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Changes in Health Care Cost Barriers with Medicaid Continuous Coverage and Enhanced Premium Tax Credits

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Congress enacted several policies to support health insurance coverage and access to affordable health care during the COVID-19 pandemic. In March 2020, Congress passed the Families First Coronavirus Response Act, providing states with a temporary increase in federal Medicaid funding in exchange for suspending disenrollments for most Medicaid beneficiaries during the public health emergency (PHE). The law enabled people to maintain Medicaid coverage without having to undergo redeterminations, even if they experienced a change in income or other circumstances that typically would make them ineligible. This policy helped drive a Medicaid enrollment increase of more than 22 million people, or 35 percent, between February 2020 and March 2023, the month before the continuous coverage requirement expired.[1] Seven states also adopted the Affordable Care Act (ACA) option to expand Medicaid between 2019 and 2022, further contributing to enrollment growth.

In addition, the American Rescue Plan Act (ARPA) of 2021 increased Marketplace premium tax credits for people with family incomes between 100–400 percent of the federal poverty level (FPL) and extended eligibility for subsidies to people with incomes over 400 percent FPL (herein referred to as enhanced Marketplace subsidies). These enhanced subsidies, accompanied by expanded consumer outreach and support (Levitis and Pandit 2021), were extended through 2025 under the Inflation Reduction Act. The subsidy enhancements were associated with increased Marketplace enrollment, from 12 million plan selections at the end of the 2021 open enrollment period (OEP) to 16.4 million in 2023 and 21.4 million in 2024 (CMS 2024). ARPA was one of several laws enacted during the PHE that

provided direct financial assistance in the form of economic impact payments, enhanced unemployment benefits, expanded child tax credits, and other safety net program expansions that may have helped families afford health care and other basic expenses (appendix table A.1).

Together, these federal and state policy changes were expected to reduce cost barriers to health care by helping people who would otherwise be uninsured to obtain or stay enrolled in coverage and providing income support. They were also expected to improve health care affordability by reducing premiums and increasing access to plans with lower cost-sharing requirements for many Marketplace consumers. Previous analysis of federal survey data finds declines in uninsurance between 2019 and 2022 and changes in reported public coverage that are smaller than those found in administrative sources (Cohen and Martinez 2023; Keisler-Starkey and Bunch 2020; Keisler-Starkey, Bunch, and Lindstrom 2023; McIntyre, Smith, and Sommers 2024). These discrepancies between surveys and administrative sources have exacerbated the long-standing Medicaid undercount in survey data (Hest, Lukanen, and Blewett 2022). Thus far, there has been less published analysis on changes in health care access and affordability (Karpman, Gonzalez, and Zuckerman 2023).

In this brief, we assess changes in health insurance coverage and cost-related barriers to care among adults ages 18 to 64 during the PHE using 2019–2022 data from the National Health Interview Survey (NHIS). We compare changes by state ACA Medicaid expansion status and family income. Our key findings include the following:

- Between 2019 and 2022, the share of adults who were uninsured at the time of the survey declined from 14.5 percent to 12.4 percent, and the share who had continuous coverage for all 12 months of the past year increased from 82.1 percent to 84.4 percent.
    - » Adults in states that expanded Medicaid between 2019 and 2022 experienced the largest decline in uninsurance (from 17.2 percent to 11.0 percent) and the largest increase in full-year coverage (from 80.0 percent to 85.8 percent).
    - » Significant reductions in uninsurance occurred for adults with family incomes below 138 percent FPL (from 27.9 percent to 23.7 percent) or between 138–249 percent of FPL (from 23.2 percent to 20.6 percent).
- The share of adults who reported delaying or forgoing needed medical care in the past year because of cost declined from 12.1 percent to 9.7 percent, representing 4.75 million fewer adults.
    - » As with uninsurance, the largest reductions in cost-related barriers to care occurred in states that expanded Medicaid between 2019 and 2022 (from 15.7 percent to 10.0 percent) and for adults with family incomes below 138 percent (from 20.3 percent to 14.9 percent) or between 138–249 percent of FPL (from 18.4 percent to 14.9 percent).
- We observed similar patterns in the share of adults who did not get needed prescription medications in the past year because of cost or did not take their medications as prescribed to save money, with the total share decreasing from 9.8 percent to 7.5 percent.

These findings highlight the significant improvements in coverage and reductions in cost-related barriers to health care during the COVID-19 PHE, which were most pronounced in states that recently expanded Medicaid and among adults with low incomes who stood to benefit most from the Medicaid continuous coverage requirement and enhanced Marketplace subsidies. Our findings underscore the challenge of sustaining progress in reducing cost barriers as states unwind the continuous coverage requirement and Congress considers extending Marketplace subsidy enhancements.

Results

Between 2019 and 2022, the share of adults who were uninsured at the time of the survey declined and the share who had continuous coverage for a full year increased.

The share of adults who reported they were uninsured at the time of the survey declined 2.1 percentage points (or 15 percent), from 14.5 percent in 2019 to 12.4 percent in 2022 (table 1), consistent with previously reported data (Cohen et al. 2021; Cohen and Terlizzi 2023). Uninsurance rates fell 1.8 percentage points (17 percent) in states expanding Medicaid before 2019, from 10.7 percent to 8.9 percent. The 1.6 percentage point decline in states not expanding Medicaid before 2023 was not statistically significant. The decline in uninsurance was largest in the seven states that expanded Medicaid between 2019 and 2022, dropping 6.2 percentage points (36 percent), from 17.2 percent to 11.0 percent.

TABLE 1

Health Insurance Coverage among Adults Ages 18 to 64, 2019 and 2022

	Share uninsured at the time of the survey			Share insured all 12 months in the past year		
	2019	2022		2019	2022	
All adults	14.5%	12.4%	**	82.1%	84.4%	**
By state Medicaid expansion status						
Adults in states expanding Medicaid before 2019	10.7%	8.9%	**	85.8%	88.1%	**
Adults in states expanding Medicaid between 2019–2022	17.2%	11.0%	**	80.0%	85.8%	**
Adults in states not expanding Medicaid before 2023	21.2%	19.6%		75.5%	76.8%	
By family income as a percent of FPL						
<138%	27.9%	23.7%	**	67.4%	72.7%	**
138-249%	23.2%	20.6%	*	72.1%	75.1%	*
250-399%	13.3%	12.8%		82.7%	83.3%	
>400%	4.6%	4.4%		93.6%	93.3%	

Source: Authors' analysis of National Health Interview Survey data, 2019–2022.

