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# Bolstered by Recovery Legislation, the Health Insurance Safety Net Prevented a Rise in Uninsurance between 2019 and 2021

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## Key Findings

When the COVID-19 pandemic began, many people were concerned that millions of Americans would lose employer-sponsored health insurance coverage and become uninsured. The normal lag in official health insurance estimates from federal sources and data collection challenges brought on by the pandemic have made it challenging to clearly assess how insurance coverage has changed in recent years. In this study, we analyze data from the National Health Interview Survey (NHIS), the Current Population Survey (CPS), and the Health Reform Monitoring Survey (HRMS) to explore trends in coverage status and type between early 2019 and early 2021. We also incorporate administrative data on enrollment in Medicaid, the Marketplaces, and employer-sponsored insurance (ESI) to help reconcile the variation in estimates across surveys. We find the following:

- The uninsurance rate among nonelderly adults (ages 18 to 64) remained flat between early 2019 and early 2021, according to all three surveys.
- Gains in public coverage offset estimated private coverage losses on all three surveys, but the CPS showed much smaller public and private coverage changes than the HRMS and the NHIS.
- Administrative data on Medicaid and ESI enrollment show substantial changes consistent with the estimates reported on the NHIS and the HRMS.
- Medicaid enrollment data indicate that the Medicaid continuous coverage requirement, which has prohibited states from disenrolling Medicaid beneficiaries during the public health emergency, has been a key driver of enrollment trends. Marketplace enrollment trends also suggest the Marketplace has played a smaller but important role in preventing uninsurance during the pandemic.

As of early 2021, the health insurance safety net, enhanced by the Families First Coronavirus Response Act, had largely prevented the catastrophic coverage losses feared at the outset of the pandemic. Moreover, evidence suggests the enhanced Marketplace subsidies under the American Rescue Plan Act may have further reduced uninsurance since early 2021. But the continuous coverage requirement in Medicaid will expire when the public health emergency ends, and the enhanced Marketplace subsidies are set to expire at the end of 2022. The Build Back Better Act, passed by the House in November 2021, could strengthen the health insurance safety net by extending the enhanced Marketplace subsidies through 2025 and filling the Medicaid coverage gap, but the bill has stalled in the Senate and its future is uncertain. Thus, without additional action, uninsurance rates could begin to rise again in the coming years.

### About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

## Background

As the number of unemployed Americans surged early in the pandemic, concerns about dramatic losses of ESI coverage and increases in uninsurance also surfaced (Banthin and Holahan 2020). Early predictions varied widely, given the unprecedented nature of the crisis. Some estimated that more than 5 million workers and their dependents could become uninsured (Dorn 2020; Garrett and Gangopadhyaya 2020), whereas others predicted about 3 million nonelderly people could become uninsured (Banthin et al. 2020). Researchers and analysts generally agreed that the number of people losing ESI would be larger than the number becoming uninsured, assuming that many people losing job-based coverage would be able to obtain other coverage. Estimates of employer coverage losses ranged from about 10 million to 30 million workers and dependents (Banthin et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020).

Estimating the pandemic's coverage implications has been particularly challenging because the associated recession has differed from past recessions in at least four ways. First, the types of jobs lost because of the pandemic have differed from jobs lost in past recessions; workers in service industries and occupations requiring in-person contact with customers have been among the hardest hit (Dvorkin 2020).<sup>1</sup> These workers are less likely to have ESI than other workers, which has had implications for the health insurance effects of the recession (Blumberg et al. 2020). Second, many workers were furloughed

or laid off temporarily rather than permanently dismissed, which allowed them to keep their health insurance coverage.<sup>2</sup>

Third, the federal government initiated a rapid and robust policy response, providing direct financial assistance to households and businesses that may have helped people maintain coverage. The Coronavirus Aid, Relief, and Economic Security Act and the Families First Coronavirus Response Act, passed in March 2020, expanded unemployment insurance and required states to maintain Medicaid coverage for beneficiaries enrolled during the public health emergency in exchange for an increased federal matching percentage for Medicaid. Finally, the economic recovery started relatively quickly after the precipitous drop in employment in March and April 2020, so some coverage losses were concentrated in a short period. The normal lag in the availability of data from federal surveys that collect information on insurance coverage and new data collection complications associated with the pandemic exacerbated these measurement challenges (Stewart 2021).

Published estimates from the US Census Bureau's Household Pulse Survey,<sup>3</sup> developed to monitor the pandemic's effects, showed that the number of uninsured nonelderly adults was 2 million higher by July 2020 (Gangopadhyaya, Karpman, and Aarons 2020) and about 2.7 million higher by December 2020 than at the start of the pandemic (Bundorf, Gupta, and Kim 2021). These estimates are consistent with the more modest predictions at the outset of the pandemic. But, low response rates and other methodological concerns with the Pulse Survey require some caution in interpreting these estimates (Banthin 2021). Moreover, the Pulse Survey estimates suggest increases in uninsurance were concentrated in the spring and summer of 2020. With estimates of health insurance coverage for all of 2020 and early 2021 available from several other sources, however, we can now more comprehensively assess coverage trends during the pandemic.

