. The policies include a temporary requirement to keep people enrolled in Medicaid; greater financial assistance to help people afford coverage in the Affordable Care Act (ACA) marketplaces; expanded coverage of COVID-19 testing, treatment, and vaccines; and funding to allow people to receive health care safely at home.

Relief provisions also helped mitigate the pandemic's outsized impacts on people of color. For example, due in large part to structural inequities resulting in their overrepresentation in low-wage jobs lacking employer coverage, Black and Latino people are disproportionately likely to be enrolled in Medicaid. The Medicaid continuous coverage provision is especially likely to have benefited groups with high Medicaid enrollment rates and who would have otherwise experienced coverage gaps when access to care was especially crucial. Significant shares of Black and of Latino adults were also eligible for zero-premium marketplace plans due to the American Rescue Plan's marketplace affordability provisions. President Biden and Congress should take steps to build on these policies that promote equitable access to care beyond the public health emergency.

Relief Measures Stabilized Coverage, Increased Affordability

In the initial months of the pandemic, analysts projected that roughly 10 to 30 million workers and their dependents would lose their employer-based coverage and 2.9 to 8.5 million people would become uninsured.[1] Rising unemployment is linked to increases in the number of people without health coverage, as only some of those who lose their employer-based coverage along with their jobs enroll in other coverage.[2]

Avoiding widespread coverage loss was especially important during the pandemic, when incomes plummeted beginning in March 2020. Access declined during the pandemic due to factors such as strains on health care capacity and avoidance of care due to risk of COVID-19 exposure.

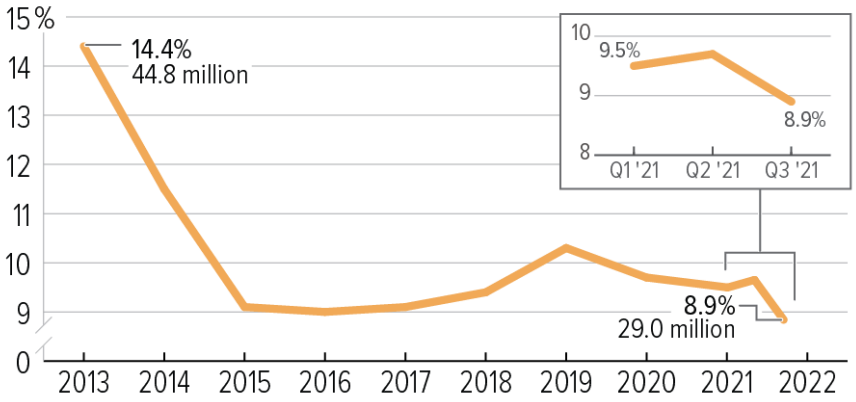
And people without health coverage are much more likely to delay or forgo medical care due to cost, to have difficulty paying medical bills, and to lack a usual source of care.[3] The link between lack of affordable health care and lower access is especially strong for low-income groups: in the year prior to April 2021, 53 percent of non-elderly parents with incomes below 138 percent of the poverty level who delayed or went without care cited cost concerns as a reason, more than twice the rate for non-elderly parents above 138 percent of the poverty level.[4]

The prospect of millions losing their jobs and income and facing severe health and financial risk due to lack of health coverage amid a deadly pandemic helped spur federal action. Multiple data sources indicate that the uninsured rate did not increase in 2020, and preliminary evidence suggests that it may now even be lower than before the pandemic.[5] (See Figure 1.)

FIGURE 1

Uninsured Rate Stabilized During Pandemic and Data Suggest Recent Declines in 2021

Uninsured rate by year, all ages



Note: Estimates of uninsured rates in 2021 reflect quarterly data through Quarter 3 of 2021. All other years are annual data.

Source: National Health Interview Survey's Health Insurance Coverage Reports, 2013-2020; Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021.