Notes: FPL = federal poverty level.

*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

The share of adults with continuous coverage for a full year increased 2.2 percentage points, from 82.1 percent in 2019 to 84.4 percent in 2022. Adults in states that expanded Medicaid during this period reported a significant increase from 80.0 percent to 85.8 percent. The increase was significant in

states that expanded Medicaid before 2019 but not in states that had not expanded Medicaid by January 2023. These differences are consistent with previous findings from another nationally representative survey (Karpman, Kenney, and Zuckerman 2022).

Reductions in uninsurance also varied by income. For adults with family incomes below 138 percent FPL, uninsurance declined from 27.9 percent to 23.7 percent, and for adults with family incomes between 138–249 percent of FPL, uninsurance declined from 23.2 percent to 20.6 percent. Adults in both income groups reported an increase in Medicaid/Children's Health Insurance Program (CHIP) coverage and a smaller decline in employer-based coverage (table 2). The increase in continuous coverage for low-income adults was statistically significant in states expanding Medicaid before 2019, indicating changes for this income group were not solely driven by recent state Medicaid expansions (appendix table A.2). Changes in uninsurance and full-year coverage were not statistically significant for adults with incomes between 250–399 percent of FPL or above 400 percent of FPL. Private nongroup coverage did not change significantly for any group, but these data do not fully capture Marketplace coverage trends during the PHE because of differences between the timing of data collection and the Marketplace OEP, as discussed in the Limitations section on page 11.

TABLE 2

Medicaid/CHIP, Employer-Based, and Private Nongroup Coverage at the Time of the Survey among Adults Ages 18 to 64, 2019 and 2022

	Medicaid/CHIP			Employer-based coverage			Private nongroup coverage	
	2019	2022		2019	2022		2019	2022
All adults	11.6%	13.5%	**	60.6%	60.6%		8.5%	8.7%
By state Medicaid expansion status								
Adults in states expanding Medicaid before 2019	15.0%	16.9%	**	61.5%	61.6%		7.8%	7.7%
Adults in states expanding Medicaid between 2019–2022	5.6%	10.5%	**	65.1%	66.6%		8.2%	8.1%
Adults in states not expanding Medicaid before 2023	6.4%	7.5%		57.7%	57.2%		10.1%	10.7%
By family income as a percent of FPL								
<138%	34.7%	40.4%	**	18.2%	15.9%	*	8.6%	8.9%
138–249%	16.0%	20.7%	**	42.9%	39.5%	**	10.5%	11.7%
250–399%	5.9%	8.8%	**	68.6%	66.0%		8.7%	9.2%
>400%	1.6%	2.1%		85.1%	84.5%		7.3%	7.1%

Source: Authors' analysis of National Health Interview Survey data, 2019–2022.

Notes: FPL = federal poverty level; CHIP = Children's Health Insurance Program. Employer-based coverage includes coverage through unions and the military. Private nongroup coverage includes insurance purchased directly or through the Marketplace. Estimates are not shown for the share of adults reporting Medicare and other public coverage.

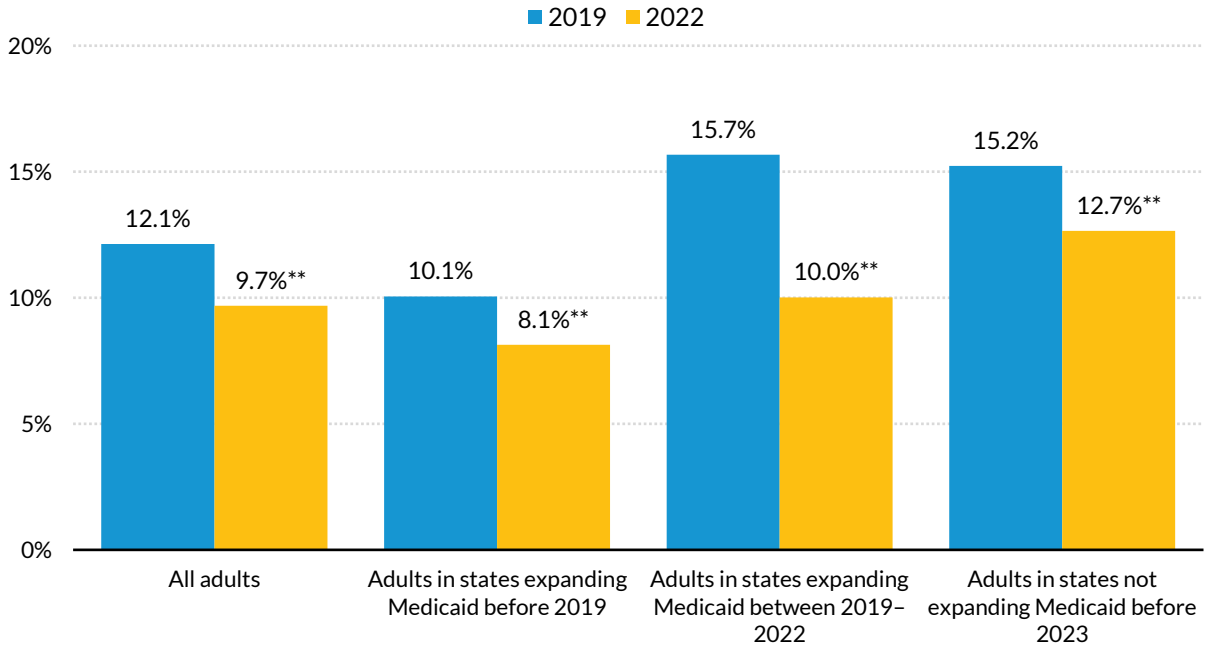
*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

Nearly 5 million fewer adults reported delaying or forgoing needed medical care in the past year because of cost, with the largest reductions in states with recent Medicaid expansions and among low-income adults.

