

The End of the COVID-19 Public Health Emergency: Lessons Learned from the Pandemic and Implications for People

Playbook for Federal and State Policymakers

The pandemic highlighted America's rigid, inequitable health care system and forced us to look at how our health care system was not working for so many people. Through this time, the health care system adapted with increased flexibility and a renewed focus on people. We now have an opportunity to create a system that prioritizes people's needs and advances health equity through carefully-crafted policies.



WHO CREATED THIS PLAYBOOK

United States of Care is a nonpartisan advocacy organization **committed to ensuring that everyone has access to quality, affordable health care.** The organization drives a unique cross-sector, people-centered approach to creating and advancing state and federal policies that meet the needs of people and result in a more equitable health care system.

United States of Care created this playbook through extensive research, interviews with members of its [Founders Council](#), [Leadership Council](#), and [Voices of Real Life Council](#), as well as feedback from external partners, to get a comprehensive perspective of the COVID-19 policy flexibilities and its impact on people.

UNITED SOLUTIONS FOR CARE

Through listening work, USofCare created [United Solutions for Care](#), a roadmap of 4 goals and 12 solutions to build a better health care system. Achieving these shared goals will move us to a system where every person can access health care, regardless of who they are, how much money they make, or where they live.

- 1 People have the certainty that they can afford their health care.
- 2 People have the security and freedom that dependable health care coverage provides as life changes.
- 3 People can get the personalized care they need, when and how they need it.
- 4 People experience a health care system that is understandable and easy to navigate.

“

I want everyone to just have standard basic care that is affordable, so people can just go get primary care at the doctor or at the hospital or whatever...I think just setting standards for health insurance plans to make sure everyone can have access to those plans.”

- Focus group participant, New York

EXECUTIVE SUMMARY

The COVID-19 pandemic upended the world and our entire U.S. health care system — killing and sickening millions, and forcing us to focus on the cracks in our health care system and how it does not work for so many people. The pandemic highlighted and exacerbated long-standing inequities in our health care system for [people of color](#), [low-income people](#), [people with a disability](#), [people who are uninsured](#), and many others.

The pandemic, and resulting policy responses, also unleashed an unprecedented level of flexibility and innovation across our entire system. This versatility enhanced people's ability to obtain and keep health care coverage, while simultaneously allowing for increased flexibility in how and when they access health care services.

Many policy flexibilities created during the pandemic and public health emergency (PHE) helped people access health care services that became more affordable, dependable, personalized, and easy to understand. Unfortunately, many of these policy flexibilities were temporary and are set to end when the PHE ends. Many policymakers have recognized the progress that has been made and created permanent policies that meet people's needs, improves access to care, and advances health equity. These proposed policies can serve as a replicable model and guide for other policymakers across the country. As a result, the end of the COVID-19 PHE provides federal and state policymakers an opportunity to enact long-term solutions that will ensure equitable access to health care for all.

To help federal and state policymakers continue and build upon the progress made during the pandemic and PHE, United States of Care created this playbook with a people- and equity-centered lens to identify:

- ★ Pandemic-era policy flexibilities, their impact on people's health care, and implications for people if the policy flexibilities are discontinued;
- ★ Federal and state initiatives that help fill in the gaps; and
- ★ Federal and state opportunities to advance a health care system that is affordable, dependable, personalized, and easy to navigate.

UNITED STATES OF CARE

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The End of the COVID-19 Public Health Emergency: Table of Contents

No Cost Access to COVID-19 Tests, Vaccines, Treatments

- **March 22, 2022:** Federal funding to cover testing and treatment for uninsured individuals [ran out](#)
- **April 5, 2022:** Federal funding to cover provider fees for vaccinations for uninsured individuals [ran out](#)
- **January 2023 (anticipated):** Federal funding to purchase and distribute vaccines will run out and these activities will [transition to the commercial market](#)
- **End of the PHE:** Many requirements protecting coverage of and access to COVID-19 tests, vaccines, and treatments are [tied to the PHE](#) and will either end right away or one year after, depending on people's coverage type

Flexibilities Addressing the Provider Workforce

- **Now:** Many provider licensure and scope-of-practice flexibilities [vary by state](#), and flexibilities in some states have expired
- **152 days after the PHE ends:** Some provider flexibilities on virtual care expire (some flexibilities for Medicare were [extended an additional 151 days](#) after the PHE is declared over)
- **October 21, 2024:** Liability protections for the [expanded pool of health care workers](#) that can administer vaccinations expires

Flexibilities for Virtual Care

- **Now:** Many virtual care flexibilities [vary by state](#), and flexibilities in some states have expired
- **End of the PHE:** The Telehealth Notification, which provides enforcement discretion regarding HIPAA Rules in using technologies, [expires](#)
- **152 days after the PHE ends:** Some virtual care flexibilities for Medicare expire (these were [extended an additional 151 days](#) after the PHE is declared over)
- **End of calendar year that PHE ends:** Medicare physician supervision requirements (which were modified to include "virtual presence" of a supervising clinician) [return to pre-PHE rules](#)

Flexibilities Addressing Social Determinants of Health

- **End of PHE:** The Center for Medicare & Medicaid Services' relaxed enforcement of its prohibition of mid-year benefit enhancements for Medicare Advantage organizations [ends](#)
- **December 31, 2024:** State fiscal recovery funds must be obligated
- **December 31, 2026:** State fiscal recovery funds must be spent

Medicaid Continuity of Coverage Requirements

- **12 months from the end of the PHE:** States must have initiated all Medicaid renewals and other outstanding eligibility actions
- **14 months from the end of the PHE:** States must have completed pending actions initiated during the unwinding period

American Rescue Plan Act (ARPA) State Funding

- **December 31, 2024:** State fiscal recovery funds must be obligated
- **December 31, 2026:** State fiscal recovery funds must be spent

Broadband Investments

- **December 31, 2024:** State fiscal recovery funds must be obligated
- **December 31, 2026:** State fiscal recovery funds must be spent

ARPA Enhanced Subsidies

- **December 31, 2025:** The Inflation Reduction Act [extended](#) the enhanced premium subsidies created by ARPA (which would otherwise have ended December 31, 2022)

Postpartum Medicaid Extension Option

- **March 31, 2027:** Statutory authority for the extended postpartum coverage option [expires](#)

The End of the COVID-19 Public Health Emergency: No Cost Access to COVID-19 Testing, Vaccines, and Treatments

To counter the COVID-19 pandemic, the federal government took action and spent billions of dollars in emergency funds to purchase vaccines, boosters, treatments, and tests and provided them free of charge to the public. Additionally, Congress enacted several bills that required public and private insurers to cover these medical countermeasures. The [Families First Coronavirus Response Act](#) (signed March 18, 2020) required most insurers to eliminate cost-sharing for COVID-19 testing and health care visits during which testing is ordered, and gives states the option to fully cover these costs for uninsured individuals at a 100% federal match. The [Coronavirus Aid, Relief, and Economic Security Act](#) (signed March 27, 2020) broadened the testing and services covered.

Both bills also funded the Health Resources and Services Administration's [COVID-19 Uninsured Claims Reimbursement](#),* which reimbursed providers for testing and treatment for uninsured individuals. Many but not all of these requirements are tied the public health emergency (PHE) and will either end right away or one year after the PHE ends.

Impact

- ★ COVID-19 vaccination efforts in the U.S. [prevented over 2 million deaths](#) and 17 million hospitalizations through March 2022
- ★ Recovery legislation waived cost-sharing for COVID-19 testing and treatment, and had a [positive effect on increasing COVID-19 testing and reducing COVID-19 related deaths](#) in Michigan from April 2020 to March 2021
- ★ No cost access to COVID-19 testing, vaccines, and treatments is necessary because:
 - Cost is a barrier to care, even for people with health coverage: 1 in 11 adults delay or go without medical care due to cost reasons but nearly [1 in 3 adults who are uninsured delay or go without medical care due to cost reasons](#)
 - [Adults, low income individuals, and people of color are at a higher risk of being uninsured](#), making them less likely than people with insurance to receive preventive care and services
 - Many adults who are uninsured work in jobs that [increase their exposure to COVID-19](#)

