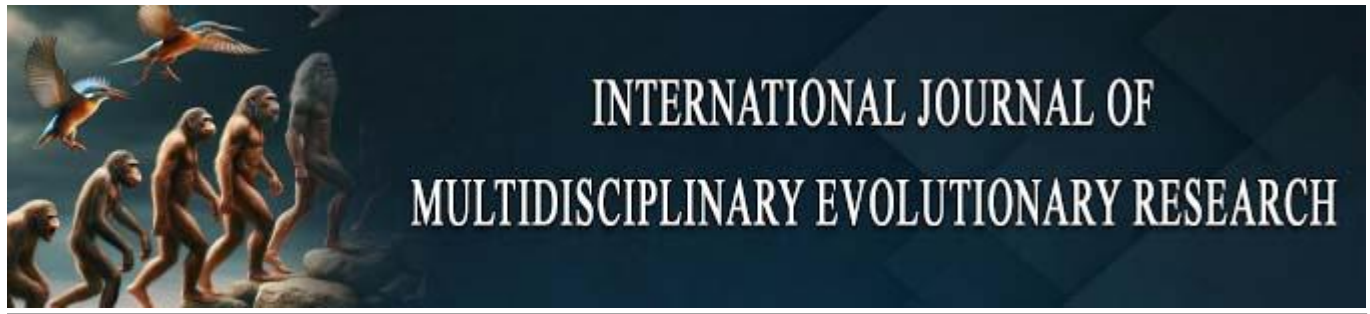




Data-Driven Assessment of Health Policy Impacts on Healthcare Costs and access among Vulnerable U.S. Populations

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Abstract

Within the past 3 years, several federal policies have reshaped how low-income and vulnerable Americans get and pay for healthcare. These policies include Medicaid protections, emergency telehealth waivers, and expanded Affordable Care Act (ACA) marketplace subsidies under the American Rescue Plan Act. This paper reviews the most current national data available 3 years post-COVID-19 pandemic, including the National Health Interview Survey, KFF's 2022 surveys on employer coverage and medical debt, peer-reviewed clinical and economic outcomes research by The Lancet Public Health and JAMA, and the Census Bureau's 2022 healthcare insurance release, to inquire and investigate whether the policies were actually effective and for whom. By the end of 2021, the uninsured rate declined to 8.8% from 10.3% in 2020, and the report showed the largest coverage gains among Latino and Black adults as well as people below 200% of the federal poverty line. Enrollment in Affordable Care Act (ACA) related coverage exceeded 35 million people by early 2022, a record high. This coverage gain was linked to a measurable reduction in all-cause mortality in a national cohort study, rather than a mere change in insurance status. Similarly, nearly 100 million Americans, including more than half of adults in households earning below \$40,000 a year, still carry dental or medical debt, a finding corroborated by independent credit-bureau research showing up to \$140 billion in medical debt in collections across the U.S., and removing geographic telehealth restrictions has helped many rural patients despite leaving device and broadband gaps unaddressed. It concludes that the targeted coverage policy has provided real, measurable gains for vulnerable U.S. populations. Meanwhile, coverage alone has not solved the deeper challenges of unaffordable care, and majority of recent progress relies on temporary provisions that will not last.

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1. Introduction

Health policy in the United States infrequently moves in a clear direction. For example, a law expands health policy coverage for a group while maintaining costs for another. Similarly, an emergency measure is so effective that people begin to ask why it was transient (Andersen, Rice, & Kominski, 2011; Jacobs & Skocpol, 2015) ^[2, 18]. In the last three years, the U.S. has produced a dense cluster of these policies, and nearly all are linked to the COVID-19 pandemic (Bergquist, Otten, & Sarich, 2020; Skinner *et al.*, 2022) ^[3, 31]. These include the Families First Coronavirus Response Act's continuous Medicaid enrolment requirement, barring states from disenrolling people during the public health emergency (Sugar *et al.*, 2021) ^[34]; the American Rescue Plan Act's enhanced ACA marketplace subsidies, lowering premiums for millions of families in the country; and multiple Medicare and Medicaid telehealth waivers that temporarily eliminated multi-year restrictions on how and where care could be delivered (Schpero & Ndumele, 2022) ^[29].

This article investigates whether the policies truly moved the needle for the individuals and groups who tend to need the most help - people with low incomes, rural residents, people of colour, and people already carrying medical debt.