As with uninsurance, cost-related barriers to care declined significantly between 2019 and 2022, with similar patterns by state group and family income. The share of adults who delayed or did not get the medical care they needed in the past year because of cost declined 2.4 percentage points (20 percent), from 12.1 percent in 2019 to 9.7 percent in 2022 (figure 1). This change represents 4.75 million fewer adults experiencing cost barriers to medical care (23.83 million in 2019 versus 19.08 million in 2022). In states that expanded Medicaid between 2019 and 2022, the share of adults reporting delayed or forgone care declined 5.7 percentage points (36 percent), from 15.7 percent to 10.0 percent. Smaller declines occurred in states that expanded Medicaid before 2019 (from 10.1 to 8.1 percent) and states that did not expand Medicaid before 2023 (from 15.2 to 12.7 percent).

FIGURE 1

Share of Adults Ages 18 to 64 Reporting They Delayed or Did Not Get Needed Medical Care in the Past Year Because of Cost, Overall and by State Medicaid Expansion Status, 2019 and 2022



URBAN INSTITUTE

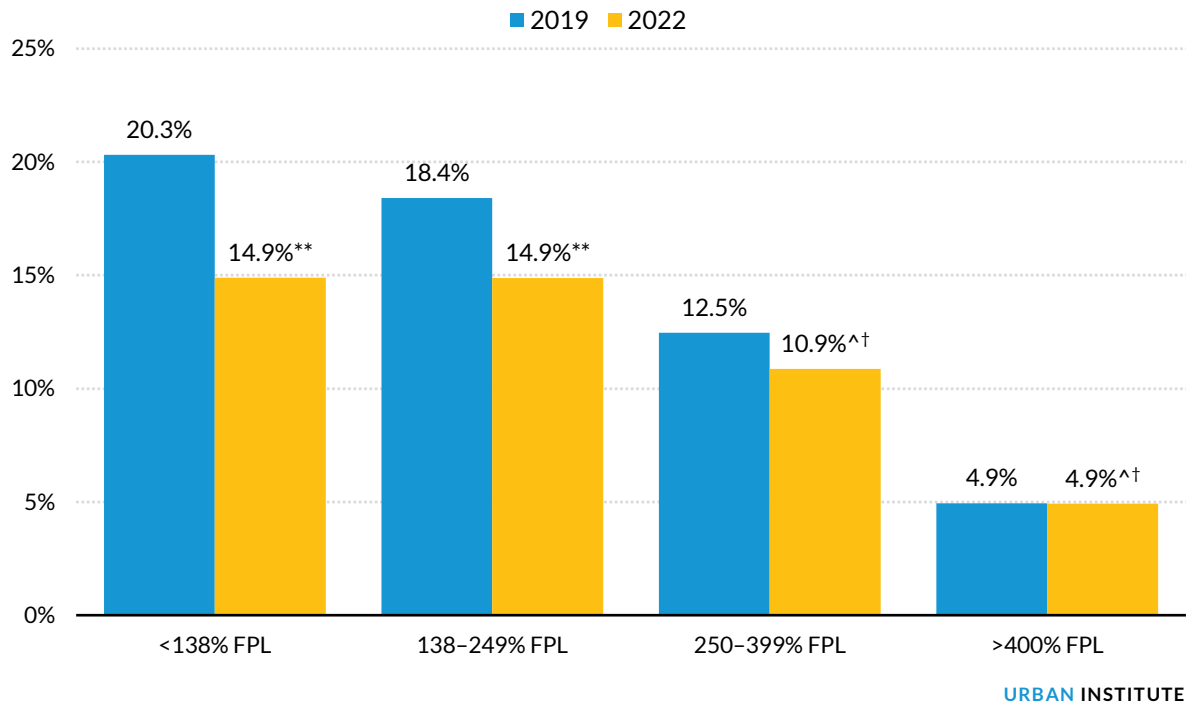
Source: Authors' analysis of National Health Interview Survey data, 2019–2022.
Notes: */** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

The reductions in cost-related barriers to care were concentrated among the two lowest-income groups (figure 2). The rate of delayed and forgone medical care because of cost declined significantly, from 20.3 percent to 14.9 percent, among adults with incomes below 138 percent of FPL and from 18.4 percent to 14.9 percent among the 138–249 percent of FPL group. Changes for these income groups

were significant even after excluding states with recent Medicaid expansions (appendix table A.3). However, both lower income groups remained more likely to report delayed or forgone medical care in 2022 relative to adults with incomes between 250–399 percent of FPL (10.9 percent) or above 400 percent of FPL (4.9 percent).

FIGURE 2

Share of Adults Ages 18 to 64 Reporting They Delayed or Did Not Get Needed Medical Care in the Past Year Because of Cost, by Family Income, 2019 and 2022



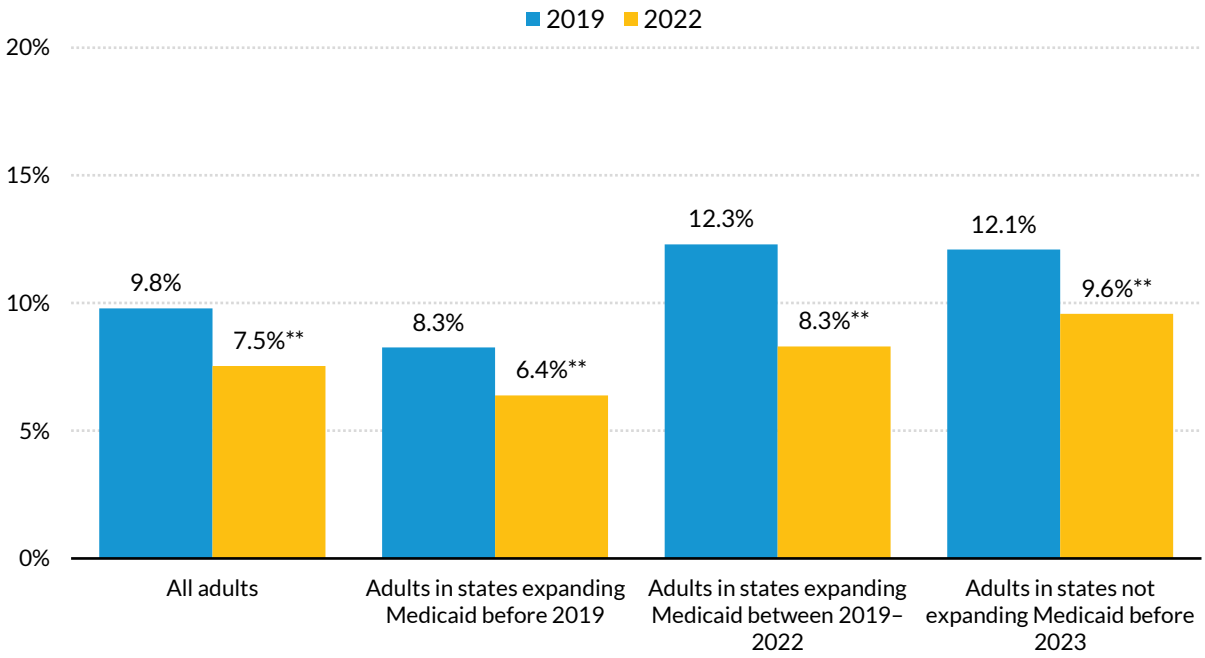
Source: Authors' analysis of National Health Interview Survey data, 2019–2022.
Notes: FPL = federal poverty level.
*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.
^ 2022 estimate differs significantly from 2022 estimate for adults with income below 138% of FPL at the 0.05 level.
† 2022 estimate differs significantly from 2022 estimate for adults with income between 138–249% of FPL at the 0.05 level.