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Public Coverage Growth Offset Declines in Employer Coverage

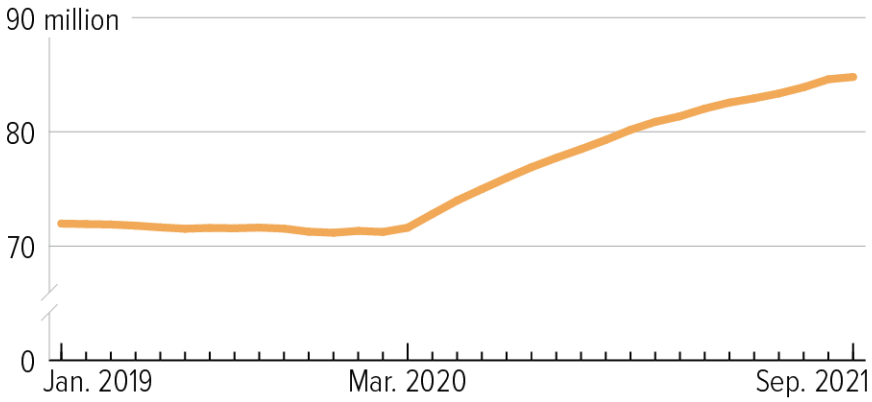
In large part, health coverage did not decline — and may even have risen — thanks to relief legislation and other policies enacted during the pandemic. Under the Families First Coronavirus Response Act — and effective March 2020 through whenever the public health emergency (PHE) ends — states have been required to maintain continuous coverage for Medicaid enrollees in order to receive a 6.2 percentage point increase in the share of Medicaid costs the federal government covers (known as the Federal Medical Assistance Percentage or FMAP).[6] That is, enrollees aren't subject to coverage redeterminations, which often result in lost coverage due to income fluctuations or to administrative "churn" (losses of coverage that are often due to difficulties navigating the administrative requirements or glitches in state processes).

As a result of this FMAP incentive, Medicaid and Children's Health Insurance Program (CHIP) enrollment grew by 13.6 million, from 71.2 million in February 2020 to a historic high of 84.8 million in September 2021.[7] (See Figure 2.) Analysis of data from state websites, which are more timely than federal administrative data, suggests continuing gains in Medicaid and CHIP enrollment through at least December 2021.[8] Moreover, although declines in employer coverage were concentrated among adults with low and moderate incomes, these declines were more than offset by increases in public coverage among this population.[9]

FIGURE 2

Medicaid Enrollment Has Risen Rapidly Due to Relief Legislation

Total monthly Medicaid/CHIP enrollment



Note: CHIP = Children's Health Insurance Program

Source: CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports: January 2014 - July 2021 (preliminary), as of January 20, 2021

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While it is typical for some workers who lose employer-based coverage to enroll in Medicaid, the increase in Medicaid enrollment is mostly not driven by a large influx of new enrollees, but rather by Medicaid enrollees remaining in coverage for longer because of the continuous coverage provision (combined with some number enrolling each month, which always occurs). After a steep decline in March and April 2020, employment increased nearly every month, by 20 million workers from April 2020 through February 2022.[10] Yet while employment recovered, Medicaid enrollment continued to

increase every month, by 12 million workers from April 2020 through September 2021 (the latest month for which national-level data are available).[11]

Further, administrative data show that after a spike in new Medicaid applications in April 2020, new applications fell below 2019 levels every month, yet Medicaid enrollment continued to rise rapidly. This indicates that the continued growth in Medicaid enrollment was not characterized by more people than usual newly entering the program each month, but instead by many fewer people than usual exiting the program.[12] That pattern is consistent with people maintaining continuous coverage due to the continuous coverage provision.