Implications at the End of the PHE

- ★ [Commercialization](#): The procurement and distribution of COVID-19 vaccines, testing, and treatments will transition from the federal government to the commercial marketplace
- ★ People may have to navigate a [complicated patchwork of COVID-19 coverage and cost-sharing](#) depending their health care coverage:
 - People with Medicare will have access to COVID-19 tests and vaccines with no cost-sharing, but [may face out-of-pocket costs for treatments](#) and testing-related office visits
 - People with full-benefit Medicaid will have access to COVID-19 tests, vaccines, and treatments [without cost-sharing](#) for at least a year after the PHE ends. Nearly all Medicaid enrollees will have access to vaccines and vaccine administration without cost-sharing for more than a year after the PHE ends
 - People with private health insurance will have access to COVID-19 vaccines, but may [face cost-sharing for tests and treatments](#)
 - Uninsured adults may get access to COVID-19 vaccines through the [Section 317 Immunization Program](#), but supply is limited because the program is discretionary
 - Uninsured children may get access to COVID-19 vaccines through the federal [Vaccines For Children \(VFC\) program](#), but may be charged an administration fee
- ★ The cost of the clinical visit and vaccine is a [common structural barrier](#) that limits people's ability to access vaccinations
- ★ As a result of historical injustices, Black and Latino people face [structural barriers like cost and less access to care](#), which results in lower vaccine uptake
- ★ People who are uninsured have a [lower uptake of COVID-19 vaccinations and boosters](#), even when free, likely because lack of health care access affects use of preventive services



Initiatives

Federal Initiatives

- ★ The House of Representatives passed the [Health and Economic Recovery Omnibus Emergency Solutions Act \(or the Heroes Act\)](#) on May 15, 2020, which would have provided \$75 billion for coronavirus testing, contact tracing, and isolation measures with special attention to disparities facing communities of color
- ★ The Biden Administration requested [\\$22.5 billion in FY22 supplemental funding for COVID-19 efforts](#), but Congress has declined to provide additional funding as of publication date
- ★ The Biden Administration requested [\\$25 billion over 10 years in the FY23 budget](#) to establish a new mandatory Vaccines For Adults (VFA) program to provide uninsured adults access to vaccines at no cost (similarly to the [VFC](#) program for children)

State Initiatives

- ★ Many states passed [policies](#) that required insurers to provide the COVID-19 vaccine for free or waive cost-sharing for COVID-19 treatment during the PHE
- ★ Eighteen states* used their Medicaid program to cover the cost of COVID-19 testing, treatment, and vaccines [for people who are uninsured](#), regardless of their income, with 100% federal matching funds to cover costs**

*As of August 27, 2021

**This option will end when the PHE ends



Recommendations

Federal Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Create sustainable funding streams to continue the COVID-19 response and ensure people have access to COVID-19 testing, vaccines, and treatments regardless of insurance status
- ★ Coordinate with health insurers to make COVID-19 testing, vaccines, and treatments available with no cost sharing and no utilization review

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ See recommendations on Medicaid redetermination to ensure people do not lose coverage and access to health care services due to procedural reasons
- ★ Require insurers on the fully insured market to [cover COVID-19 testing, vaccines, and treatments](#) without cost-sharing and utilization review beyond the end of the PHE
- ★ Encourage employers providing employer-sponsored insurance to [cover COVID-19 testing, vaccines, and treatments](#) without cost-sharing and utilization review
- ★ Increase funding and support to safety-net providers like federally qualified health centers and rural health centers to sustain the provision of no-cost COVID-19 prevention and treatment services to people who are underinsured and uninsured

LONGER-TERM SOLUTIONS

- ★ [Expand Medicaid](#) to decrease the number of people who are uninsured and improve people's access to health care services like COVID-19 vaccines and treatments

“ My family getting sick and me not having the funds to get them the care they need.”

-[COVID-19 National Survey](#) participant on his worries and concerns. Male. 24-34. Very Conservative. High School Education. Black.



NEARLY 1 IN 3 ADULTS WHO HAVE NOT BEEN VACCINATED (AS OF APRIL 2021) EXPRESSED OUT-OF-POCKET COSTS AS A CONCERN

Source: [Kaiser Family Foundation COVID-19 Vaccine Monitor: April 2021](#)

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December 2022



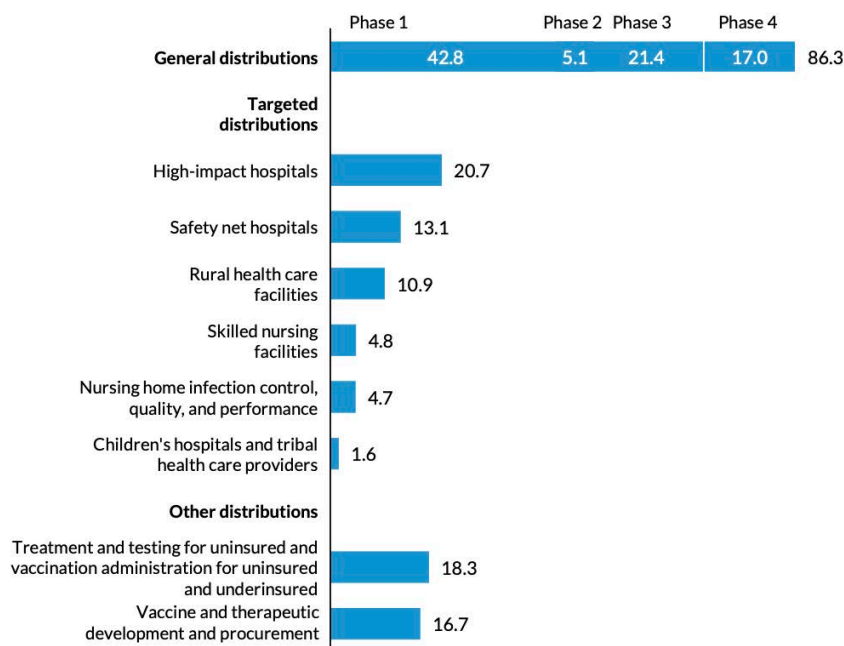
The End of the COVID-19 Public Health Emergency: Flexibilities Addressing the Provider Workforce

The COVID-19 pandemic only [worsened the existing provider shortage](#) and increased worker burnout, exhaustion, and trauma. To address the provider shortage during the pandemic:

- ★ The federal government allocated \$178 billion to the COVID-19 [Provider Relief Fund](#) (PRF) to support hospitals and health care providers and compensate them for financial losses and unanticipated costs due to the coronavirus
- ★ The American Rescue Plan Act (ARPA) allocated \$8.5 billion in [ARP Rural payments](#) to health care providers that serve rural Medicaid, Children's Health Insurance Program (CHIP), or Medicare patients
- ★ Forty-nine states and D.C. [substantially waived or relaxed licensing regulations](#)
- ★ The Centers for Medicare & Medicaid Services and many states [relaxed or waived regulations defining scope of practice](#) for health professionals

Allocations of the Provider Relief Fund, February 2022

In billions of dollars



URBAN INSTITUTE

Source: GAO, *Current and Future Federal Preparedness Requires Fixes to Improve Health Data and Address Improper Payments* (Washington, DC: US Government Accountability Office, 2022).

Note: Provider Relief Fund grants total \$178 billion. Fund administrative costs of \$0.9 billion are not included in figure.

Impact

- ★ The PRF helped health organizations facing workforce shortages and staff burnout to [support recruitment and retention efforts](#)
- ★ Over \$40 billion in ARPA funds have been committed to [strengthening and expanding the workforce](#)
- ★ Although there is no evidence of what effect emergency policies like licensure reciprocity has on health workforce supply and access to care, New Jersey's Temporary Emergency Reciprocity Licensure Program [increased the state's health care workforce supply during the pandemic and likely expanded care for underserved populations](#)
- ★ Expanded state nurse practitioner practice regulations are associated with [greater provider supply and improved access to care](#) among rural and underserved populations without decreasing care quality

Implications of the Provider Shortage

- ★ Thirty-seven states are predicted to have a [shortage of primary care physicians](#) by 2025 and a [national shortage of more than 300,000 registered nurses](#) by 2030, which have only been exacerbated by the pandemic
- ★ People will experience [longer wait times for patient visits, longer waits for appointments, and the need to travel farther to see a provider](#) as a result of provider shortages
- ★ Physician shortages are [concentrated in low-income and rural areas](#), whereas primary care nurse practitioner supply is well-distributed and growing in low-income and rural areas
- ★ [Rising provider burnout](#) may lead health care providers serving low-income populations to migrate to lower stress retail work settings and digital health companies, exacerbating provider shortages for low-income populations
- ★ Removing restrictive nurse practitioner scope-of-practice regulations can [increase access to care for racial and minority populations](#)



Initiatives

Federal Initiatives

- ★ The [Consolidated Appropriations Act of 2021](#) (signed December 27, 2021) included 1,000 new Medicare-supported graduate medical education (GME) positions, the first increase in the program in nearly 25 years
- ★ The [Physician Shortage Reduction Act of 2021](#) (introduced) would have added 14,000 residency slots over seven years
- ★ The [Opioid Workforce Act of 2021 and the Substance Use Disorder Workforce Act of 2021](#) (introduced) would have added 1,000 residency slots over four years
- ★ The Health Resources and Services Administration, Department of Health and Human Services, and Indian Health Service sponsor different [loan repayment and/or forgiveness programs](#) for health care providers working in rural, tribal, and underserved areas