Adults became less likely to report forgoing needed prescription medications or not taking their medications as prescribed to save money.

The share of adults who did not get needed prescription medications in the past year because of cost or did not take their medications as prescribed to save money decreased by 2.3 percentage points (23 percent), from 9.8 percent to 7.5 percent. Figures 3 and 4 show the subgroups with the largest reductions include adults in states expanding Medicaid between 2019 and 2022 (4.0 percentage points [33 percent]), with incomes below 138 percent of FPL (3.5 percentage points [21 percent]), and with incomes between 138–249 percent of FPL (3.1 percentage points [23 percent]).

FIGURE 3

Share of Adults Ages 18 to 64 Reporting They Did Not Get Needed Medications or Did Not Take Medications as Prescribed to Save Money, Overall and by State Medicaid Expansion Status, 2019 and 2022



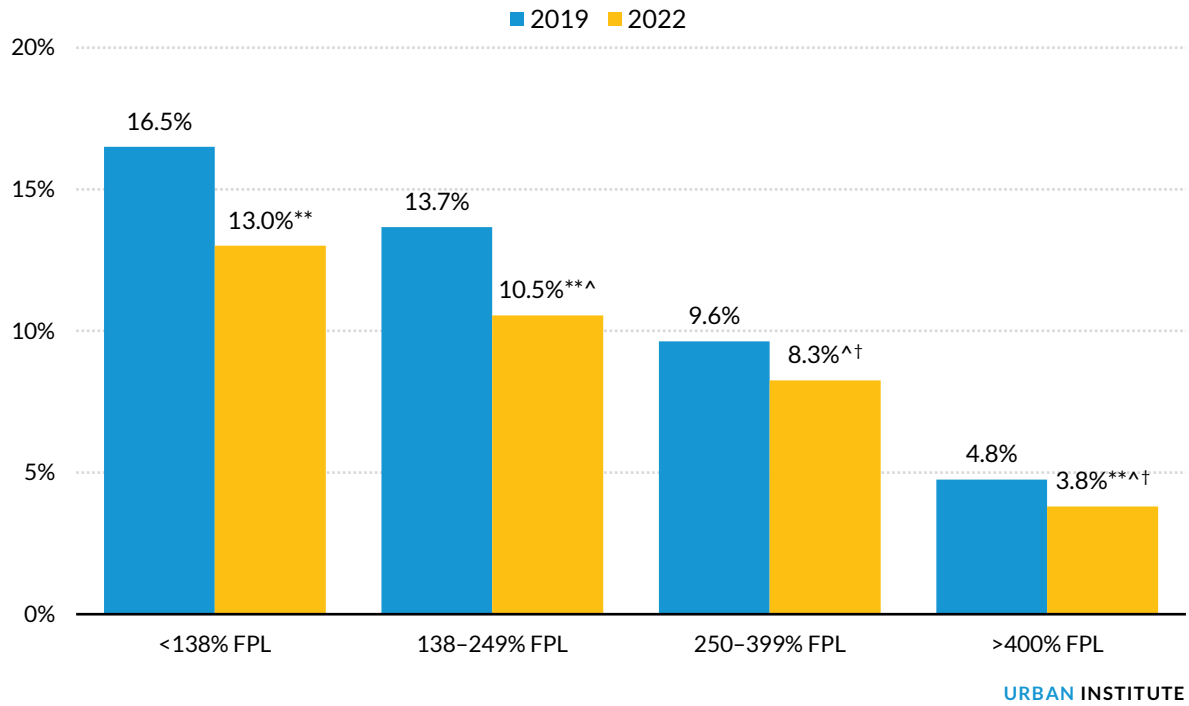
URBAN INSTITUTE

Source: Authors' analysis of National Health Interview Survey data, 2019–2022.

Notes: */** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

FIGURE 4

Share of Adults Ages 18 to 64 Reporting They Did Not Get Needed Medications or Did Not Take Medications as Prescribed to Save Money, by Family Income, 2019 and 2022



Source: Authors' analysis of National Health Interview Survey data, 2019–2022.
Notes: FPL = federal poverty level.
*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.
^ 2022 estimate differs significantly from 2022 estimate for adults with income below 138% FPL at the 0.05 level.
† 2022 estimate differs significantly from 2022 estimate for adults with income between 138–249% FPL at the 0.05 level.

Discussion

Between 2019 and 2022, the prevalence of uninsurance and cost-related barriers to care fell among nonelderly adults while the share with continuous health insurance coverage for a full year increased. Coverage gains and reductions in cost barriers were more pronounced among adults with incomes below 138 percent FPL and between 138–249 percent of FPL, the income groups that would have been most affected by the Medicaid continuous coverage requirement and the availability of the enhanced Marketplace subsidies. Our estimates imply that nearly 5 million fewer adults experienced cost-related barriers to accessing medical care in 2022 relative to 2019.