In October 2021, the US Department of Health and Human Services summarized coverage estimates from several sources and reported a stable uninsurance rate in 2020 alongside declining employer coverage and rising Medicaid and Marketplace coverage (Ruhter et al. 2021). In this study, we provide additional analysis of coverage estimates from the NHIS, the CPS, and the HRMS to further explore trends in coverage status and type between early 2019 and early 2021. We also incorporate administrative data on enrollment in Medicaid, the Marketplaces, and employer coverage to help reconcile the variation in estimates across surveys. Finally, we discuss implications for coverage in 2022 and beyond as pandemic protections expire and policymakers consider additional recovery legislation.

## Data and Methods

We rely on data from three nationally representative surveys for this analysis: the NHIS, the CPS, and the HRMS. We chose these surveys because they each provide point-in-time coverage estimates for early 2019 and early 2021. This allows us to explore comparable coverage trends without relying on 2020 survey estimates, which likely suffered the most significant data collection challenges and nonresponse bias related to the pandemic (Dahlhamer et al. 2021; Stewart 2021).

The NHIS is the principal source of information on the nation’s health, providing nationally representative estimates for the noninstitutionalized civilian population. We use publicly reported estimates from the 2019 and 2021 NHIS Early Release Program, which produces nationally representative estimates for each calendar-year quarter (Cohen and Cha 2020, 2021). The reported estimates include the shares of nonelderly adults with public, private, and no health insurance coverage at the time of the survey. Public coverage includes Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, military health plans, and other government- or state-sponsored coverage. Private coverage includes ESI and insurance purchased directly, purchased through local or community programs, and purchased through the federal or state-based Marketplaces. People can report multiple coverage types, and those identified as uninsured report no comprehensive public or private coverage.<sup>4</sup> Following a redesign in 2019, the survey has approximately 8,000 responses each quarter for a randomly selected adult from each family surveyed.

The CPS is a nationally representative survey of the noninstitutionalized civilian population conducted by the Census Bureau and the Bureau of Labor Statistics that serves as the primary source of monthly US labor force statistics. In addition to the demographic and labor force data the survey collects monthly, the CPS Annual Social and Economic Supplement (ASEC), fielded between February and April, collects detailed data on health insurance coverage, income, work experience, noncash benefits, and migration. Most of the ASEC data are collected in March. The ASEC samples more than 90,000 households annually, providing information on about 107,000 nonelderly adults in 2019 and about 96,000 in 2021.

The ASEC, redesigned in 2014, asks about health insurance coverage at the time of the survey and during the prior calendar year. Though published Census Bureau reports emphasize estimates for the prior year, our analysis focuses on coverage at the time of the survey for consistency with the NHIS and the HRMS. ASEC respondents can report more than one coverage type for themselves and the other members of their households. In this brief, we focus on the shares of nonelderly adults reporting ESI (defined as employment-based coverage and excluding coverage through the military), public coverage (defined as Medicaid, CHIP, and other means-tested programs; Medicare; and CHAMPVA or Veterans Affairs health care), and no coverage at the time of the survey.

The Urban Institute’s HRMS is a nationally representative, internet-based survey of adults ages 18 to 64 launched in 2013 to provide timely information on the Affordable Care Act before data from federal surveys are available. HRMS samples are drawn from Ipsos’s KnowledgePanel, the nation’s largest probability-based online research panel, which includes households with and without internet access. The HRMS is currently fielded annually in the spring, and this analysis draws on data from the March 2019 and April 2021 survey rounds. Approximately 9,500 adults participated in the survey in March 2019, and approximately 9,000 participated in April 2021. Though the cumulative response rate for the HRMS is much lower than the response rates for federal surveys such as the NHIS and the CPS, analyses have found that estimated coverage changes in the HRMS benchmark well against those from the NHIS and other surveys (Karpman and Long 2015).

The HRMS measures health insurance coverage on the basis of responses to a question adapted from the American Community Survey about current coverage at the time of the survey. Respondents can report more than one coverage type, and the survey asks respondents who do not report any coverage to verify that they do not have health insurance. The survey uses additional follow-up questions to develop a logical editing process for determining the most likely type of insurance among respondents reporting multiple coverage types; it applies the following hierarchy of responses so that coverage estimates sum to 100 percent: ESI, including coverage through a current or former employer or union and coverage through the military (e.g., TRICARE and Veterans Affairs health care); public coverage, including Medicare, Medicaid, CHIP, and other state- or government-sponsored plans for which eligibility is based on income or disability; private nongroup coverage purchased through or outside the Marketplaces; and other unspecified coverage. We use previously published HRMS estimates in this brief (Karpman and Zuckerman 2021).