State Initiatives

- ★ Many states have [loan repayment or forgiveness programs](#) for health care providers
- ★ Thirty-seven states, D.C., and Guam have joined the [physician's Interstate Medical Licensure Compact](#)
- ★ Thirty-seven states, Guam, and Virgin Islands have enacted the [Nurse Licensure Compact](#)
- ★ Multiple states have passed [legislation expanding scope of practice for advanced practitioners](#)
- ★ Arizona: The state is the first to pass a bill that [recognizes out-of-state occupational licenses across the board](#)



Recommendations

Federal Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Pass legislation to expand and support the mental health workforce as outlined in the Senate Finance Committee's [discussion draft legislation](#), including:
 - The [Training Psychiatrists for the Future Act](#), which would add 400 psychiatric residency slots per year
 - The [More Behavioral Health Providers Act](#), which would expand Medicare's Health Professional Shortage Area bonus program to attract mental health providers to shortage areas
 - The [Protect Our Physicians Act](#) to increase access to mental health programs for physicians

LONGER-TERM SOLUTIONS

- ★ Increase GME funding and residency slots
- ★ Expand the availability, eligibility, and funding for loan repayment and forgiveness programs so providers intending to pursue primary care are able to do so since medical school debt led medical students to switch to [higher-paying specialties](#)
- ★ Invest in [mental health](#) to address provider burnout

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Align permanent licensure policies with COVID-era licensure policies (e.g., interstate licensure compacts, etc.)
- ★ Explore opportunities to build on scope of practices flexibilities allowed during the pandemic that [prioritize patients](#)
- ★ Adopt virtual care flexibilities to address geographic imbalances in provider supply and availability

LONGER-TERM SOLUTIONS

- ★ Adopt [loan forgiveness programs](#) for health care workers
- ★ Invest in [mental health](#) to address provider burnout

“Difficulty finding doctors, health care providers.”

- Focus group participant, South Carolina on "What comes to mind when you hear the term health care?"



According to the [American Medical Association's 2021 Telehealth Survey Report](#), **52%** of physicians reported that telehealth has improved the satisfaction of their work.

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December 2022



The End of the COVID-19 Public Health Emergency: Flexibilities for Virtual Care

Some virtual care flexibilities enacted during the COVID-19 pandemic include:

- ★ The [Centers for Medicare & Medicaid Services \(CMS\)](#) recognized patients' homes as an originating site, expanded eligibility for virtual care services, allowed telehealth visits for new patients, expanded services allowed via telehealth, allowed audio-only, and reimbursed [federally qualified health centers \(FQHCs\) and rural health centers \(RHCs\)](#) as a distant site
- ★ [State Medicaid programs](#) expanded coverage and access to virtual care services
- ★ CMS paused enforcement action against health insurance issuers in the individual/group market making [mid-year changes](#) to provide greater coverage for telehealth services or to reduce/eliminate cost-sharing requirements for virtual care
- ★ States temporarily [waived licensure requirements](#)



OF PEOPLE HAD SOMETHING
POSITIVE TO SAY ABOUT THEIR
VIRTUAL CARE EXPERIENCE

Source: [United States of Care Public Opinion Research Findings, 2020](#)

“Geography [should] not
[be] a restraint on quality.”

- Sean Duffy,
Leadership Council Member

Impact

- ★ Overall telehealth utilization for office visits and outpatient care was 78 times higher in April 2020 than in February 2020, and has stabilized at [38 times higher than before the pandemic](#) (as of July 2021)
 - Virtual care accounted for [40% of mental health \(MH\) and substance disorder \(SUD\) outpatient visits](#) during the pandemic's peak (compared to <1% pre-pandemic), and still comprised 36% of MH and SUD outpatient visits one year later
- ★ During the pandemic, virtual care services were [accessed more in urban area than rural areas](#) and [white Medicare enrollees were more likely to use virtual care than Black Medicare enrollees](#), demonstrating that virtual care can exacerbate existing disparities in health care access
- ★ Virtual care can help [address barriers in accessing behavioral health care](#), including stigma, provider shortages, cultural, and linguistic differences
- ★ More than 80% of physicians report that [patients have better access to care since using telehealth](#)
- ★ [A report by the Office of the Inspector General](#) suggests that telehealth fraud, waste, or abuse was rare during the pandemic when virtual care access was expanded (only 0.2% of Medicare providers posed a high risk for fraud, waste, or abuse)

Implications at the End of the PHE

- ★ People will have to navigate a complicated patchwork of virtual care flexibilities depending on the state they live in, their urban-rural classification, their health care coverage, and the health care services they seek
- ★ Waivers related to Medicare coverage of virtual care services (including waivers related to originating site, eligible practitioners, FQHCs and RHCs, in-person requirements for mental health and audio-only) are set to end 152 days after the PHE expires, an extension created by the [Consolidated Appropriations Act of 2022](#) (signed March 15, 2022) to avoid a “virtual care cliff”
- ★ Medicaid enrollees may lose access to virtual care services in states that have not maintained or expanded virtual care policies, especially since limits on reimbursement had [constrained widespread use of telehealth](#) before the pandemic
- ★ Most people [prefer a mix of in-person and virtual care](#), and the removal of virtual care flexibilities make it harder for people to access the health care services they need
- ★ Lack of digital literacy remains a telehealth barrier, especially among [older adults](#), [people with less education](#), and [racial/ethnic minority populations](#)



Initiatives

Federal Initiatives

- ★ The [Consolidated Appropriations Act of 2022](#) (signed March 15, 2022) permanently removed geographic and originating site restrictions for MH/SUD services delivered via telehealth
- ★ The House of Representatives passed the bipartisan [Advancing Telehealth Beyond COVID-19 Act of 2022](#), which would have extended the Medicare virtual care flexibilities until December 31, 2024
- ★ The [2022 Medicare Physician Fee Schedule \(PFS\) Final Rule](#) permanently covers audio-only telehealth for MH/SUD services
- ★ The [2023 Medicare PFS Proposed Rule](#) proposes to postpone the effective date for the in-person visit requirement for telehealth services under certain conditions

State Initiatives

- ★ Many states have [aligned their permanent virtual care policies](#) with their COVID-era virtual care policies, which expanded the virtual care services available for people
- ★ At least 40 states have made virtual care [reimbursable via private insurance](#)*
- ★ Twenty-nine states and DC Medicaid programs [reimburse for audio-only](#) (often with limitations)
- ★ California: The Department of Health Care Services' [Telehealth Advisory Group](#) is proposing to expand the telehealth services covered by Medi-Cal permanently and were guided by the principles of equity, access, standard of care, patient choice, confidentiality, stewardship, and payment appropriateness

*As of March 4, 2022



Recommendations

Federal Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ CMS should issue guidance to clarify that states can make telehealth flexibilities permanent in their Medicaid program (e.g., state plan amendments, templates, etc.)

LONGER-TERM SOLUTIONS

- ★ Address [barriers to accessing virtual care](#) to ensure [equitable access](#), including structuring carrier and provider incentives to [allow a mix of in-person and virtual care](#), allowing access to [audio-only and asynchronous care](#), expanding providers permitted to provide virtual care, and expanding broadband access
- ★ Conduct research and evaluations on the return on investment of virtual care services to inform efforts to make certain flexibilities permanent

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ [Align permanent virtual care policies](#) with their COVID-era virtual care policies, which expanded the virtual care services available for people

LONGER-TERM SOLUTIONS

- ★ Address [barriers to accessing virtual care](#) to ensure [equitable access](#), including:
 - Structuring carrier and provider incentives to [allow a mix of in-person and virtual care](#)
 - Allowing access to [audio-only and asynchronous care](#)
 - Expanding providers permitted to provide virtual care, and expanding broadband access
- ★ Address [provider barriers](#) by ensuring adequate reimbursement (especially for safety net systems), permanently remove geographic barriers on distant/originating sites, and make training materials and resources available to improve digital literacy
- ★ Create reimbursement mechanisms for [coordination](#) and virtual consultation between providers

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December 2022



The End of the COVID-19 Public Health Emergency: Flexibilities Addressing Social Determinants of Health



Contrary to beliefs that COVID-19 would be a great equalizer, the COVID-19 pandemic has disproportionately impacted certain populations. Social determinants of health (SDOH) – like poverty, racism, physical environment, food security, and others – have a profound impact on health outcomes. Some flexibilities enacted during the COVID-19 pandemic that helped address SDOH include:

- ★ American Rescue Plan Act (ARPA) state funds
- ★ The Centers for Medicare & Medicaid Services' (CMS) [relaxed enforcement](#) of its prohibition on mid-year benefit enhancements (MYBE) for Medicare Advantage (MA) organizations
- ★ [Federal policies](#) that addressed health-related social needs, such as the eviction moratorium and increased Supplemental Nutrition Assistance Program benefits