These coverage and access improvements followed the introduction of the Medicaid continuous coverage requirement, increased premium tax credits and enrollment in Marketplace plans, ACA Medicaid expansions in several states, and federal pandemic relief and stimulus spending. Though this analysis cannot disaggregate the effects of each of these policies, the growth in reported Medicaid coverage and duration suggests a key factor was the continuous coverage requirement, which

suspended periodic redetermination processes that have historically contributed to "churning" on and off Medicaid (MACPAC 2021). These results are consistent with a recent finding that the continuous coverage requirement was associated with fewer transitions from Medicaid to uninsurance and with studies before the pandemic finding that churning was associated with a greater likelihood of delaying care and lower use of medications (Nelson et al. 2023; Sugar et al. 2021). Additionally, if the continuous coverage requirement reduced transitions from Medicaid to private insurance, it may have mitigated exposure to high deductibles and cost-sharing requirements (Johnston et al. 2020).

The extent to which the Medicaid continuous coverage requirement protected people from disruptions in coverage and care has important implications as states have resumed processing Medicaid redeterminations following the policy's expiration in April 2023. Data through April 2024 show over 20 million adults and children have been disenrolled from Medicaid during the first year of the continuous coverage requirement's unwinding, with net enrollment falling by nearly 12 million.[2] Though data from major federal surveys on coverage and access during unwinding are not yet available, analysis of experimental survey data finds rising uninsurance for nonelderly adults.[3] Coverage losses are expected to increase avoidance of needed health care because of costs (DeLeire 2019; Tarazi, Green, and Sabik 2017). As states continue the unwinding, they have a variety of tools and strategies available through 1902(e)(14)(A) waivers and other mechanisms to support enrollees, such as to improve rates of ex parte, or automatic, renewals and connect ineligible people to other coverage (MACPAC 2023).[4] Greater use of these flexibilities and extensions of flexibilities beyond the unwinding are likely needed to sustain the coverage and access gains found here.

The ARPA and Inflation Reduction Act enhanced Marketplace subsidies, accompanied by additional funding for outreach and enrollment support, also led to growth in Marketplace enrollment. Marketplace enrollment has increased dramatically since 2021 and will likely continue to grow as many people losing Medicaid during unwinding are projected to qualify for subsidized Marketplace plans (ASPE 2022; Buettgens and Green 2022; CMS 2024). However, the increased premium subsidies are set to expire after 2025, which could result in declining enrollment, reduced cost protections, and greater risk of cost-related access barriers (Buettgens, Banthin, and Green 2022). Moreover, with the largest Marketplace enrollment gains in nonexpansion states, expiration of the enhanced subsidies could further exacerbate differences in coverage and affordability by state Medicaid expansion status (Ortaliza, Cox, and Amin 2024).

The largest decrease in uninsurance, increase in continuous coverage, and reduction in cost-related barriers to care we observed between 2019 and 2022 occurred for adults living in states that recently implemented ACA Medicaid expansion. These patterns are consistent with previous evidence of impacts of Medicaid expansions on coverage and access (Guth and Ammula 2021; Guth, Garfield, and Rudowitz 2020; Mazurenko et al. 2018; White House 2021). Adoption of expansion in the remaining 10 nonexpansion states, as well as other options such as extension of pregnancy-related coverage for 12 months postpartum, could reduce uninsurance further and improve access in those states (Buettgens and Ramchandani 2023).[5]

Finally, while reported cost barriers fell between 2019 and 2022, many adults continued to forgo needed care because they could not afford it, including in Medicaid expansion states (McGough, Amin, and Cox 2023). Access challenges remain most common among low-income adults, who stand to lose the most from unwinding of the Medicaid continuous coverage requirement and potential expiration of enhanced Marketplace subsidies. Thus, additional efforts would be needed to reduce cost barriers, such as state-funded Marketplace premium and cost-sharing subsidies (Buddenbaum 2023; Heyison, Lueck, and Sullivan 2024; Holahan and Simpson 2022).[6] These findings suggest policies promoting coverage continuity, such as 12-month continuous eligibility in Medicaid for adults, may be another potential avenue for reducing uninsurance and barriers to care.

Appendix: Data and Methods

Data

Our analysis draws on public and restricted-use 2019–2022 data from the NHIS, a nationally representative survey conducted by the National Center for Health Statistics (NCHS). The NHIS is a principal source of health information for the US civilian noninstitutionalized population. It is fielded continuously throughout the year and had a sample of 33,138 households in 2019 and 28,854 households in 2022, with household response rates of 61.1 percent and 49.6 percent, respectively (NCHS 2020, 2023). We report on changes in key outcomes for sample adults (a randomly selected adult in each household) since 2019, the first year of data collection following a significant redesign of the NHIS structure and content. Our analysis focused on adults ages 18 to 64, the age group most directly affected by Medicaid expansion and Marketplace policy changes. There were 41,437 respondents ages 18 to 64 in our analysis sample, including 22,621 in 2019 and 18,816 in 2022. To produce estimates for groups of states based on Medicaid expansion decisions, we obtained access to restricted-use state identifiers through the NCHS Research Data Center.

Measures

Health insurance coverage outcomes of interest include coverage status at the time of the survey and continuous coverage in the past 12 months. Respondents who reported more than one coverage type at the time of the survey were assigned to mutually exclusive categories based on the following hierarchy of responses: Medicare; private nongroup coverage (purchased directly from an insurance company or through the ACA Marketplaces); employer-based coverage (including through unions or the military); Medicaid or CHIP; or another government or state program. Respondents who did not report one of these types of comprehensive health insurance coverage were categorized as uninsured. The measure of continuous coverage is based on whether respondents reported having insurance at the time of the survey and for all 12 months of the past year.

The two measures of cost barriers to health care are whether respondents (a) reported delaying or forgoing needed medical care because of the cost in the past 12 months and (b) reported needing a

prescription medication in the past 12 months but not getting it because of the cost or not taking a medication as prescribed to save money by skipping medication doses, taking less medication, or delaying filling a prescription.