2. Data Sources and Method

This review is a narrative statistical assessment drawing on the recent nationally representative data, namely;

- A. The U.S. Census Bureau's Current Population Survey Annual Social and Economic Supplement, which covers calendar year 2021 health insurance coverage and figures from the 2022 American Community Survey (Keisler-Starkey & Bunch, 2020) ^[20].
- B. The National Health Interview Survey (NHIS), analyzed by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) in a 2022 issue brief on coverage trends through the fourth quarter of 2021 (Chu *et al.*, 2022; Lee *et al.*, 2022) ^[10, 25].
- C. Kaiser Family Foundation's (KFF) 2022 ^[21] Employer Health Benefits Survey, an annual survey of more than 2,100 employers on deductibles, premiums, and cost-sharing (Claxton *et al.*, 2021; KFF, 2022a; Zhang & Yu, 2022) ^[11, 21, 36].
- D. The Kaiser Family Foundation (KFF) Health Care Debt Survey, which is a nationally representative poll of U.S. adults on medical and dental debt, published in partnership with KFF Health News and NPR, with supporting analysis from the Urban Institute using credit bureau data (KFF, 2022b; Kluender *et al.*, 2021; Stephenson, 2022) ^[22, 24, 33].
- E. Peer-reviewed and federal analyses of Medicare

telehealth utilization during the pandemic, including Centers for Medicare & Medicaid Services (CMS) claims data (Brotman & Kotloff, 2021) ^[5] on the shift from under 1% of Medicare services delivered by telehealth before the COVID-19 pandemic in 2020.

Each source listed above captures a unique piece of the picture: NHIS and Census data measure the individuals and groups who have coverage; KFF's employer survey measures the cost of the coverage; the medical debt survey measures the consequence of gaps in coverage and cost; and the telehealth utilization data measures whether a particular pandemic-era access policy reached the populations it was designed for. Collectively, they foster policy assessment along the coverage, affordability, and access tracks.

3. Results

3.1. Coverage

Results showed that coverage produced a real and measurable gain. It is also concentrated among groups. This represents the clearest success story, where the analysis of the NHIS data by ASPE reported that the uninsured rate for the U.S. population declined from 10.3% in the 2020 4th quarter to 8.8% in the 2021 4th quarter – representing a 1.5% drop that reflects up to 4.9 million people gaining health coverage within a single year [See Figure 1]. In early 2022, enrolment in ACA-based coverage, such as the Basic Health Program, Medicaid expansion, and the ACA marketplace plans, had reached a record high of more than 35 million Americans (Chu *et al.*, 2022) ^[10].

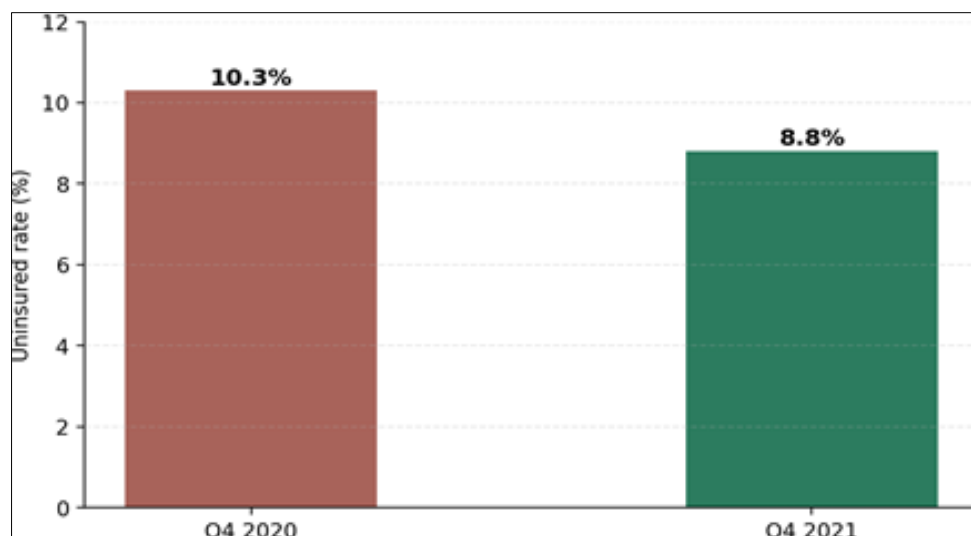


Fig 1: U.S. uninsured rate [Q4 2020 and Q4 2021] [Adapted from ASPE Issue Brief].