Impact

- ★ ARPA funds that were used to [address SDOH](#) include:
 - \$1.247 trillion addressed economic stability
 - \$482 billion addressed neighborhood and built environment
 - \$182 billion addressed education access and quality
 - \$126 billion addressed health care access and quality
 - \$19 billion addressed social and community contexts
- ★ MA organizations were able to redesign benefit packages mid-year to address social needs such as meal delivery and transportation services in response to the pandemic
 - Humana increased its [monthly Healthy Foods Card](#) allowances for several dual-eligible special needs plans
 - Independence Blue Cross collaborated with United by Blue to offer four [weekly grocery deliveries](#) for enrollees in Health Maintenance Organization plans with chronic obstructive pulmonary disease

Implications at the End of the PHE

- ★ The current health care system infrastructure does not adequately address drivers of health like economic security, food, housing, and education
- ★ Without permanent approaches to addressing SDOH, populations that have been historically marginalized will continue to disproportionately experience negative health outcomes
- ★ Current MYBE for MA plans are only allowed if they are provided in connection with the COVID-19 outbreak and may end with the end of the COVID-19 PHE, which limits the ability of MA plans to respond to changing circumstances and meet the needs of their enrollees after the COVID-19 PHE

Tracked funds

\$1,663,930,412,841

Proportions of funds to social determinant of health
Use to categorize relevant federal departments



“The realities of the difficulties of life don’t happen on an annual schedule.”

- Lauren Driscoll,
Leadership
Council Member

Federal Initiatives

- ★ CMS issued a [State Health Official letter](#) in January 2021 identifying opportunities for states to better address SDOH under Medicaid and CHIP and to support states with designing programs, benefits, and services that address SDOH
- ★ The Centers for Disease Control and Prevention launched the [Closing the Gap with Social Determinants of Health Accelerator Plans pilot project](#) to accelerate the development of action plans that address SDOH and reduce chronic diseases among people experiencing health disparities

State Initiatives

- ★ Many states [require their Medicaid managed care organizations \(MCOs\)](#) to address SDOH:
 - Twenty-seven states require MCOs to screen for SDOH
 - Thirty-five states require MCOs to make referrals to social services
 - Thirty-seven states require MCOs to coordinate social services for their members
 - Twenty-one states require MCOs to coordinate with other state and federal programs
 - Twenty-three states require MCOs to partner with community-based organizations (CBOs) to support unmet social needs
- ★ Several states are using [value-based payment in Medicaid](#) to address social needs through section 1115 waivers, MCO contracts, or Accountable Care Organizations
- ★ Many states established [health equity task forces](#) to apply a cross-sectoral approach and address SDOH

Federal Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Allow MA plans to have benefit flexibilities that meet the needs of their enrollees, with guardrails outlining that changes are limited to those that improve coverage or reduce cost-sharing and benefits cannot be limited or eliminated to offset the costs of increasing the generosity of other benefits

LONGER-TERM SOLUTIONS

- ★ Invest in efforts that identify and address underlying systemic and environmental factors that impact health

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Use unspent ARPA funds on data initiatives to fill in data gaps on health disparities and understand people's social needs
- ★ Require MCOs to identify and address social needs

LONGER-TERM SOLUTIONS

- ★ Use [Section 1115 demonstrations \(and other waivers\)](#) to address health-related social needs, such as [housing](#)
- ★ Provide Medicaid benefits that address social needs directly or mitigate access barriers, such as non-emergency Medicaid transportation, case management, and others
- ★ Allow Medicaid managed care plans to have benefit flexibilities that meet the needs of their enrollees with guardrails outlining that changes are limited to those that improve coverage or reduce cost-sharing and benefits cannot be limited or eliminated to offset the costs of increasing the generosity of other benefits
- ★ Provide sustainable funding for CBOs to help them address the increased demand for services
- ★ Direct and encourage the use of [community benefit spending](#) towards identified community needs and SDOH

“ [We don’t want to create a] bridge to nowhere: all new inbound demand with the same finite resources to fill them.”

- Robert Garber, member of United States of Care network

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This one-pager is part of USofCare's playbook, "The End of the COVID-19 Public Health Emergency: Lessons Learned from the Pandemic and Implications for People."

December 2022

The End of the COVID-19 Public Health Emergency: Medicaid Continuity of Coverage Requirement

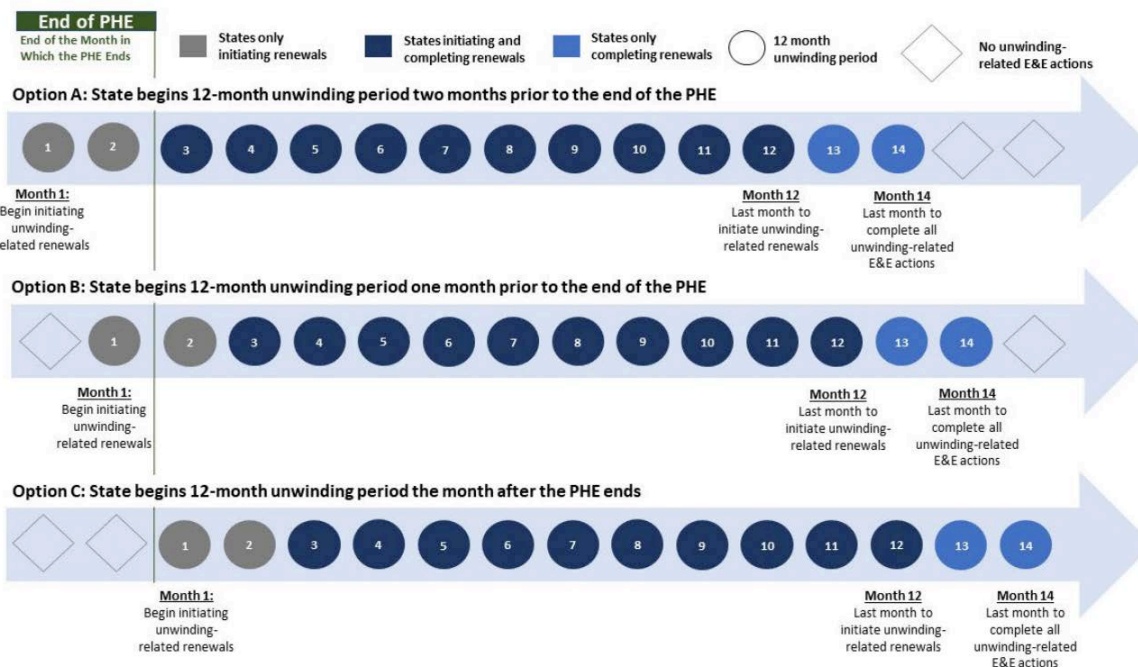
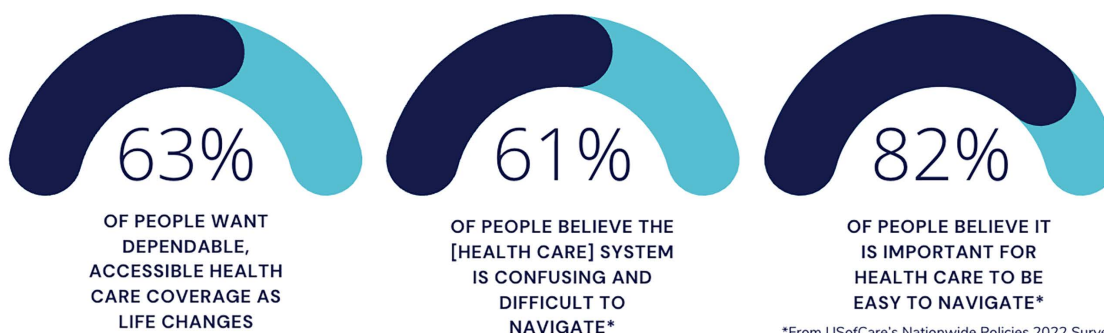
The [Families First and Coronavirus Response Act](#) (signed March 18, 2020) authorizes a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), the federal share of Medicaid spending, to states that meet certain maintenance of eligibility requirements including [continuous coverage](#) for current enrollees during the public health emergency (PHE). Thus, states may not disenroll Medicaid enrollees that were enrolled as of March 18, 2020 or any time thereafter until the end of the month in which the PHE ends. The enhanced FMAP is available though the quarter in which the PHE ends.