Analysis

We assessed changes in coverage and cost barriers between 2019, the year before the PHE, and 2022, the most recent year with available annual NHIS data. The Medicaid continuous coverage requirement and enhanced Marketplace subsidies may have affected adults differently based on states' Medicaid expansion decisions. For instance, all else equal, states that expanded Medicaid before the PHE had a larger baseline population of adults who would have maintained Medicaid benefits under the continuous coverage requirement. The requirement also offered protection to Medicaid enrollees in nonexpansion states, such as new mothers who would have been able to stay enrolled throughout the PHE. We estimated changes for three groups of states: 32 states (including the District of Columbia) that expanded Medicaid before 2019, seven states that expanded Medicaid between 2019 and 2022, and 12 states that did not expand Medicaid before 2023.[7]

Because the effects of the Medicaid continuous coverage requirement and enhanced Marketplace subsidies were expected to vary by income, we estimated changes for adults in four groups of family income as a percentage of FPL based on the following cutpoints:

- 138 percent of FPL, the ACA Medicaid expansion income eligibility limit for adults;
- 250 percent of FPL, the threshold below which adults qualify for the most generous Marketplace subsidies (i.e., with benchmark plan premiums capped at no more than 4 percent of income under ARPA) as well as cost-sharing reductions;
- and 400 percent of FPL, the pre-ARPA income eligibility limit for Marketplace premium subsidies.

The Medicaid continuous coverage requirement was expected to have the greatest effect on coverage of adults with incomes below 138 percent of FPL and between 138–249 percent of FPL by preventing disenrollment even if income changes exceeded states' Medicaid eligibility thresholds. NCHS uses multiple imputation procedures to impute missing data on family income and then calculates the ratio of income to the FPL based on each respondent's family size.

We report differences between 2019 and 2022 that are statistically significant at the 0.05 level using two-tailed independent samples t-tests. All percentage and population estimates are weighted to be nationally representative of the civilian noninstitutionalized population, and standard errors account for the complex design of the NHIS and multiple imputation of family income.

Limitations

This analysis has several limitations. We cannot be certain that estimated changes in coverage and access were caused by the Medicaid continuous coverage requirement, enhanced Marketplace

subsidies, or state Medicaid expansions since we lack a comparison group to serve as a counterfactual and cannot disentangle the effects of these policies from other factors. We are also unable to determine how these policy changes interact. For instance, changes in nongroup coverage under enhanced subsidies may have been larger in the absence of the Medicaid continuous coverage requirement.

Because the NHIS is continuously fielded throughout the year, the 2019–2022 data do not reflect the full impact of policy changes implemented during this period. Most of the 2019 data in Maine and Virginia were collected after these states expanded Medicaid in January 2019 and, therefore, do not fully capture coverage and access changes in these states following expansion. Although these NHIS data account for increased Marketplace enrollment during the 2022 OEP, they do not account for most of the increased enrollment during the 2023 OEP (November 2022 to January 2023) or for the Marketplace enrollment increases during the 2024 OEP, understating coverage and access changes under enhanced Marketplace subsidies.

Health insurance coverage and experiences of delayed and forgone care because of the costs are self-reported and subject to measurement error (Pascale 2008). Sample size limitations hinder our ability to detect significant changes in outcomes by state Medicaid expansion status within income groups.

TABLE A.1

Selected Federal Relief Programs and Safety Net Expansions During the COVID-19 Public Health Emergency

	Month started	Month ended	Initial authorizing legislation[a]
Health insurance coverage			
Medicaid continuous coverage requirement	March 2020	March 2023	FFCRA
Enhanced Marketplace premium tax credits[b]	January 2021	December 2025	ARPA
COBRA premium subsidies[c]	April 2021	September 2021	ARPA
Unemployment insurance			
Pandemic unemployment assistance (PUA)[d]	February 2020	September 2021	CARES Act
Federal pandemic unemployment compensation (FPUC)[e]	April 2020	September 2021	CARES Act
Pandemic emergency unemployment compensation (PEUC)[f]	April 2020	September 2021	CARES Act
Nutrition and housing assistance			
SNAP emergency allotments[g]	March 2020	February 2023	FFCRA
Emergency rental assistance[h]	January 2021	September 2025	CAA
Tax credits and direct cash assistance			
Economic impact payments[i]	March 2020	n/a	CARES Act
Economic impact payments	December 2020	n/a	CAA
Economic impact payments	March 2021	n/a	ARPA
Expanded child tax credit[j]	January 2021	December 2021	ARPA

Notes: [a] FFCRA refers to the Families First Coronavirus Response Act of March 2020. ARPA refers to the American Rescue Plan Act of March 2021. CARES refers to the Coronavirus Aid, Relief, and Economic Security Act of March 2020. CAA refers to the Consolidated Appropriations Act of December 2020.

[b] Enhanced Marketplace premium tax credits were extended through the end of 2025 by the Inflation Reduction Act of August 2022. Changes were retroactive to January 2021 (Pollitz 2021).

[c] COBRA refers to Consolidated Omnibus Budget Reconciliation Act coverage. COBRA premium subsidies covered the full cost of COBRA insurance premiums for employers and employees.
[d] PUA extended eligibility for unemployment insurance to self-employed workers, independent contractors, and other workers ineligible for regular state unemployment benefits. Claims could be retroactive to February 2020. CAA and ARPA extended the PUA through September 2021. Twenty-two states ended PUA early in June–July 2021 (National Employment Law Project 2021; Whittaker and Isaacs 2021).
[e] FPUC provided a $600 weekly supplemental increase in unemployment benefits through July 2020. A Lost Wages Assistance Program provided a $300–$400 supplement to eligible workers between August and September 2020. CAA and ARPA provided a $300 weekly supplement between December 2020 and September 2021. Twenty-six states ended FPUC early in June–July 2021 (National Employment Law Project 2021; Whittaker and Isaacs 2021).
[f] PEUC extended the duration of unemployment benefits by a total of 49 weeks under the CARES Act, CAA, and ARPA. Twenty-two states ended PEUC early in June–July 2021 (National Employment Law Project 2021; Whittaker and Isaacs 2021).
[g] SNAP refers to the Supplemental Nutrition Assistance Program. SNAP emergency allotments provided households with the greater of the maximum SNAP benefit for their household size or an additional $95 in monthly benefits. Eighteen states ended their SNAP emergency allotments early in 2021 or 2022. See US Food and Nutrition Service, "Changes to SNAP Benefit Amounts—2023," accessed June 3, 2024, https://www.fns.usda.gov/snap/changes-2023-benefit-amounts.
[h] Emergency rental assistance programs providing financial assistance and housing stability services were authorized by the CAA and ARPA. Only 6 percent of the first program's funding had been expended on financial assistance by May 2021 (Driessen, McCarty, and Perl 2023). A smaller amount of funding for emergency rental assistance was authorized by the CARES Act.
[i] Economic impact payments included payments of $1,200 per tax filer, $500 per child in March 2020; $600 per tax filer, $600 per child in December 2020; and $1,400 per tax filer, $1,400 per child in March 2021. See Pandemic Response Accountability Committee, "Update: Three Rounds of Stimulus Checks. See How Many Went Out and for How Much," accessed June 3, 2024, https://www.pandemicoversight.gov/data-interactive-tools/data-stories/update-three-rounds-stimulus-checks-see-how-many-went-out-and.
[j] Advance monthly child tax credit payments were provided between July 2021 and December 2021. The expansion of the total child tax credit amount applied to the 2021 tax year.