We also rely on administrative estimates of Medicaid and Marketplace coverage to provide additional context for interpreting patterns in the population-based surveys. The Centers for Medicare & Medicaid Services provides monthly Medicaid enrollment counts for all 50 states and the District of Columbia, which are based on information submitted by each state's Medicaid agency. The monthly Medicaid enrollment estimates in this brief represent the total number of enrollees with comprehensive benefits as of the last day of each month.<sup>5</sup> These estimates exclude CHIP enrollees but include children with Medicaid. The Centers for Medicare & Medicaid Services also provides information on the number of people enrolled in Marketplace coverage each month. For the purposes of this brief, we focus on effectuated enrollment, which reflects the total number of people who have an active Marketplace policy and have paid any required premiums. Effectuated enrollment differs from plan selections in that some people who select a plan during the open enrollment period do not make their required premium payment, and their coverage does not become effective.

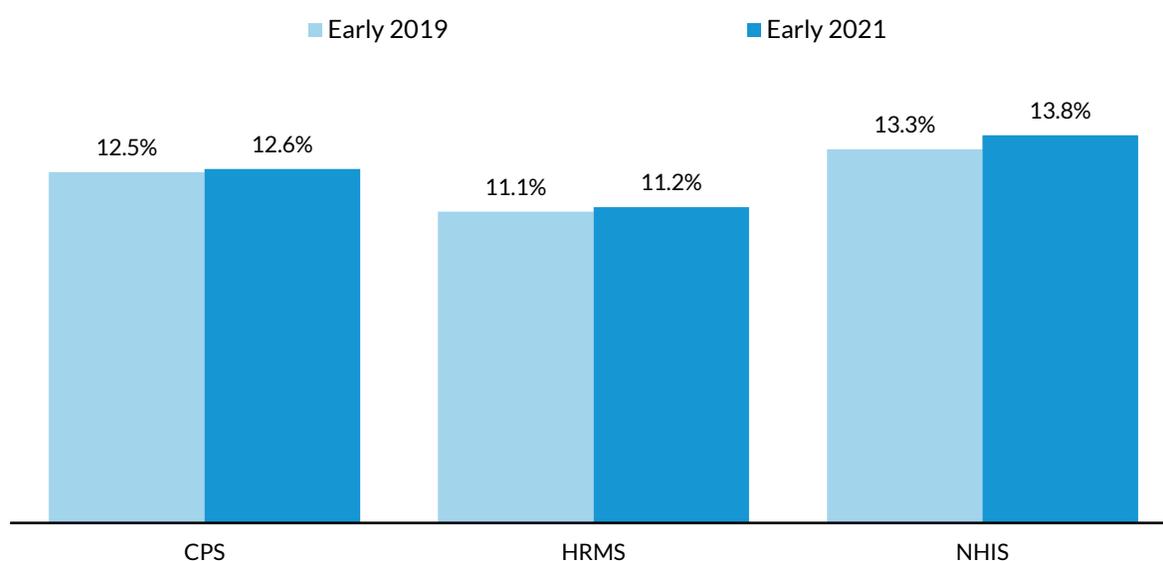
## Limitations

This analysis has several limitations; some predate the public health emergency and others were directly caused by it. First, comparing coverage estimates across surveys always presents challenges. The three surveys vary in the timing of their data collection; in their classification of specific coverage types into public and private categories; and in their designs, including question order and mode of data collection (SHADAC 2020). We do not report 2020 data to avoid the worst effects of the pandemic on data collection, but some nonresponse bias may linger into 2021 on all surveys. In addition, we can identify ESI separately from other private coverage in the HRMS and the CPS, but we cannot do so with the NHIS because of the data limitations of the Early Release reports. We therefore refer to "ESI/private insurance" when comparing private coverage in the NHIS with ESI coverage in the CPS and the HRMS. Further, despite our best efforts to produce comparable estimates, all coverage data are self-reported and subject to measurement error. Data from 2021 are not yet available from other major surveys of US health insurance coverage, including the American Community Survey, the Medical Expenditure Panel Survey, and the Behavioral Risk Factor Surveillance System.

# Results

Across all three surveys, increases in uninsurance between early 2019 and early 2021 were small and statistically insignificant (figure 1). Uninsurance rates were relatively flat on both the CPS and the HRMS; they were 12.5 percent and 12.6 percent in March 2019 and March 2021 on the CPS and 11.1 percent and 11.2 percent in March 2019 and April 2021 on the HRMS. Both the uninsurance rates and the magnitude of the increases in such rates were somewhat larger on the NHIS; uninsurance grew from 13.3 to 13.8 percent from early 2019 to early 2021, but this increase was statistically insignificant.