The Medicaid continuous coverage provision is especially likely to benefit groups with high Medicaid enrollment rates and who would otherwise experience gaps in coverage. Both Black and Latino people are disproportionately likely to be enrolled in Medicaid, due in large part to structural inequities resulting in their overrepresentation in low-wage jobs lacking employer coverage. Prior to the pandemic, 33 percent of Black and 30 percent of Latino non-elderly people were enrolled in Medicaid or CHIP compared to 16 percent for people who are not Black or Latino.[13] Latino people enrolled in Medicaid are more likely to experience coverage gaps: in 2018, 26 percent of low-income, non-elderly Latino people who were enrolled in Medicaid lost coverage and became uninsured, relative to 14 percent among people who are not Latino.[14] The limited data available from states suggest that Medicaid enrollment gains during the pandemic occurred at higher rates among Black and Latino people than among all races and ethnicities, relative to their shares of the population.[15]

ACA Marketplace and Other Policies Increased Coverage and Affordability

Under the Biden Administration, relief legislation and administrative actions also boosted ACA marketplace coverage and affordability, helping avoid a health coverage crisis. The American Rescue Plan increased the value of premium tax credits for 2021 and 2022 while making more people eligible for them. As a result, the share of uninsured people eligible for zero-premium plans increased from 43 to 62 percent, and the share eligible for plans with monthly premiums of $50 or less increased from 57 to 73 percent.[16]

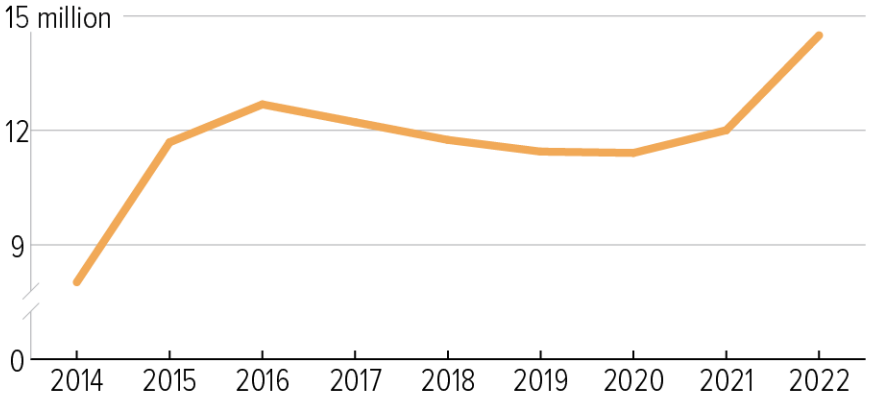
In addition to reducing premiums for marketplace enrollees, the premium tax credit improvements ensured that enrollees with moderate incomes pay no more than 8.5 percent of their incomes toward premiums, which is particularly helpful for those with high premium burdens such as older people and people who live in areas with high premiums.[17] The Rescue Plan also provided people who received unemployment benefits with access to zero- or low-cost health plans in the ACA marketplace in 2021.

As marketplace coverage became more affordable, the Administration opened a six-month pandemic-related special enrollment period in 2021 and substantially increased funding for outreach and consumer assistance, leading to record enrollment in marketplace plans by the end of the special enrollment period.[18] The continuation of Rescue Plan premium tax credit increases, combined with further enhanced outreach and consumer assistance, spurred even more enrollment gains during the 2022 open enrollment period, with 14.5 million people selecting marketplace plans, up from 11.4 million in 2020.[19] (See Figure 3.) Nearly one-third of enrollees who used HealthCare.gov selected a plan for $10 per month or less during 2022 open enrollment, and average monthly premiums fell by 23 percent compared to those signing up during 2021 open enrollment, prior to Rescue Plan premium tax credit enhancements.[20]

FIGURE 3

Record ACA Marketplace Enrollment in 2022, Spurred by Affordability and Outreach Efforts

Affordable Care Act (ACA) marketplace open enrollment plan selections



Source: Health Insurance Marketplace Open Enrollment Reports for 2014, 2015, and 2016, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services; Marketplace Open Enrollment Period Public Use Files for 2017, 2018, 2019, 2020, and 2021, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services; 2022 data from CMS Marketplace 2022 Open Enrollment Period Report: Final National Snapshot