Currently, the Medicaid continuous coverage requirement prohibits states from disenrolling individuals from Medicaid during the PHE. When the PHE ends, [state Medicaid agencies](#) will have:

- ★ 12 months to initiate all renewals and other outstanding eligibility actions
- ★ 14 months to complete pending actions initiated during the 12-month unwinding period

Impact

- ★ Medicaid enrollment [grew by 27%](#) (an additional 17.4 million enrollees) from February 2020 to May 2022
- ★ Medicaid enrollment is estimated to grow 25% (an additional 22.2 million enrollees) from 2019 to 2022, of which the continuous coverage requirement accounts for [18.7 million of the additional enrollees](#)
- ★ All states have seen [at least 13% growth in Medicaid enrollment](#), while states like Oklahoma, Utah, Nebraska, and Iowa have seen growth over 40%
- ★ Most of the increase in Medicaid enrollment were [adults under age 65 without a disability](#), likely driven by the fact that working age adults are most likely to have faced employment disruptions due to the pandemic



“The paperwork that goes with [insurance] is hard to keep up with to use your insurance. So, you have to turn in this paperwork, and if you use your payment card, you have to turn in this other paperwork.”

-Focus group participant, South Carolina

Implications at the End of the PHE: Coverage

- ★ 15 million people, including 5.3 million children, are [predicted to lose Medicaid coverage](#) when the PHE ends
- ★ 66% of individuals predicted to be ineligible for Medicaid [live in expansion states](#), while 34% live in non-expansion states
- ★ People moving from Medicaid and Children's Health Insurance Program (CHIP) coverage to the exchanges are [more likely to experience gaps in coverage](#) than other people
- ★ 383,000 individuals ineligible for Medicaid at the end of the PHE [fell into the coverage gap](#) in the remaining 12 non-expansion states and were not enrolled or eligible for any insurance

Federal Initiatives

- ★ The Centers for Medicare & Medicaid Services (CMS) is [working closely](#) with state Medicaid agencies, Marketplaces, navigators, health plans, and others to ensure individuals remain connected to coverage at the end of the PHE
- ★ CMS released a [State Health Official letter](#) providing guidance to states on the redetermination process and strategies for states to minimize beneficiary burden, promote continuity of coverage, and reduce churn
- ★ CMS created a list of [top ten fundamental actions for states](#) to complete to prepare for unwinding
- ★ The Department of Health and Human Services (HHS) is investing \$98.9 million in [grant funding for navigator organizations](#) for the 2023 Open Enrollment Period to help people navigate enrollment through the Marketplace, Medicaid, and CHIP
- ★ CMS [proposed a rule](#) that would streamline Medicaid eligibility and enrollment and improve continuity of coverage

State Initiatives

- ★ Several states have expanded continuous coverage for some of their Medicaid population, including:
 - Massachusetts: The state will provide 12-month continuous Medicaid and CHIP enrollment for eligible enrollees upon release from correctional settings and 24-month continuous Medicaid enrollment for enrollees experiencing homelessness through an [1115 waiver](#)
 - Oregon: The state will provide continuous Medicaid enrollment for children up to age six without the need to renew their coverage and two-year continuous Medicaid enrollment for people ages six and up through an [1115 waiver](#)
- ★ Several states have proposed to provide premium assistance to people not eligible for Medicaid, including:
 - Connecticut: The state submitted a new section 1115 waiver proposal for Covered Connecticut to provide [premium assistance to individuals up to 175% federal poverty level \(FPL\)](#) who purchase a silver-level Qualified Health Plan on the exchange
 - Rhode Island: Legislators proposed to establish a [premium payment program](#) to help individuals and families transition from Medicaid to commercial insurance at the end of the PHE
- ★ Several states have initiatives to help bridge coverage for people leaving Medicaid, including:
 - California: Covered California will [automatically enroll people in a qualified health plan](#) when they lose Medicaid coverage and are eligible for advanced premium tax credits
 - Oregon: The [Oregon Bridge Plan](#) provides basic health and dental coverage for people making 138%- 200% FPL, who are [most at risk of losing coverage at the end of the PHE](#)

Federal Policy Recommendations

IMMEDIATE PRIORITIES

- ★ Gradually phase down the enhanced FMAP to reduce the FMAP cliff at the end of the PHE, and strategically tie an enhanced FMAP with equity goals like continuous coverage, increasing benefits that reduce disparities, etc.

LONGER-TERM SOLUTIONS

- ★ Enact a [federal public health insurance option](#)
- ★ Support waivers that allow for continuous coverage (Sections 1115, 1331, 1332)
- ★ Offer a state plan amendment option for adult 12-month continuous eligibility
- ★ Provide states with funding to update eligibility and enrollment systems

State Policy Recommendations

IMMEDIATE PRIORITIES

- ★ Develop a [plan](#) to prioritize redeterminations, phase disenrollments, collect and monitor data, and pause and fix the process if too many people are losing coverage due to procedural reasons
- ★ Encourage Medicaid agencies to work with Medicaid plans that also offer a Qualified Health Plan to [transition members no longer eligible for Medicaid to the exchange](#)

LONGER-TERM SOLUTIONS

- ★ Expand Medicaid across all 50 states to address the coverage gap
- ★ Pursue waivers that allow for continuous coverage (Sections 1115, 1331, 1332)
- ★ Pass a [state public health insurance option](#)
- ★ Transition to a [state-based health insurance marketplace](#), which allows states to establish more tailored approaches to how and when people can enroll in coverage and streamline eligibility and enrollment processes

Implications at the End of the PHE: Navigating Redetermination

- ★ States will have to undertake the critical task of handling redetermining eligibility for nearly every Medicaid enrollee and have to [make decisions](#) on how to distribute and prioritize redeterminations, how to update enrollee contact information, how to manage workforce capacity, how to partner with providers and community-based organizations to reach enrollees, and how to keep people connected to coverage
- ★ States will have to take thoughtful and intentional [steps to promote enrollment and retention](#), minimize the administrative burden for enrollees, and ensure that the redetermination process will not exacerbate disparities in coverage
 - 9.5% of Medicaid enrollees (or 8.2 million people) will [leave Medicaid due to loss of eligibility](#) and 7.9% (6.8 million people) will lose coverage due to administrative churning despite still being eligible
 - Eligibility loss will [disproportionately impact](#) children, young adults, and Latino and Black individuals, and two-thirds of the children predicted to lose Medicaid will be [children of color](#)
 - Individuals with [limited English proficiency](#) make up a disproportionate share of the Medicaid population, and are more likely to experience barriers when completing Medicaid renewal applications
- ★ States will have the opportunity to [learn from other states](#) and their approaches to redetermination, which may help develop longer-term enrollment improvements. Resources include:
 - USofCare and Softheon's presentation on ["What the public health emergency \(PHE\) unwinding means for people enrolled in Medicaid"](#), which discussed how Oregon, Massachusetts, and Rhode Island are approaching the PHE unwinding
 - Medicaid and CHIP Payment and Access Commission's (MACPAC) [September Public Meeting](#), which discussed how Arizona, Florida, and Pennsylvania are approaching the PHE unwinding

Federal Initiatives

- ★ CMS released a [State Health Official letter](#) providing guidance to states on the redetermination process and strategies for states to minimize beneficiary burden, promote continuity of coverage, and reduce churn
- ★ CMS created a list of [top ten fundamental actions](#) for states to complete to prepare for unwinding
- ★ HHS is investing \$98.9 million in [grant funding for navigator organizations](#) for the 2023 Open Enrollment Period to help people navigate enrollment through the Marketplace, Medicaid, and CHIP
- ★ CMS [proposed a rule](#) that would streamline Medicaid eligibility and enrollment and improve continuity of coverage

State Initiatives

- ★ States are utilizing [strategies to minimize administrative disenrollment](#) including:
 - Ex-parte renewals (42 states)
 - Follow up with enrollees for missing information when enrollees to avoid a loss of coverage (41 states)
 - Online accounts to submit and access information (48 states)
 - Data matches with the U.S. Postal Service and managed care organizations to update addresses (46 states)
- ★ Thirty-three states give Medicaid enrollees the option to choose to [receive their notices about their coverage electronically](#)
 - Montana: The [state sent text and email messages to enrollees](#) when it received returned mail asking for an updated mailing address and about 25% of enrollees who received a text message responded to update their mailing address
- ★ Some Medicaid agencies and marketplaces in states with SBMs are using [consistent communication and collaboration](#) to facilitate shifts to marketplace coverage
- ★ Several states have implemented [easy enrollment programs](#), including CO, MD, PA, and VA
- ★ States are [prioritizing outstanding eligibility using different approaches](#): population-based approach (11 states), time-based approach (8), hybrid approach (8)

Federal Policy Recommendations

IMMEDIATE PRIORITIES

- ★ The Federal Communications Commission should clarify its regulations related to the [Telephone Consumer Protection Act](#) to allow Medicaid agency contractors, like managed care organizations, to communicate with Medicaid enrollees about the upcoming Medicaid redetermination process
- ★ Increase funding to support improving enrollment processes, including funding for additional navigators and care coordinators to help people renew their Medicaid coverage and enroll in marketplace coverage

LONGER-TERM SOLUTIONS

- ★ Enact a [federal public health insurance option](#)
- ★ Support waivers that allow for continuous coverage (Sections 1115, 1331, 1332)
- ★ Offer a state plan amendment option for adult 12-month continuous eligibility
- ★ Provide states with funding to update eligibility and enrollment systems