**FIGURE 1**  
**Uninsured Share of Nonelderly Adults Ages 18 to 64, by Survey, Early 2019 and Early 2021**



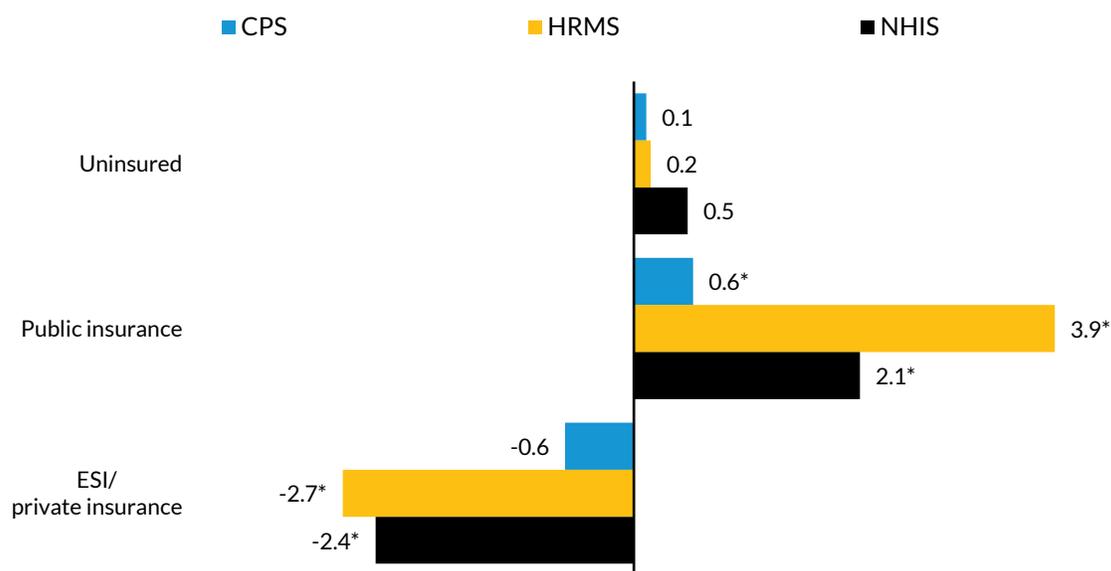
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**Sources:** Current Population Survey (CPS) estimates are from authors' tabulations of public-use data. Health Reform Monitoring Survey (HRMS) estimates are from Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased" (Washington, DC: Urban Institute, 2021). National Health Interview Survey (NHIS) estimates are from Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January–December 2019" (Hyattsville, MD: National Center for Health Statistics, 2020); and Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2020–March 2021" (Hyattsville, MD: National Center for Health Statistics, 2021).

**Notes:** All estimates are based on insurance status at the time of the interview. CPS estimates are from February to April of each year, and most interviews occurred in March. HRMS estimates are from March 2019 and April 2021. NHIS estimates are from the first quarter of each year (January through March). For all data sources, estimates for 2021 are not statistically different ( $p > 0.05$ ) from those for 2019.

These small changes in uninsurance obscure some larger changes in underlying coverage sources (figure 2). Both the HRMS and the NHIS show meaningful declines in ESI/private insurance coverage from early 2019 to early 2021. The share of adults with ESI declined by 2.7 percentage points from March 2019 to April 2021 on the HRMS, whereas the rate of private coverage on the NHIS declined by 2.4 percentage points from the first quarter of 2019 to the first quarter of 2021. The CPS, however, showed a much smaller and statistically insignificant decline in ESI of 0.6 percentage points from March 2019 to March 2021. On all three surveys, increases in public insurance coverage largely offset declines in ESI/private coverage. The rate of public insurance coverage increased by 3.9 percentage points on the HRMS and by 2.1 percentage points on the NHIS,<sup>6</sup> but it increased by a much smaller amount, 0.6 percentage points, on the CPS.

**FIGURE 2**  
**Percentage-Point Change in Coverage Type among Nonelderly Adults Ages 18 to 64, by Survey, Early 2019 to Early 2021**



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**Sources:** Current Population Survey (CPS) estimates are from authors' tabulations of public-use data. Health Reform Monitoring Survey (HRMS) estimates are from Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased" (Washington, DC: Urban Institute, 2021). National Health Interview Survey (NHIS) estimates are from Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January–December 2019" (Hyattsville, MD: National Center for Health Statistics, 2020); and Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2020–March 2021" (Hyattsville, MD: National Center for Health Statistics, 2021).