Figure 1 above shows a non-uniform gain, demonstrating that individuals with incomes below 200% of the federal poverty level experienced larger declines in uninsurance than higher-income households, and that coverage gains spanned racial and ethnic groups tracked, although they were largest where

the starting gap was largest (Chu *et al.*, 2022) ^[10]. The uninsured rate declined by 3.5% among Latino adults, 1.8% among Black adults, and 0.5% among White adults between 2020 and 2021.

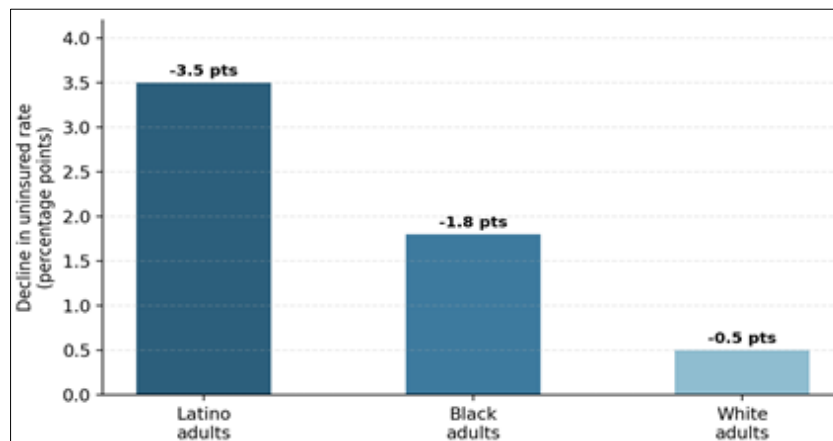


Fig 2: Decline in uninsured rate by ethnicity and race [Second half 2020 – Second half 2021]

Three policies collectively explain this pattern: the American Rescue Plan Act's temporary boost to ACA marketplace subsidies, making mid-tier plans free or near-free for numerous lower-income enrollees; new state adoptions of ACA Medicaid expansion; and the Medicaid continuous enrolment requirement, which stopped states from removing people from the rolls during the public health emergency, irrespective of small changes in paperwork lapses or income that would have warranted disenrollment (Buettgens & Green 2021) [6].

This survey-based coverage report is consolidated by peer-reviewed clinical outcomes research using a different methodology. A national observational cohort study published in *The Lancet Public Health* followed mortality trends across all fifty states and found a relationship between Medicaid expansion and a statistically significant reduction in all-cause mortality, which persisted through the follow-up period. However, the effect's magnitude varied by state characteristics, including the size of the pre-expansion uninsured population (Lee, Dodge, & Terrault, 2022) [26]. This suggests that coverage gains documented by the NHIS and Census were not just a change in insurance, but are associated with substantial survival benefits for the low-income populations the expansion was designed to reach.

3.2. Affordability

On affordability, analyses show that coverage gains have not precisely led to financial relief. In other words, having insurance and being able to afford care are different things

(Call *et al.*, 2021) [8]. According to the KFF's 2022 [21] Employer Health Benefits Survey, the average annual premium for family coverage accrued up to \$22,463, but was up 20% over the preceding five years and 43% over the preceding ten years (Keisler-Starkey & Bunch, 2020; Yagi *et al.*, 2022) [20, 35]. Essentially, deductibles are a persistent burden, as 88% of workers with single coverage face an average annual deductible of \$1,763, and workers at small firms face steeper out-of-pocket exposure than workers at large firms (Hart, 2019) [16], with an average deductible of \$2,543 versus \$1,493 respectively.

The medical debt scale remains the most critical evidence that coverage has not resolved affordability. The KFF Health Care Debt Survey found that more than half of adults in the U.S. report having gone into debt because of a dental or medical bill at some point within the past five years, and that this burden falls steeply along income lines (Ahmadi *et al.*, 2022; Himmelstein *et al.*, 2022) [1, 17]. Specifically, 57% of adults in households earning below \$40,000 per annum currently carry dental or medical debt, compared with 26% of adults in households earning \$90,000 or above. Meanwhile, this debt is unevenly distributed across race or geography. According to a companion Urban Institute analysis of demographic data and credit bureau data, the debt is rather concentrated in the southern U.S. and among Black communities (Braga, McKernan, & Quakenbush, 2019) [4]. This pattern is linked to lower rates of employer coverage, higher chronic illness rates, and the fact that many southern states are yet to adopt the ACA's Medicaid expansion.