TABLE A.2

Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status and Family Income, 2019 and 2022

	Share uninsured at the time of the survey			Share insured all 12 months in the past year		
	2019	2022		2019	2022	
All states, excluding states expanding Medicaid between 2019–2022						
<138% FPL	25.9%	22.4%	*	69.0%	73.5%	**
138-249% FPL	22.2%	19.7%		72.9%	75.8%	*
250-399% FPL	11.8%	11.4%		83.5%	84.1%	
States expanding Medicaid before 2019						
<138% FPL	16.7%	13.6%		77.1%	83.6%	**
138-249% FPL	18.3%	14.9%	*	77.3%	80.9%	*
250-399% FPL	10.0%	9.6%		85.2%	86.4%	
States not expanding Medicaid before 2023						
<138% FPL	40.0%	37.0%		56.2%	57.1%	
138-249% FPL	28.9%	28.0%		65.4%	66.9%	
250-399% FPL	15.0%	14.9%		80.5%	79.8%	

Source: Authors' analysis of National Health Interview Survey data, 2019–2022.
Notes: FPL = federal poverty level.
*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

TABLE A.3

Cost-Related Barriers to Health Care among Adults Ages 18 to 64, by State Medicaid Expansion Status and Family Income, 2019 and 2022

	Share who delayed or did not get needed medical care because of costs			Share who did not get needed medications or did not take medications as prescribed to save money		
	2019	2022		2019	2022	
All states, excluding states expanding Medicaid between 2019–2022						
<138% FPL	19.1%	15.5%	**	15.6%	13.5%	
138-249% FPL	17.8%	14.8%	**	13.0%	10.8%	*
250-399% FPL	12.8%	11.2%		10.5%	8.7%	
States expanding Medicaid before 2019						
<138% FPL	14.5%	12.1%		12.7%	11.3%	
138-249% FPL	15.9%	13.4%		11.9%	10.0%	
250-399% FPL	12.3%	9.8%	*	10.7%	8.0%	*
States not expanding Medicaid before 2023						
<138% FPL	26.3%	21.1%	*	20.1%	16.9%	
138-249% FPL	21.1%	17.2%	*	15.0%	12.1%	
250-399% FPL	13.7%	13.8%		10.0%	10.1%	

Source: Authors' analysis of National Health Interview Survey data, 2019–2022.

Notes: FPL = federal poverty level.

*/** Estimate for 2022 differs significantly from estimate for 2019 at the 0.05/0.01 level, using two-tailed tests.

Notes

[1] Centers for Medicare & Medicaid Services, "March 2023 Medicaid and CHIP Enrollment Trends Snapshot," accessed May 3, 2024.

[2] KFF, "Medicaid Enrollment and Unwinding Tracker," accessed May 3, 2024, https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/; and Georgetown University Center For Children and Families, "What Is the impact of unwinding on Medicaid Enrollment?," accessed May 3, 2024, https://ccf.georgetown.edu/unwinding-enrollment-data/.

[3] Robert Hest and Lindsey Lanigan, "Tracking Health Insurance Coverage During the Unwinding: Monthly Data from the Household Pulse Survey," SHADAC (blog), July 24, 2023, https://www.shadac.org/news/tracking-unwinding-HPS.

[4] Centers for Medicare and Medicaid Services, "Unwinding and Returning to Regular Operations after COVID-19," accessed May 3, 2024, https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

[5] The American College of Obstetricians and Gynecologists, "Status of State Actions to Extend Postpartum Medicaid Coverage," accessed May 3, 2024, https://www.acog.org/en/advocacy/policy-priorities/extend-postpartum-medicaid-coverage/status-of-state-actions.

[6] Colin Baillio, Miranda Dietz, and Laura Waddell, "Affordability Beyond Premiums: State Policy Efforts to Lower ACA Marketplace Out-of-Pocket Costs," presented at Center for American Progress, virtual discussion, April 18, 2024, https://www.americanprogress.org/events/affordability-beyond-premiums-state-policy-efforts-to-lower-marketplace-out-of-pocket-costs/.

[7] States expanding Medicaid before 2019 include AK, AZ, AR, CA, CO, CT, DC, DE, HI, IL, IN, IA, KY, LA, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. States expanding Medicaid between 2019

and 2022 include ID (Jan. 2020), ME (Jan. 2019), MO (Oct. 2021), NE (Oct. 2020), OK (July 2021), UT (Jan. 2020), and VA (Jan. 2019). States not expanding Medicaid before 2023 include AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, and WY. Wisconsin used state funds to expand Medicaid to adults with incomes up to 100 percent of FPL in 2014. South Dakota expanded Medicaid in July 2023, and North Carolina expanded Medicaid in December 2023. See KFF, "Status of State Medicaid Expansion Decisions: Interactive Map," updated May 8, 2024, accessed June 20, 2024, https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

References

ASPE (Office of the Assistant Secretary for Planning and Evaluation). 2022. *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches.* Washington, DC: US Department of Health and Human Services.

Buddenbaum, Laura. 2023. "State-Based Marketplaces Continuing to Innovate for Open Enrollment 2024." Princeton, NJ: State Health & Value Strategies.

Buettgens, Matthew, Jessica Banthin, and Andrew Green. 2022. "What If the American Rescue Plan Act Premium Tax Credits Expire? Coverage and Cost Projections for 2023." Washington, DC: Urban Institute.

Buettgens, Matthew, and Andrew Green. 2022. *The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage.* Washington, DC: Urban Institute.

Buettgens, Matthew, and Urmi Ramchandani. 2023. *2.3 Million People Would Gain Health Coverage in 2024 If 10 States Were to Expand Medicaid Eligibility.* Washington, DC: Urban Institute.