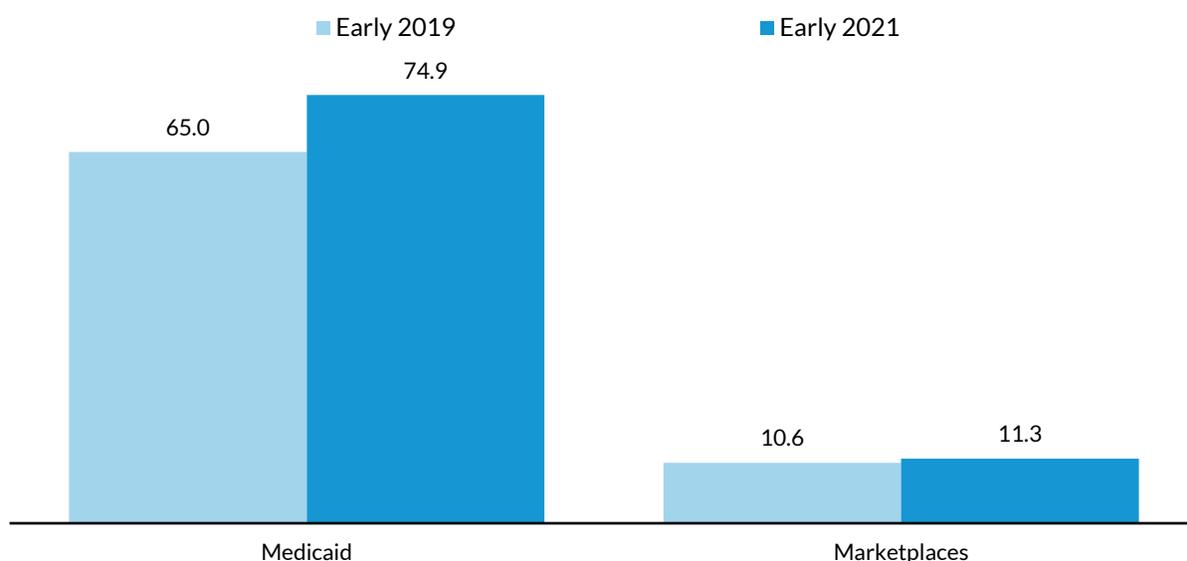
**Notes:** ESI = employer-sponsored insurance. All estimates are based on insurance status at the time of the survey. CPS estimates are from February to April of each year, and most interviews occurred in March. HRMS estimates are from March 2019 and April 2021. NHIS estimates are from the first quarter of each year (January through March). The "ESI/private insurance" category reflects changes in ESI on the CPS and the HRMS, but it reflects changes in all private coverage on the NHIS. The CPS and the NHIS report some people with both public coverage and ESI or private coverage. The HRMS reports each person in a single coverage category.

\* Estimate is statistically different from zero ( $p < 0.05$ ).

When we examine administrative data on Medicaid and Marketplace enrollment from early 2019 to early 2021, the patterns align more closely with those observed on the HRMS and the NHIS than those on the CPS. Medicaid enrollment increased by more than 9.9 million people, or more than 15 percent, between March 2019 and March 2021, whereas enrollment in the Marketplaces increased by more than 700,000 people, or 6.7 percent, between February 2019 and February 2021 (figure 3).<sup>7</sup> The increase in Marketplace enrollment may contribute to the decline in private coverage observed on the NHIS being somewhat smaller than the decline in ESI only observed on the HRMS.

**FIGURE 3**  
**Medicaid and Marketplace Enrollment, Early 2019 and Early 2021**

*Millions of people*



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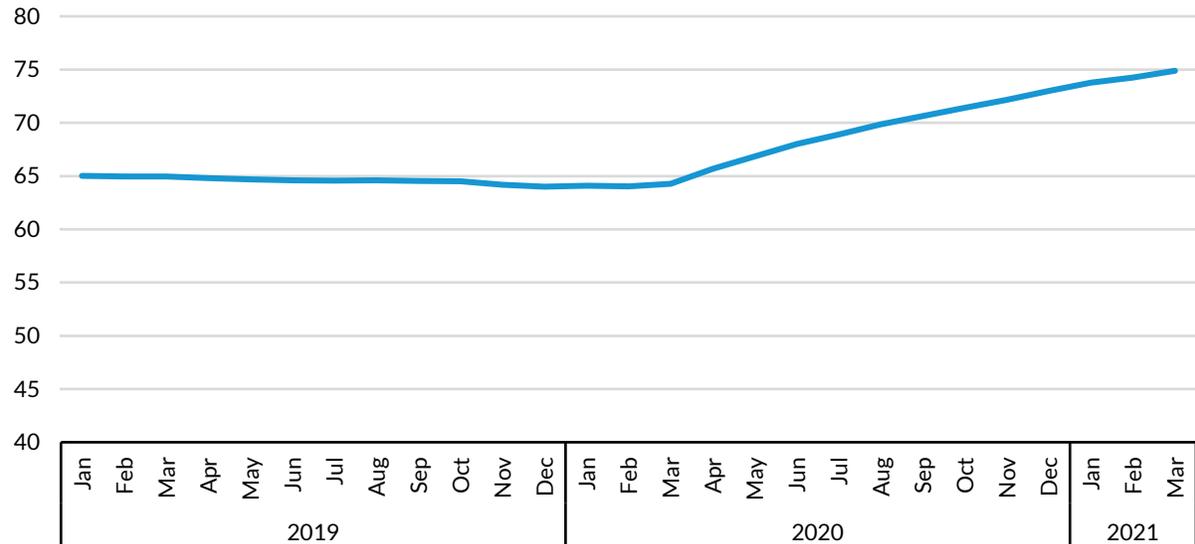
**Sources:** Medicaid and Children’s Health Insurance Program enrollment trend snapshots and Marketplace effectuated enrollment reports from the Centers for Medicare & Medicaid Services.