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The Biden Administration's support for ACA marketplace outreach and enrollment assistance during the pandemic was particularly important for people of color. The Administration invested $100 million in advertising and marketing during the 2021 special enrollment period, in addition to $80 million in grant awards for navigators to help uninsured consumers find coverage for 2022, the largest-ever investment in the program.[21] Navigator awardees will focus on communities that have faced greater barriers to coverage, including people of color, people in rural communities, families with low incomes, communities with large numbers of immigrants, and people with transportation or language barriers.[22] Evidence suggests that outreach and enrollment assistance is particularly helpful for Latino adults, who are more likely to encounter application and language barriers to marketplace enrollment.[23] Studies have also found that mistrust in the health care system is a common obstacle to enrollment for Black and Latino adults, and that navigators increase enrollment by gaining the trust of patients.[24]

Black and Latino adults also likely benefited from the marketplace affordability provisions in relief legislation. Under the American Rescue Plan, an estimated 69 percent of uninsured Latino adults are eligible for zero-premium plans and 80 percent are eligible for plans with $50 or less in monthly premiums. For Black, non-Latino uninsured adults, 66 percent are eligible for zero-premium plans and 76 percent eligible for plans with $50 or less in monthly premiums.[25]

Another factor that helped avert a coverage crisis is that declines in employer-based coverage were smaller than anticipated. Some estimates indicate that employer-based coverage declined by about 2 to 3 million in 2020, while another survey reported a decline of 5.5 million among non-elderly adults between March 2019 and April 2021 — substantial but lower than projected.[26] The nature of the

COVID-19 recession played an important role: the spike in the unemployment rate began to subside relatively quickly, thanks in part to relief efforts; job losses were concentrated in industries whose workers are less likely to have employer-based coverage; and many employers maintained coverage for temporarily furloughed workers.[27] The Rescue Plan likely contributed to employers maintaining coverage for furloughed workers, as it included a provision that fully reimbursed employers for COBRA premiums for up to six months in 2021 for workers who lost employer-based coverage due to job loss or reduced work hours.[28]

Relief Legislation Increased Access to COVID-19 Testing, Vaccines, and Treatment

Federal relief legislation included critical funding and policies to help people access COVID-19 testing, vaccines, and treatment as these were developed and made available.

- Families First requires state Medicaid programs to cover COVID-19 testing, vaccination, and treatment without cost sharing as one condition of receiving the law's 6.2 percentage point increase in the federal matching rate during the PHE. The law also created an optional Medicaid eligibility group for states to provide access to tests and diagnostic services to people who are uninsured and not otherwise eligible for Medicaid. The federal government pays for the full cost of this eligibility group. Fifteen states have taken up this option.[29] Families First also requires private health insurance plans to cover COVID-19 testing without imposing cost sharing during the PHE.[30]
- The Coronavirus Aid, Relief, and Economic Security (CARES) Act created the Health Resources and Services Administration Uninsured Program to reimburse providers for COVID-19 tests and treatment delivered to people who are uninsured and ineligible for Medicaid. As of January 2022, the fund has reimbursed providers for $17.1 billion in testing, vaccination, and treatment delivered to uninsured people.[31] The CARES Act also requires private health insurance plans to cover COVID-19 vaccines without cost sharing and without regard to provider network during the PHE.
- The American Rescue Plan requires that Medicaid cover testing, vaccines, and treatment with no cost sharing for more than a year after the end of the PHE. The law also added treatment and vaccines to the services covered through the optional group previously limited to testing and filled treatment gaps for people in limited benefit categories.

Between March 2020 and August 2021, these protections coupled with the Medicaid continuous coverage requirement allowed more than 4.9 million Medicaid and CHIP enrollees to receive affordable treatment for COVID-19.[32] During the same period, Medicaid paid for nearly 400,000 COVID-19 hospitalizations and 43.3 million COVID-19 tests. Ensuring free access to vaccinations regardless of insurance status also contributed to the success of mass vaccination efforts as vaccines and boosters became widely available.