State Policy Recommendations

IMMEDIATE PRIORITIES

- ★ Develop a [plan](#) to prioritize redeterminations, phase disenrollments, collect and monitor data, and pause and fix the process if too many people are losing coverage due to procedural reasons (and make the plan publicly available)
- ★ Start [communicating](#) with Medicaid enrollees now about the actions they need to take to retain Medicaid coverage, with a [plan to prioritize populations](#) most likely to face largest barriers in retaining coverage
- ★ Increase funding for navigators and care coordinators to help people renew Medicaid coverage and enroll in marketplace coverage
- ★ Establish outreach plans with key stakeholders and target populations with coverage disparities
- ★ Develop a communications toolkit with standardized messaging for stakeholders

LONGER-TERM SOLUTIONS

- ★ Implement [policies to reduce churn](#) and promote continuous coverage, like continuous and presumptive eligibility, ex-parte renewals, taking into account reasonably predictable changes in income, and easy enrollment

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The End of the COVID-19 Public Health Emergency: American Rescue Plan Subsidies

The American Rescue Plan Act (ARPA) allocated \$195.3 billion in recovery funds to states and D.C. to help with the pandemic's health, economic and fiscal impacts and contribute to recovery. State fiscal recovery funds (FRF) must be obligated by December 31, 2024 and spent by December 31, 2026.

The [Treasury Department's guidance](#) encouraged states to:



Focus on people
"most
disproportionately
impacted by the
pandemic"



Use the funds for a
strong, inclusive, and
equitable recovery



Reduce health
inequities across
racial and economic
groups

Impact

- ★ State FRF provided states the flexibility to use the funds to address pandemic-related budget gaps and help people hit hardest
- ★ States have disbursed about [\\$148 billion](#) of the \$195.3 billion allocated*
- ★ [10% of all state FRF funding](#) have been allocated to health and the public health response, and 46 states have allocated their FRF for these purposes*
- ★ ARPA provided an infusion of funding to states ([4.9%-22.7% of state budgets in FY20](#)) and allowed states to jumpstart long-term investments in health

*As of September 2, 2022

Implications When State FRF are Obligated and Spent

- ★ States have an opportunity to allocate [remaining state FRF funds to sustainable programs](#) that improve health care coverage, make coverage more affordable, and advance health equity
- ★ States that do not allocate resources to programs to help communities that were hardest hit by the pandemic may exacerbate health disparities
- ★ States that allocated funding on projects with one-time costs will have to figure out ways to maintain the projects when FRF run out



1 in 4 adults are skipping care or medicine due to rising costs, and nearly half of adults in lower-income households are doing so.

Source: [West Health and Gallup Study, 2022](#)



Initiatives

State Initiatives that Made Care More Affordable

- ★ Maine: \$39 million for the [Small Business Health Insurance Premium Relief Program](#) to provide premium payment relief to small businesses that provide their employees with group health insurance
- ★ Mississippi: \$60 million to [defray increases in state and school employee health insurance costs](#)
- ★ Washington: \$35 million for health care services for [uninsured and underinsured individuals under 200% federal poverty level, regardless of immigration status](#)

State Initiatives that Made Care More Personalized

- ★ California: \$597.55 million to [Mental Health Services Oversight and Accountability Commission](#) for partnerships between counties and schools, and to develop and expand evidence-based behavioral health programs
- ★ Colorado: \$550 million to create a [behavioral and mental health cash fund](#), of which \$31.75 million has gone to the [Primary Care and Behavioral Health Statewide Integration Grant Program](#) for the implementation of evidence-based clinical integration care models
- ★ Maine: \$4.5 million to establish the [Family Caregiver Grant Pilot Program](#) to increase the number of families served by the Respite Care Fund and provide eligible family caregivers up to \$2,000 a year if they are not otherwise receiving payment for caregiving services



Recommendations

Federal and State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Continue to center people and apply an equity lens to economic recovery programs using resources like PolicyLink's [American Rescue Plan Act: Centering Equity and Impacted Communities](#) and The Century Foundation's [Health Coverage Equity Framework](#)
- ★ Develop sustainable funding streams for initiatives that used ARPA funds

LONGER-TERM SOLUTIONS

- ★ Invest in health care programs that improve affordability and outcomes, and advance health equity
- ★ Strategically disseminate funding announcements to ensure groups representing and serving low-income communities of color and difficult to reach communities are aware of funding opportunities

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December 2022



The End of the COVID-19 Public Health Emergency: Broadband Investments

The COVID-19 pandemic highlighted the need for broadband to connect people to health care services, the classroom, and each other, and accelerated investments in broadband infrastructure. Broadband access has been a means to connect people to health care providers and address distance and transportation barriers. Unequal access to broadband can impede access to health care, especially virtual care. Some of the policies implemented to increase broadband availability during the pandemic include:

- ★ American Rescue Plan Act (ARPA) state funds, which were used to make improvements to broadband infrastructure
- ★ Subsidies for broadband access like the [Emergency Broadband Benefit Program \(EBB\)](#)

Impact

- ★ States have [disbursed about \\$148 billion](#) of the \$193.5 billion allocated for state Fiscal Recovery Funds (FRF), 5.7% of all state FRF funding have been [allocated towards broadband](#), and 31 states have allocated their FRF for these purposes*
- ★ [Nine million households were enrolled](#) in the EBB Program when it ended on December 31, 2021
- ★ Households in some [tribal areas enrolled in the EBB program in relatively large numbers](#)

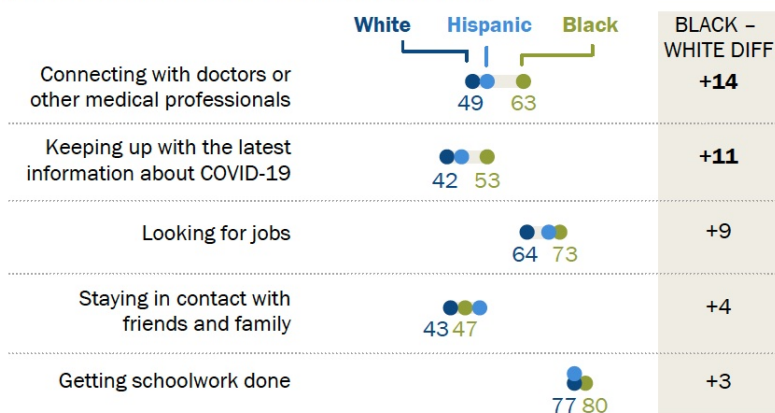
*As of September 2, 2022

Implications of the Digital Divide

- ★ Sixty-three percent of Black adults report that not having high-speed Internet access at home is a [major disadvantage in connecting with doctors or other medical professionals](#) during the COVID-19 pandemic, compared to 49 percent of white adults
- ★ [Black adults and Hispanic/Latino adults](#) are less likely to have broadband service at home compared to white adults
- ★ Only about [half of adults making less than \\$30,000](#) have broadband access at home
- ★ Seventy-two percent of rural residents have [broadband access at home](#) compared to 77% of urban residents and 79% of suburban residents
- ★ Sixty percent of [health care facilities outside of metro areas](#) lack broadband access

Black adults more likely than White adults to say lack of high-speed home Internet is major disadvantage in connecting with doctors, keeping up with COVID-19

% of U.S. adults who say that people who do NOT have high-speed internet access at home are **at a major disadvantage** during the COVID-19 pandemic when it comes to each of the following



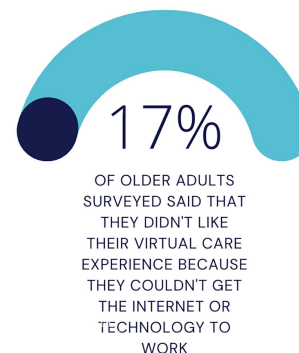
Note: Statistically significant differences are in bold. White and Black adults include those who report being only one race and are not Hispanic. Hispanics are of any race. Respondents who did not give an answer or who gave other responses are not shown.

Source: Survey of U.S. adults conducted Jan. 25–Feb. 8, 2021.

PEW RESEARCH CENTER

“Tablets, computers, internet, anything like that you can forget that. Most of the people don’t have it, and the only way the ones that do have it is through their kids.”

-Focus group participant, South Carolina



Source: [United States of Care and West Health, Older Adults' Experiences with Virtual Care Two Years Into the Pandemic](#)



Initiatives

Federal Initiatives

- ★ [The Infrastructure Investment and Jobs Act](#) (signed November 15, 2021), or Bipartisan Infrastructure Law, provided \$14.2 billion to extend the EBB program to a longer-term broadband affordability program called the [Affordable Connectivity Program](#) (ACP)*

*There are differences in eligibility and benefits between the EBB and ACP.