**Notes:** Medicaid enrollment estimates are for March of each year and include adults and children but exclude Children’s Health Insurance Program enrollment. Marketplace estimates reflect total effectuated enrollment in both the state-based and federal Marketplaces for February of each year.

Medicaid enrollment increases coincided with the Families First Coronavirus Response Act’s continuous coverage requirement. In exchange for an enhanced federal match, this requirement prevents states from disenrolling beneficiaries from Medicaid while the public health emergency is in place, and Medicaid enrollment has increased steadily since the law was passed in March 2020 (figure 4). Marketplace enrollment was also notably more stable in 2020 than in recent years prior; Marketplace enrollment declined beginning in about April of 2018 and 2019 but remained more stable throughout 2020 (figure 5). This likely reflects (1) less attrition among people who enroll during the annual open enrollment period and (2) more people signing up for Marketplace plans outside of that

window either because of new qualifying life events during the pandemic, like losing ESI, or because many state-based Marketplaces opened special enrollment periods in 2020.<sup>8</sup>

**FIGURE 4**  
**Monthly Medicaid Enrollment, January 2019 to March 2021**  
*Millions of people*



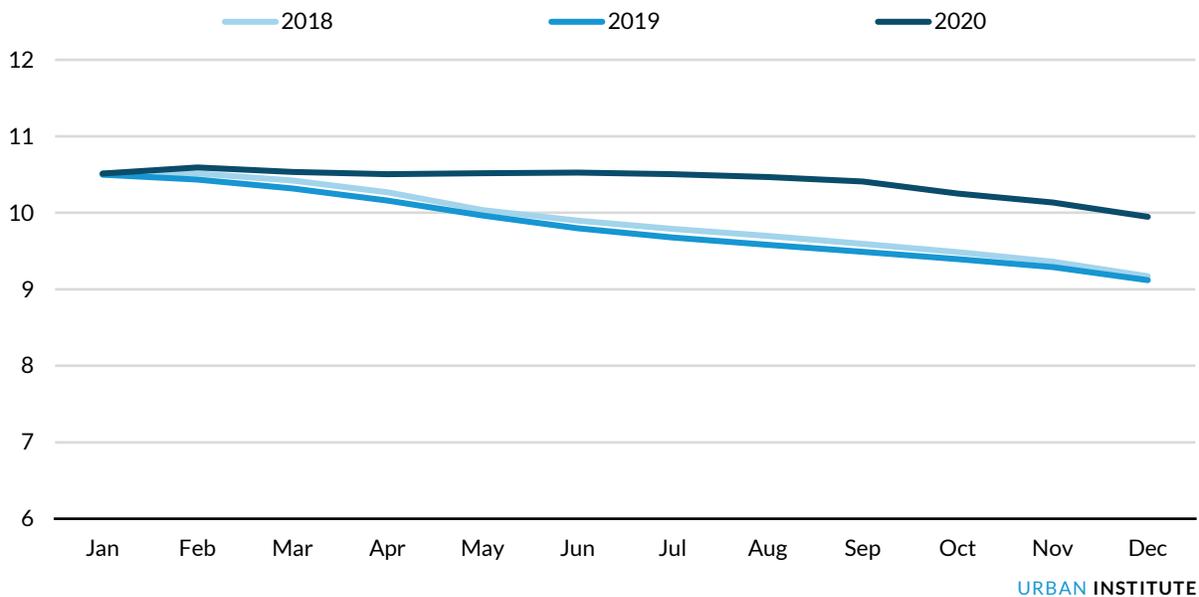
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**Source:** Medicaid and Children’s Health Insurance Program enrollment trend snapshots from the Centers for Medicare & Medicaid Services.