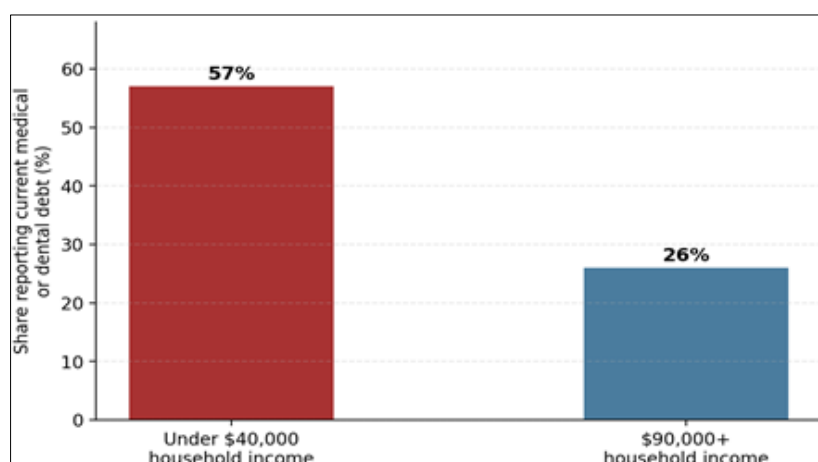


Fig 3: Share of U.S. adults reporting current medical or dental debt [by household income] [Adapted from KFF Health care Debt Survey (KFF, 2022b) [22]]

The financial burden is directly linked to forgone care. Specifically, 51% of adults currently carrying dental or medical debt implied that cost has been the major factor in why they could not get a treatment or test recommended by a doctor (Crowley *et al.*, 2020) ^[12]. This forms the basis of the affordability challenge: expanding coverage for an individual or group does not prevent people from skipping care they cannot afford, particularly if the underlying care cost, via deductibles, premiums, and cost-sharing, remains persistently high (Sommers *et al.*, 2015) ^[32]. Analysis of a nationally representative sample of credit bureau records, a study published in JAMA, estimated that Americans held up to \$140 billion in medical debt in collections as of June 2020. Therefore, this debt was disproportionately distributed in Southern states and others that had not adopted the ACA's Medicaid expansion (Kluender *et al.*, 2021) ^[24]. Likewise, the authors argued that medical debt should be treated as a social health determinant, distinct from employment or income status because it is rarely voluntary, while following directly from an accident, a medical emergency, or a new chronic disease diagnosis instead of ordinary consumer spending (Mendes de Leon & Griggs, 2021) ^[27]. Elsewhere, drawing on a survey of more than 140,000 U.S. adults, acquiring medical debt was a predictor of subsequent declines in other health determinants, including 1.7 times to 3.1 times higher risk of worsening food and housing insecurity among those who took on medical debt (Himmelstein *et al.*, 2022) ^[17].

3.3. Access

Telehealth is another important policy track in this review. Pre-pandemic, telehealth made up less than 1% of all Medicare services (Juie *et al.*, 2021) ^[19]. However, upon the issuance of emergency waivers that removed geographic and originating site restrictions, rules that had previously limited telehealth reimbursement mostly to rural patients traveling to a qualifying rural facility, utilization increased to more than 32% of Medicare claims in April 2020 and eventually settled to a range of 13% to 17% by mid-2021. In the first year of the pandemic, 44% of continuously enrolled Medicare fee-for-service beneficiaries had a minimum of one telehealth visit, making up millions of visits U.S.-wide (Brotman & Kotloff, 2021) ^[5].

For rural and underserved communities, there is emphasis on the geographic-restriction requirement, being the single most important change. This was because, previously, only rural patients were eligible for telehealth reimbursement if they physically travelled to a qualifying clinic to receive it (Hamadi *et al.*, 2022) ^[15]. By removing that requirement, people received telehealth visits from home - a different and more accessible policy than allowing rural clinics to provide telehealth on-site.

Despite this, researchers investigating Medicare beneficiaries during the period identified a consistent list of barriers that the waivers did not affect, including older age, technology and internet access, rural location, and lower income, which all continued to predict who could and could not use the newly available telehealth option (Edmiston & AlZuBi, 2022; Samson *et al.*, 2021) ^[13, 28]. This implies that the policy successfully removed a legal and reimbursement barrier. However, they failed to provide the broadband connection, digital literacy, or device needed by a patient to use the benefit.