Relief Legislation Helped People Get Health Services Safely at Home

The American Rescue Plan provided states with a higher federal match for spending on home- and community-based services (HCBS) for 12 months. These funds were designed to help states address COVID-19-related HCBS needs like ensuring sufficient workforce to provide home care services, increasing access to telehealth services, and purchasing personal protective equipment.

The funds could also be used to make deeper systemic investments that promote the use of HCBS rather than institution-based, long-term services and supports. These include investments in cross-system partnerships, technology and telehealth infrastructure, and expansions of programs to help people transition from institutional settings to the community. States are prohibited from reducing HCBS services or cutting provider payment rates while receiving the additional funds.

More than a quarter of COVID-19 deaths in the United States have been among residents and staff at long-term care facilities.[33] The Rescue Plan funding for HCBS and the associated requirement that states temporarily refrain cutting HCBS has allowed more seniors and people with disabilities to receive services safely in the community rather than in nursing homes and other congregate care settings where the risk of exposure to the virus is higher. The funding has also helped states address increased demand for home care workers amid shortages caused by the pandemic.[34]

Additional Measures Needed to Build Upon Progress

While pandemic relief measures have been successful in helping people maintain coverage and in mitigating the impacts of the pandemic on access and affordability, they also highlight gaps that require further action. Most of the relief measures are temporary, and lack of any further policy action could result in coverage loss when those measures expire. In order to maintain and build on the progress that's been made, permanent policies are needed that move toward universal coverage, advance racial equity, and stabilize Medicaid financing to better address the nation's ongoing health challenges and prepare for the next crisis.

Close the Medicaid Coverage Gap

Congress must close the Medicaid coverage gap, providing a pathway to affordable coverage to an estimated 2.2 million uninsured adults — 60 percent of whom are people of color — who have incomes too low to qualify for marketplace assistance but are ineligible for Medicaid due to their states' refusal to enact the ACA's Medicaid expansion.[35] By definition, adults in the coverage gap are largely left out of existing federal assistance for health coverage. Yet their ineligibility for Medicaid and marketplace assistance also made them unable to benefit from the Medicaid continuous coverage provision and the American Rescue Plan premium improvements — the two relief measures with arguably the largest impacts on health coverage and affordability during the pandemic. Closing the coverage gap is one of the most important steps policymakers can take to improve racial equity in health coverage.[36]

Improve Continuity of Coverage and Reduce Enrollee Burden

The Medicaid continuous coverage provision let millions of children and adults keep their coverage throughout the pandemic who otherwise would have lost it, for example due to small income fluctuations or failure to provide paperwork on a tight timeframe. Access to Medicaid has been a critical lifeline for millions during this time of increased hardship.[37] But the continuous coverage requirement is temporary.

State Medicaid agencies should follow up on the success of the continuous coverage provision by requiring continuous eligibility for children and adults beyond the PHE.[38] Continuous eligibility allows people to maintain their Medicaid coverage for 12 months without interruption (a shorter period than the continuous coverage provision currently in effect, which lasts for the duration of the

PHE), regardless of fluctuations in their income throughout the year. Research shows that continuous eligibility reduces administrative costs and can lower health care expenses when enrollees receive regular care for chronic conditions and access preventative care.[39]

States should also maximize *ex parte* renewals, where an enrollee's coverage is automatically renewed using electronic or existing data sources, with no action required from the enrollee.[40] *Ex parte* renewals ensure that eligible individuals retain their coverage, minimizing gaps in coverage that can increase costs over time for states and enrollees alike and cause adverse health outcomes when enrollees forgo care due to being uninsured.