State Initiatives

- ★ Georgia: \$408 million in grants to [expand broadband access](#) (using state FRF)
- ★ Florida: \$400 million to Department of Economic Opportunity to [expand broadband to unserved areas](#) (using state FRF)
- ★ New Jersey: Launched [NJHealthConnect @ Your Library](#), a statewide telehealth program (using state FRF)
- ★ California: \$6 billion in a [statewide broadband plan](#) to bridge the digital divide, with \$2 million in direct funding for last-mile network construction in rural and urban areas that prioritizes unserved and underserved residents
- ★ Delaware: Launched [Telehealth Kiosk and Device Lending Initiative](#) at local libraries to increase access to health and social services



Recommendations

Federal Policy Recommendations

IMMEDIATE PRIORITIES

- ★ Work with community-based organizations (CBOs) to boost awareness of broadband programs like the [ACP](#) and [Lifeline](#) broadband program

LONGER-TERM SOLUTIONS

- ★ Provide funding for states to expand broadband access

State Policy Recommendations

IMMEDIATE PRIORITIES

- ★ Work with CBOs to boost awareness of broadband programs like the [ACP](#) and [Lifeline](#) broadband program
- ★ Allocate ARPA state funds to expand broadband access in unserved and underserved areas (ARPA funds must be obligated by December 31, 2024 and spent by December 31, 2026)
- ★ Cover audio-only health services so people without broadband can access the health care services they need

LONGER-TERM SOLUTIONS

- ★ Provide funding to anchor institutions like libraries and schools that provide broadband access to people

“The only problem that I didn’t like about [virtual care] is because the internet service... all of a sudden it go out, then we have to keep calling each other back. That’s the only thing I didn’t like about virtual. You gotta have a good internet.”

- Focus group participant, South Carolina

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December 2022



The End of the COVID-19 Public Health Emergency: American Rescue Plan Act Enhanced Subsidies



The [American Rescue Plan Act](#) (ARPA) (signed March 11, 2021) increased financial assistance to people buying health insurance coverage on the marketplace by:

- ★ Providing people with income up to 150% federal poverty level (FPL)** with silver plans for zero premium and reduced deductibles
- ★ Increasing premium subsidies for people at every income level up to 400% FPL
- ★ Capping the premium amount to 8.5% of household income towards the benchmark plan for people with income above 400% FPL

The ARPA enhanced premium subsidies were set to expire at the end of 2022.*

ARPA Enhanced Subsidies: Impact

- ★ A record high of [14.5 million people](#) enrolled in the marketplace in 2022, a 21% increase from 2021
- ★ ARPA subsidies [increased access to zero-premium plans on healthcare.gov](#) from 43% to 62% of uninsured non-elderly adults, and access to low-cost plans (<\$50 month in premium) increased from 57% to 73% of consumers
- ★ ARPA subsidies are [critical for middle-income people](#), including older adults (ages 50-64) and people living in rural areas often experience higher premiums
- ★ Uninsured people who are newly eligible for assistance [tend to be young adults, people without college educations, Hispanic/Latino, and non-native English speakers](#)
- ★ [360,000 uninsured Black individuals](#) are predicted to be newly eligible to save money on health care coverage and 328,000 are predicted to be eligible for zero-dollar benchmark Marketplace plans with the passage of ARPA

Inflation Reduction Act: Impact

The [passage of the Inflation Reduction Act \(IRA\)](#) in August 2022 extended the premium subsidies for three years through 2025, among other things. As a result of IRA:

- ★ Over 3.0 million people who would have become uninsured will get to keep their health care coverage
- ★ Millions of people will have access to more affordable marketplace plans

If the ARPA subsidies were allowed to expire at the end of 2022:

- ★ People would have faced a [median proposed premium increase of 10% in 2023](#), with health insurers in 13 states and D.C. proposing premium increases of 5-14%
- ★ People buying coverage from healthcare.gov would have faced an [average 53% increase in health insurance premiums](#), with average costs per person increasing from \$2,261 to \$3,460 in people state-based marketplaces
- ★ An [estimated 3.0 million people](#) would have become uninsured, 8.9 million would have seen reduced premium subsidies, and 1.5 million would have lost their subsidies entirely but remain insured
- ★ [Non-Hispanic Black individuals, young adults, and people with incomes between 138-400% FPL](#) would have experienced the largest coverage losses
- ★ An [additional 850,000 women of reproductive age](#) would have become uninsured

“ They [health care providers] bill for the hospital physician, bill for the bed, bill for the drugs they gave you, and bill for the IV they gave you. They even bill for the man who drove you down the hall and the person that spoke to you in the hallway. It’s ridiculous.”

- Focus group participant, South Carolina

*Although the premium subsidies were set to expire at the end of 2022, the Inflation Reduction Act (IRA) extended the subsidies for another three years. [More information here.](#)

**150% FPL is \$20,385 for a household size of one and \$41,625 for a household size of four; and 400% FPL is \$54,360 for a household size of one and \$111,000 for a household size of four, as of January 12, 2022. [More information here.](#)



Initiatives

Federal Initiatives

- ★ The [passage of IRA](#) extended the ARPA enhanced premium subsidies for three years into 2025
- ★ [Special enrollment period in response to COVID-19](#) to allow people to sign up for health insurance coverage amid uncertainty and exceptional circumstances

State Initiatives

- ★ Several states, including CA, CO, CT, MA, MD, NJ, NM, and VT, have [state marketplace subsidies](#) to help with premiums and cost-sharing
- ★ New Mexico: \$28 million for [premium and cost-sharing reductions](#) for New Mexico health insurance exchange enrollees and Medicaid transition premium buy-downs for exchange eligible consumers
- ★ California: \$333.4 million for the purpose of [health care affordability programs](#) operated by its Exchange, and requires the Exchange to develop options for providing cost sharing reduction subsidies for low- and middle-income Californians



Recommendations

Federal Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Increase funding for outreach and enrollment assistance for consumers, with strategic outreach into communities that newly received coverage and/or have historically experienced barriers to seeking coverage

LONG TERM SOLUTIONS

- ★ Extend the enhanced premium subsidies on a permanent basis

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Increase funding for outreach and enrollment assistance for consumers, with strategic outreach into communities that newly received coverage and/or have historically experienced barriers to seeking coverage

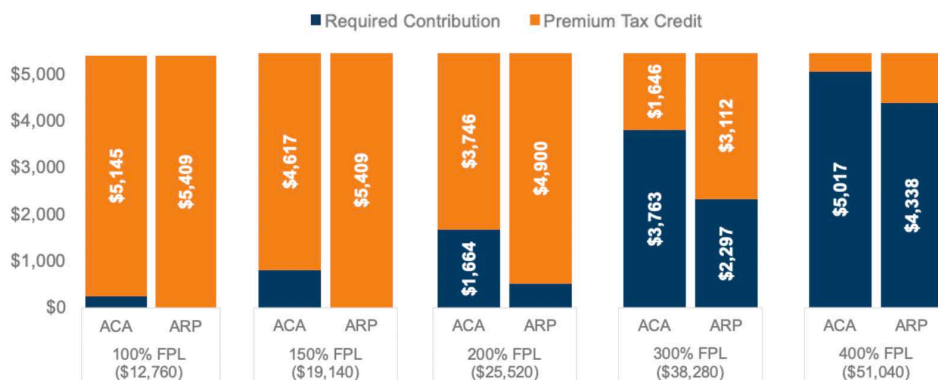
LONG TERM SOLUTIONS

- ★ Provide [state-based subsidies \(premiums, cost-sharing\)](#) to provide individuals with affordable coverage options, including individuals currently ineligible for existing federally-funded subsidies (e.g. individuals without documentation)
- ★ Establish [regulatory interventions to control costs](#), like cost-growth benchmarks

“My job was a casualty of COVID. I may have gotten caught in a life-threatening situation if I didn't know that life changes such as layoffs (and losing your employer-sponsored health insurance) allow you to get coverage outside of open enrollment windows. I can probably do without doctor visits and labs for a while, but I can go maybe a month without insurance for my RXs, and that's if and only if my automatic 90-day renewals are aligned. If not, I'm stuck. And probably close to bankrupt.”

- Claire Sachs,
Voices of Real Life Council Member

Average Annual Benchmark Premium (\$5,409) Contribution and Tax Credit for a 40-year-old in 2021 Under ACA and ARP



Source: KFF, "Health Insurance Marketplace Calculator." Mar 10, 2021.

KFF

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December 2022

The End of the Public Health Emergency: Postpartum Medicaid Extension Option

The American Rescue Plan Act (signed March 11, 2021) gave states the option of extending their Medicaid postpartum coverage from 60 days to 12 months by filing a State Plan Amendment (SPA) to their Medicaid program.* States that use the new SPA option must provide full Medicaid benefits** during pregnancy and the postpartum period. The option is effective April 1, 2022 and available to states for five years until March 31, 2027, when the statutory authority expires.