**Note:** Enrollment includes adults and children but excludes enrollment in the Children’s Health Insurance Program.

**FIGURE 5**  
**Monthly Marketplace Enrollment, January 2018 to December 2020**

Millions of people



**Source:** Effectuated enrollment reports from the Centers for Medicare & Medicaid Services.

**Note:** Marketplace estimates reflect total effectuated enrollment for both the state-based and federal Marketplaces.

Though no comprehensive administrative data source tracks ESI enrollment, several sources appear to confirm a significant decline in group health insurance enrollment between 2019 and 2021. Ruhter and colleagues (2021) reported a decline in group health insurance enrollment of about 2.3 million people between January 2019 and January 2021 based on Interstudy data. Estimates from Mark Farrah Associates indicate a decline in ESI enrollment of about 3.3 million people between December 2019 and December 2020 across both full-risk and administrative-services-only employer plans.<sup>9</sup> Using midyear estimates for June 2019 and June 2021,<sup>10</sup> a longer period that aligns better with our survey estimates, the estimated decline in ESI was about 4.6 million enrollees.<sup>11</sup> Assuming a denominator of about 201 million nonelderly adults,<sup>12</sup> implied estimates of 5.5 million nonelderly adults losing ESI from the HRMS and 4.8 million losing private coverage from the NHIS between early 2019 and early 2021 are relatively consistent with the highest estimate from these other data sources.

## Discussion

Data from the NHIS, the CPS, and the HRMS show that the uninsurance rate remained relatively flat between early 2019 and early 2021, suggesting that the 2020 increase in uninsurance of about 2.7 million nonelderly adults found on the Household Pulse Survey was fleeting. Our analysis of the NHIS and the HRMS also finds substantial gains in public coverage that largely offset significant losses in ESI/private coverage between early 2019 and early 2021. Estimates from the CPS also suggest offsetting public coverage gains and ESI losses, but the magnitudes are less remarkable than those on

the other surveys. The estimated increase in public coverage on the CPS was only 0.6 percentage points, compared with 2.1 percentage points on the NHIS and 3.9 percentage points on the HRMS. Moreover, administrative data on Medicaid and ESI appear to support the larger changes indicated by the NHIS and the HRMS. Together, these findings suggest the health insurance safety net successfully prevented a lasting rise in uninsurance about a year after the pandemic began.

Our findings also underscore the importance of the various enhancements to the safety net instituted during the pandemic. In aggregate, gains in Medicaid coverage largely offset significant losses of employer coverage. However, these shifts in aggregate numbers do not mean the same people who lost ESI also gained Medicaid. Evidence suggests much of the increase in Medicaid enrollment during the pandemic was not from new enrollees but rather existing enrollees maintaining their coverage (Dague et al. 2022).<sup>13</sup> Moreover, estimates from the Commonwealth Fund suggest that among the 6 percent of adults who lost ESI since the start of the pandemic, one-third remained uninsured in mid-2021, whereas about half had regained ESI or other private coverage, and only about 16 percent had enrolled in Medicaid (Collins, Aboulaflia, and Gunja 2021). Without the Families First Coronavirus Response Act protections that allowed Medicaid beneficiaries to stay enrolled in the program, the observed pattern among people losing ESI would almost certainly have resulted in a significant increase in uninsurance through early 2021.

The American Rescue Plan Act, passed in March 2021, has important implications for coverage patterns at the end of 2021 and in 2022. The law included several provisions aimed at making coverage more affordable, most notably the establishment of more generous federal subsidies for Marketplace coverage.<sup>14</sup> Administrative data suggest Marketplace enrollment has grown considerably since the law was enacted. During the February to August 2021 special enrollment period, during which the American Rescue Plan Act's enhanced subsidies were in place for the first time, more than 2.8 million Americans signed up for Marketplace coverage; this number is in addition to the number of people who had already signed up during the annual open enrollment period ending in December 2020.<sup>15</sup> By August 2021, effectuated Marketplace enrollment was about 12.2 million, an increase of more than 1.5 million relative to August 2020.<sup>16</sup> Based on evidence from the 2022 open enrollment period, during which 14.5 million plan selections were made between November 1, 2021, and January 15, 2022, Marketplace enrollment patterns in early 2022 appear similarly strong.<sup>17</sup>

Medicaid enrollment was also still growing in July 2021, the date of the most recent available estimates.<sup>18</sup> Together, administrative data on both Medicaid and Marketplace enrollment suggest uninsurance may have been lower at the end of 2021 than it was at the start. The most recent NHIS estimates suggest uninsurance among nonelderly adults declined from 13.8 percent in the first quarter of 2021 to 13.0 percent in the third quarter, but the decline does not appear to be statistically significant (Cohen and Cha 2022). Household Pulse Survey estimates also suggest a decline in uninsurance between April and October 2021 but no further declines through early 2022.<sup>19</sup>