Improve Affordability and Access to Care for People With Private Coverage

Policymakers should permanently extend the Rescue Plan's increases in premium tax credits for ACA marketplace coverage, which are set to expire after 2022. Making these enhancements permanent would make health coverage more affordable for millions while building on the recent historic enrollment levels in the marketplaces. On the other hand, failing to extend these enhancements could lead to steep increases in out-of-pocket premiums for millions of marketplace enrollees and runs the risk of squandering recent advances in coverage.[41]

In addition, policymakers should enact other policies that build on the Rescue Plan's improvements in affordability. First, policymakers should fix the "family glitch" by determining the affordability of employer-based coverage using the family premium rather than the premium for employee-only coverage. This would allow an employee's family members to receive a premium tax credit when family coverage is unaffordable, even if the employee's self-only premium is affordable.[42]

Second, policymakers should enhance cost sharing subsidies in the ACA marketplace, which help pay for deductibles and out-of-pocket costs other than premiums. Currently, cost sharing subsidies phase down for those with incomes above 200 percent of the poverty level and are unavailable for those whose incomes exceed 250 percent of the poverty level. This leaves many with unaffordable deductibles and other out-of-pocket expenses even if their premiums are low. For example, a person whose annual income is roughly $26,000 to $32,000 (200 to 250 percent of the federal poverty level) faces an average deductible of about $3,400, equivalent to 11 to 13 percent of their income.[43] Furthermore, in recent years growth in average deductibles for marketplace enrollees without cost sharing subsidies has considerably outpaced growth in worker wages (as is the case for people with employer-based coverage).[44] Research shows that higher out-of-pocket costs reduce access to health care while increasing racial and ethnic disparities, and that reducing deductibles and other out-of-pocket costs could lead more people to buy coverage.[45]

Stabilize State Medicaid Financing

The COVID-19 recession highlighted the need for policies that automatically stabilize state budgets during recessions. While many provisions of the relief legislation enacted by policymakers proved effective, in general it is highly unpredictable how policymakers will respond to economic crises and whether those responses will be timely and adequate. Policymakers should institute a countercyclical approach to the FMAP that would provide automatic, predictable federal funding that protects coverage while stabilizing state Medicaid budgets during future downturns. Medicaid and CHIP often come under pressure for cuts during recessions as states struggle with budget shortfalls.[46]

A countercyclical FMAP would automatically increase the federal government's portion of Medicaid funding during an economic downturn according to a pre-specified formula; when a state returns to full employment, the FMAP would automatically phase back down again, without requiring any action from Congress. Such an approach would protect health coverage by averting state cuts to Medicaid benefits and coverage, while helping prevent ill-timed state tax increases that could hinder economic recovery.

Make Lasting Investments in Home- and Community-Based Services

Rescue Plan funding created an important foundation for improving and expanding access to HCBS; states are using it to invest in provider retention and capacity, IT infrastructure, cross-sector partnerships, and more.[47] But more than 665,000 people were on waiting lists for HCBS in 2020.[48] The Rescue Plan funding is temporary and insufficient to create or sustain the kind of transformative change necessary to ensure all Medicaid enrollees who can live in the community with the right services and supports are able to do so, or to provide long-term workforce stability. Lasting HCBS investments are crucial.

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[6] All states have implemented continuous coverage. States may still terminate coverage under limited circumstances, such as an enrollee moving out of state or requesting to terminate coverage.

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[13] CBPP analysis of 2019 American Community Survey. Black and Latino people are more likely to be enrolled in Medicaid largely because they are more likely to live in families with low incomes, a legacy rooted in unequal opportunities due to racism and discrimination.

[14] CBPP analysis of Medical Expenditure Panel Survey. It is uncertain why Latino people experience more frequent disruptions in Medicaid coverage, but reasons could include higher rates of income volatility or administrative obstacles to renewing coverage, such as language barriers.

[15] CBPP analysis of Medicaid enrollment data from the following states that present enrollment by race and ethnicity on their websites: Arizona, California, Connecticut, Maryland, Michigan, New York, Oklahoma, and Utah.

[16] Estimates are for uninsured non-elderly adults potentially eligible for marketplace coverage in HealthCare.gov states. D. Keith Branham *et al.*, "Access to Marketplace Plans with Low Premiums on the Federal Platform," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 31, 2021, https://aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-uninsured-american-rescue-plan.

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