3.4. The Significance of State Policy Choices

Federal policy explains the coverage evidence, but state-level choices profoundly explain other coverage. In early 2022, 38 U.S. states and the District of Columbia had adopted the ACA's Medicaid expansion, while 12 states had not (KFF, 2022c) ^[23]. National Health Statistics Report No. 176 reported that the gap between the two groups of states is large and extensively documented. Essentially, among adults under age 65, people in non-expansion states were nearly twice as likely to be uninsured as those in expansion states (Finegold *et al.*, 2021) ^[14], at a 19.1% versus 9.4% ratio.

The national average, however, masks sharper state-level differences. The CDC analysis found uninsured rates among adults under 65 as high as 29.4% in Texas and 19.2% in Georgia, which are both non-expansion states as of then, compared with low rates (3.0% and 6.1%) in Massachusetts and Michigan, respectively, which are both expansion states (CDC, 2022). According to Buettgens, Banthin, & Green (2022) ^[7], a separate Urban Institute microsimulation estimated that 3.7 million currently uninsured people in the states would gain coverage if the remaining non-expansion states adopted ACA's Medicaid expansion.

By Q1 2022, NHIS data analyzed by ASPE reported that these combined policies at the federal and state levels had led to the increase in the national uninsured rate to an all-time low of 8.0%. This demonstrates a consistent theme across the sources reviewed: federal subsidy and enrolment-protection policy set a nationwide floor, while a state's Medicaid expansion decision is the single largest lever for determining whether a low-income resident of the state has coverage.

4. Discussion

Collectively, the data indicate that coverage policy was effective, while few attempts on cost policy, and access policy worked partially. The 1.5% drop in the uninsured rate over a year, with the largest gains concentrated among Latino and Black adults and lower-income households, is a real achievement, supporting health economists' prediction on stacking three coverage-expanding policies, namely new Medicaid expansions, enhanced subsidies, and continuous enrolment protections on top of each other simultaneously. Meanwhile, the medical debt numbers are pointers to the fact that coverage was not the only challenge. A household earning less than \$40,000 a year is more than twice as likely to incur debt as one earning \$90,000 or more. This gap exists within a system where many Americans have some type of insurance. Hence, the next constraint on access for vulnerable populations is not whether an individual has a card in their wallet, but what the card covers once a copay, deductible, or coinsurance requirement is applied. The major federal policies reviewed in this paper were, however, not designed primarily to reduce the cost of care, but to lower costs or expand access and coverage availability.

Moreover, the findings on telehealth carry a similar lesson. Eliminating a regulatory barrier is requisite but not adequate. CMS's decision to waive geographic restrictions was an ambiguous improvement for rural patients who had previously been excluded from home-based telehealth by rule (Schwamm *et al.*, 2017) ^[30]. The same research consistently finds that device ownership, broadband access, and digital literacy are yet unaddressed, and the barriers are along the same lines of income, rurality, and age that the policy was designed to

support. This implies that a change in rule can be partially effective.

Finally, many of the gains documented in this paper depend on temporary legal provisions. The Medicaid continuous enrollment requirement was linked to the COVID-19 public health emergency, and the enhanced ACA marketplace subsidies from the American Rescue Plan Act were set to expire by the end of 2022, in the absence of additional congressional action. Therefore, the impact of these policies should be assessed as a system snapshot in the emergency-era rules, rather than a description of a permanent policy environment.

5. Limitations

This review is limited by its focus on and use of survey and administrative data rather than a unified dataset. Definitions of income, race, ethnicity, or insurance status vary across the NHIS, Census, CMS, and KFF sources. Coverage estimates for 2022 were partially released or at the preliminary stage, and the full-year 2022 insurance figures were not available at the time. The KFF debt and employer surveys are subject to the usual survey research limitations, including non-response and recall bias. Finally, since most of the policies reviewed were enacted in direct response to the COVID-19 pandemic, it remains uncertain how much of the coverage gain will remain once emergency provisions expire and states bring back standard Medicaid eligibility redeterminations.

6. Conclusion

In conclusion, the federal response policy to the pandemic generated one of the largest and fastest coverage gains in recent history in the U.S., and the gain reached the populations it was designed to reach, that is, lower-income adults, and Latino and Black adults, with the steepest declines in uninsurance. This achievement is useful for future coverage policy. However, coverage was not the only barrier facing the vulnerable populations, and the persistent widespread medical debt and incomplete reach of telehealth expansion into rural and low-connectivity communities show that affordability and access are separate challenges requiring unique policy tools. As many provisions reviewed in this article approach expiration, the question is not about whether policy can improve these numbers, since it is obvious it can, but whether the political will exists to make the successful parts permanent while addressing the cost side of the equation untouched by the pandemic-era policy.

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