CMS (Centers for Medicare & Medicaid Services). 2024. *Health Insurance Marketplaces 2024 Open Enrollment Report.* Baltimore: CMS.

Cohen, Robin A., and Michael E. Martinez. 2023. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2023.* Hyattsville, MD: National Center for Health Statistics.

Cohen, Robin A., Amy E. Cha, Emily P. Terlizzi, and Michael E. Martinez. 2021. *Demographic Variation in Health Insurance Coverage: United States, 2019. National Health Statistics Reports* 159. Hyattsville, MD: National Center for Health Statistics.

Cohen, Robin A., and Emily P. Terlizzi. 2023. *Demographic Variation in Health Insurance Coverage: United States, 2022. National Health Statistics Reports* 193. Hyattsville, MD: National Center for Health Statistics.

DeLeire, Thomas. 2019. "The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, and Health and Health Care Utilization." *Health and Labor Markets 47:* 155–194. https://doi.org/10.1108/S0147-912120190000047006.

Driessen, Grant A., Maggie McCarty, and Libby Perl. 2023. *Pandemic Relief: The Emergency Rental Assistance Program.* Congressional Research Service. Washington, DC: Congressional Research Service.

Guth, Madeline, and Meghana Ammula. 2021. *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021.* San Francisco: KFF.

Guth, Madeline, Rachel Garfield, and Robin Rudowitz. 2020. *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020.* San Francisco: KFF.

Hest, Robert, Elizabeth Lukanen, and Lynn A. Blewett. 2022. "Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage." Minneapolis, MN: SHADAC.

Heyison, Claire, Sarah Lueck, and Jennifer Sullivan. 2024. "Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges." Washington, DC: Center on Budget and Policy Priorities.

Holahan, John, and Michael Simpson. 2022. "Next Steps in Expanding Health Coverage and Affordability: What Policymakers Can Do Beyond the Inflation Reduction Act." New York: The Commonwealth Fund.

Johnston, Emily M., Genevieve M. Kenney, Dulce Gonzalez, and Erik Wengle. 2020. *Employer-Sponsored Insurance Access, Affordability, and Enrollment in 2018*. Washington, DC: Urban Institute.

Karpman, Michael, Dulce Gonzalez, and Stephen Zuckerman. 2023. "Health Care Affordability Improved between 2019 and 2022 under Pandemic Health Coverage Policies." Washington, DC: Urban Institute.

Karpman, Michael, Genevieve M. Kenney, Stephen Zuckerman. 2022. "Full-Year Health Insurance Coverage Increased for Nonelderly Adults in Medicaid Expansion States between 2019 and 2022." Washington, DC: Urban Institute.

Keisler-Starkey, Katherine, and Lisa N. Bunch. 2020. *Health Insurance Coverage in the United States: 2019*. Washington, DC: US Census Bureau.

Keisler-Starkey, Katherine, Lisa N. Bunch, and Rachel A. Lindstrom. 2023. *Health Insurance Coverage in the United States: 2022*. Washington, DC: US Census Bureau.

Levitis, Jason, and Sonia Pandit. 2021. "Supporting Insurance Affordability with State Marketplace Subsidies." Princeton, NJ: State Health & Value Strategies.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2021. "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." Washington, DC: MACPAC.

———. 2023. "Increasing the Rate of Ex Parte Renewals." Washington, DC: MACPAC.

Mazurenko, Olena, Casey P. Balio, Rajender Agarwal, Aaron E. Carroll, and Nir Menachemi. 2018. "The Effects of Medicaid Expansion under the ACA: A Systematic Review." *Health Affairs* 37 (6): 944–950. https://doi.org/10.1377/hlthaff.2017.1491.

McGough, Matthew, Krutika Amin, and Cynthia Cox. 2023. "How Has Healthcare Utilization Changed since the Pandemic?" Peterson-KFF Health System Tracker.

McIntyre, Adrianna, Rebecca B. Smith, and Benjamin D. Sommers. 2024. "Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility." *JAMA Health Forum* 5 (4): e240430. https://doi.org/10.1001/jamahealthforum.2024.0430.

NCHS (National Center for Health Statistics). 2020. "National Health Interview Survey, 2019 Survey Description." Hyattsville, MD: NCHS.

———. 2023. "National Health Interview Survey, 2022 Survey Description." Hyattsville, MD: National Center for Health Statistics.

National Employment Law Project. 2021. "4.7 Million Workers Face Premature Cutoff of Pandemic Unemployment Programs." New York: National Employment Law Project.

Nelson, Daniel B., Anna L. Goldman, Fang Zhang, and Hao Yu. 2023. "Continuous Medicaid Coverage during the COVID-19 Public Health Emergency Reduced Churning, but Did Not Eliminate It." *Health Affairs Scholar* 1 (5): qxad055. https://doi.org/10.1093/haschl/qxad055.

Ortaliza, Jared, Cynthia Cox, and Krutika Amin. 2024. "Another Year of Record ACA Marketplace Signups, Driven in Part by Medicaid Unwinding and Enhanced Subsidies." San Francisco: KFF.

Pascale, Joanne. 2008. "Measurement Error in Health Insurance Reporting." *Inquiry* 45 (4): 422–437. https://doi.org/10.5034/inquiryjrnl_45.04.422.

Pollitz, Karen. 2021. "How the American Rescue Plan Will Improve Affordability of Private Health Coverage." San Francisco: KFF.

Sugar, Sarah, Christie Peters, Nancy De Lew, and Benjamin D. Sommers. 2021. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Washington, DC: US Department of Health and Human Services.

Tarazi, Wafa W., Tiffany L. Green, and Lindsay M. Sabik. 2017. "Medicaid Disenrollment and Disparities in Access to Care: Evidence from Tennessee." *Health Services Research* 52 (3): 1156–1167. https://doi.org/10.1111/1475-6773.12515.

White House. 2021. "The Effects of Earlier Medicaid Expansions: A Literature Review." Washington, DC: White House Council of Economic Advisors.

Whittaker, Julie M., and Katelin P. Isaacs. 2021. *Current Status of Unemployment Insurance (UI) Benefits: Permanent-Law Programs and COVID-19 Pandemic Response.* Washington, DC: Congressional Research Service.

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