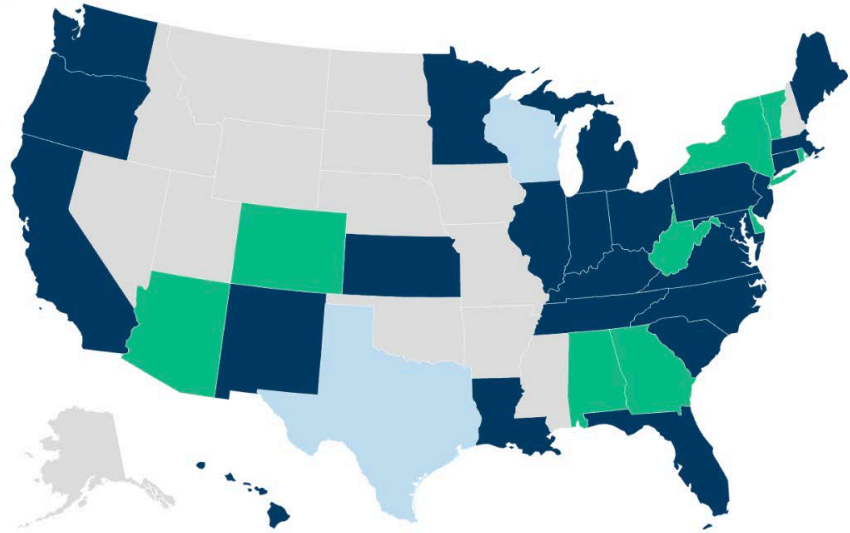
Provide better maternal and newborn care: 75% support

75% of people surveyed support policies that "provide better maternal and newborn care by expanding postpartum in-home visits by nurses who can connect families with additional resources, and increasing coverage for the different ways people give birth." This is supported by 85% of Democrats, 69% of Independents, and 66% of Republicans.

Source: [United States of Care National Survey, 2021](#)

Postpartum Coverage Tracker Map

- 12-month extension implemented (26 states including DC)
- Planning to implement a 12-month extension (8 states)
- Limited coverage extension proposed (2 states)



SOURCE: Data KFF analysis of approved and pending 1115 waivers, state plan amendments, and state legislation, as of October 6, 2022 • PNG

KFF

Impact

- ★ Twenty-six states and D.C. have successfully [extended postpartum Medicaid to one year](#), and eight states are planning to implement a one year postpartum extension (as of October 2022)
- ★ Extending postpartum Medicaid eligibility to one year is associated with additional months of postpartum insurance enrollment and [an increase in probability of continuous insurance coverage during the first year after birth](#)
- ★ Pregnancy-related mortality disproportionately impact [non-Hispanic Black birthing people and non-Hispanic American Indian/Alaskan Native birthing people](#), and continuity of coverage can improve access to care and narrow these disparate health outcome
- ★ If all states extended pregnancy-related Medicaid eligibility to one year postpartum, 720,000 people would [experience expanded postpartum coverage annually](#)

Implications if States do not take the Medicaid Postpartum Extension Option

- ★ Birthing and pregnant people in states that have not extended their postpartum Medicaid program will only have **Medicaid coverage connected to their pregnancy** for the federally mandated 60 days after birth, and these states will not capture reductions in maternal and infant mortality or reductions in racial health inequities
- ★ In states that do not extend postpartum Medicaid, disruptions in perinatal insurance coverage will continue to disproportionately impact [indigenous, Hispanic/Latino, and Black birthing people](#) and [low income families](#) (100-185% federal poverty level)

*States have previously [expanded their postpartum coverage beyond the 60 days using waivers](#). A SPA option allows states to expand coverage more quickly and without a budget neutrality requirement.

**Currently, states are allowed to cover a more narrow set of pregnancy-related benefits to people qualifying for Medicaid through the pregnancy pathway.



Initiatives

Federal Initiatives

- ★ The [Build Back Better Act](#), which passed the House of Representatives on November 19, 2021, would have required all states to extend Medicaid Postpartum Coverage to 12 months permanently
- ★ The Department of Health and Human Services (HHS) allocated [\\$350 million in awards to states](#) in September 2021 to expand home visiting services, support the Healthy Start initiative, increase the availability of community-based doulas, and improve data reporting on maternal mortality
- ★ The White House released a [Blueprint for Addressing the Maternal Health Crisis](#) with actions for different agencies in July 2022
- ★ The Centers for Medicare & Medicaid Services released its [Maternity Care Action Plan](#) in July 2022 to improve health outcomes and reduce inequities for people during pregnancy, childbirth, and the postpartum period

State Initiatives

- ★ Twenty-six states and D.C. have successfully extended postpartum Medicaid to one year, and eight states are planning to implement a one year postpartum extension (as of October 2022)
- ★ Several states have passed [bills to expand coverage and improve maternal and child health outcomes](#) (beyond the one year postpartum option), including:
 - California: The state passed the [California Momnibus Act](#) which aims to close existing racial gaps in maternal and infant mortality rates through research and data collection, a stakeholder work group to implement the new Medi-Cal doula benefit, among others
 - Colorado: The state passed [Cover All Coloradans](#), which included the expansion of full health coverage for pregnant people who would otherwise be eligible for Medicaid and CHIP if not for their immigration status, and continues coverage through 12 months postpartum



Recommendations

Federal Policy Recommendations

LONGER-TERM SOLUTIONS

- ★ Reauthorize the statutory authority for the SPA option extending postpartum Medicaid to one year before it expires in 2027
- ★ Require states to provide one-year of postpartum coverage in Medicaid with full benefits and provide an enhanced federal medical assistance percentage (FMAP) to states
- ★ Continue investments in programs that improve maternal health outcomes

State Policy Recommendations

IMMEDIATE OPPORTUNITIES

- ★ Adopt a SPA to extend postpartum Medicaid to one year

LONGER-TERM SOLUTIONS

- ★ Protect coverage for pregnant and postpartum people through [strategies](#) including:
 - Expand Medicaid
 - Evaluate and expand current income eligibility levels beyond the federally-required minimum (138% Federal Poverty Level (FPL)) for the pregnancy eligibility group
 - Expand pregnant and postpartum coverage to immigrant populations
- ★ Adopt [initiatives that improve maternal health outcomes](#), including covering and reimbursing different provider types (like doulas and midwives), increasing alternative sites for birthing (like at-home births and alternative birth centers), and increasing care coordination for birthing people

“It’s important and a great idea to provide additional support to families with newborns, and letting mothers have the freedom they deserve. Everyone should be able to have the opportunity to build a family.”

–[ReMesh](#) research participant on providing better maternal and newborn care. Male. 18-34. Democrat. Graduate or advance degree. White.

UNITED STATES OF CARE

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

This one-pager is part of USofCare's playbook, "The End of the COVID-19 Public Health Emergency: Lessons Learned from the Pandemic and Implications for People."

December 2022



The End of the COVID-19 Public Health Emergency: Lessons Learned from the Pandemic and Implications for People

Playbook for Federal and State Policymakers

CONCLUSION

The eventual end of the COVID-19 PHE will be disruptive to the health care system and challenging for people. Without policy protections and guardrails, many people may lose health care coverage, disproportionately impacting people of color and exacerbating existing racial health inequities. Additionally, people may lose the flexibility to get the health care services how and when they need it – including access to virtual care and telehealth, adding unnecessary roadblocks to provider visits.

However, this moment also provides a unique opportunity to improve the health care system. **The pandemic provided many lessons, and shows that carefully-crafted and intentional policies can help address health disparities and create a more flexible system that better meets people’s needs.** The flexibilities created during the pandemic were incredibly far-reaching, and touched people’s health care experiences in different ways. Federal and state policymakers must center people and health equity in planning for the end of the PHE, while prioritizing permanent policies and programs that improve health care coverage and access.

We cannot end this playbook without acknowledging how horrible this deadly pandemic was. More than one million people have died from COVID-19, workers and communities are facing significant economic hardship, students are falling behind academically and face widened opportunity and achievement gaps, and more. We also cannot “return to normal.” “Normal” before the pandemic is not good enough. The U.S. is still experiencing a [maternal health crisis](#), with significant disparities in outcomes by race, ethnicity, and socioeconomic status. Informal caregivers [experience many different challenges](#) depending on their race and ethnicity, geographic location, socioeconomic status, and type of caregiving. There are [huge gaps in data collection and reporting](#) that prevent health care stakeholders from identifying and addressing disparities. There remains many opportunities to [address unmet social needs](#) in health care. As United States of Care works to support policymakers, it is committed to building an equitable health care system that works for everyone.

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“There can be real opportunities [but I am] worried that the health equity attention will fade. Health equity needs to be mainstream.”

- Andrew Dreyfus, member of United States of Care network