Ultimately, the health insurance safety net, including Medicaid and subsidized Marketplace coverage enhanced by the Families First Coronavirus Response Act and the American Rescue Plan Act, has largely prevented the catastrophic coverage losses feared at the outset of the pandemic. It also may

have further reduced uninsurance from prepandemic levels. However, the approaching expiration of the continuous coverage requirement has considerable implications for Medicaid enrollees. Assuming the requirement would expire at the end of 2021 and that the enhanced federal matching rate would expire in March 2022, Buettgens and Green (2021) found that Medicaid enrollment could decline by as many as 15 million people in the year following the requirement's termination. However, the authors also found that almost two-thirds of children and roughly one-third of adults losing Medicaid coverage could qualify for CHIP or subsidized private health coverage in the Marketplaces. This implies that coordination between state Medicaid agencies and the Marketplaces will be critical to avoid large coverage losses (Corlette et al. 2022). State policymakers have also noted that setting a specific date for the expiration of the continuous coverage requirement, rather than relying on the uncertain end of the public health emergency, would help states plan for resuming their redetermination processes.<sup>20</sup> Experts also suggest that timely public reporting of call center statistics and disenrollments for procedural reasons will be essential to monitoring the requirement's rollback and will allow states to react quickly to avoid disenrolling people who remain eligible for Medicaid.<sup>21</sup>

In November 2021, the House passed the Build Back Better Act, which would extend the American Rescue Plan Act's enhanced Marketplace subsidies currently set to expire at the end of 2022 and would fill the Medicaid coverage gap by extending eligibility for Marketplace subsidies to people with incomes below the federal poverty level in the 12 states that have not yet expanded Medicaid.<sup>22</sup> Urban Institute research has documented these provisions' potential to reduce uninsurance: If both provisions were made permanent, as many as 7.0 million fewer people would be uninsured in 2022 than in the absence of the American Rescue Plan Act (Banthin, Simpson, and Green 2021). Even if only the subsidies were made permanent, as many as 4.2 million fewer people would be uninsured in 2022 (Banthin et al. 2021). Moreover, the bill would provide enhanced federal Medicaid funding for states that make "good faith efforts" to avoid disenrollments due to administrative burdens (Schpero and Ndumele 2022). However, as noted, the legislation has stalled in the Senate, and its future is uncertain. Consequently, some current Marketplace enrollees will lose their enhanced subsidies when they expire at the end of 2022, and adults with incomes below the federal poverty level in states that have not expanded Medicaid will continue to have few options for affordable coverage. Moreover, administrative hurdles to getting and staying enrolled and restrictions that exclude millions of immigrants from eligibility for any subsidized coverage will continue to present challenges to reaching universal coverage. The pandemic has demonstrated the importance of the health insurance safety net in the US, but addressing its remaining weaknesses will be critical for continuing to lower the uninsurance rate.

## Notes

- <sup>1</sup> "Where Low-Income Jobs Are Being Lost to COVID-19," Urban Institute, last updated August 6, 2021, <https://www.urban.org/features/where-low-income-jobs-are-being-lost-covid-19>.
- <sup>2</sup> US Bureau of Labor Statistics, "The Employment Situation – June 2020," news release, July 2, 2020, [https://www.bls.gov/news.release/archives/empsit\\_07022020.pdf](https://www.bls.gov/news.release/archives/empsit_07022020.pdf).

- <sup>3</sup> “Household Pulse Survey: Measuring Social and Economic Impacts during the Coronavirus Pandemic,” US Census Bureau, last revised January 21, 2022, <https://www.census.gov/householdpulse>.
- <sup>4</sup> We also consider people reporting only Indian Health Service coverage or a single-service insurance plan (e.g., dental, accidents) to be uninsured.
- <sup>5</sup> See “Medicaid and CHIP Eligibility and Enrollment Performance Indicators: Data Dictionary,” Centers for Medicare & Medicaid Services, May 20, 2014, <https://www.medicaid.gov/medicaid/downloads/performance-indicators-datadictionary.pdf>; and July 2021 data available from “Medicaid and CHIP Enrollment Trend Snapshot,” Medicaid.gov, accessed February 7, 2022, <https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>.
- <sup>6</sup> The estimated increase in public coverage on the HRMS might be inflated by an anomalous result for unspecified coverage in 2019. For details, see Karpman and Zuckerman (2021).
- <sup>7</sup> These estimates include enrollment for adults and children, but where separate estimates are available for adults only, the patterns are similar. See “May 2021 Medicaid and CHIP Enrollment Trends Snapshot,” Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, and Medicaid and CHIP Learning Collaboratives, accessed February 7, 2022, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2021-medicaid-chip-enrollment-trend-snapshot.pdf>; and “Marketplace Plan Selections by Age,” Kaiser Family Foundation, accessed February 7, 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-plan-selection-by-age/>.
- <sup>8</sup> Twelve of the 13 state-based Marketplaces established a special enrollment period in response to the pandemic, and many have invested resources into outreach and coordination efforts with other state agencies to encourage enrollment. See Rachel Schwab, Justin Giovannelli, and Kevin Lucia, “During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured,” Commonwealth Fund blog, May 19, 2020, <https://doi.org/10.26099/k7w5-kj74>.
- <sup>9</sup> “Year-over-Year Health Insurance Enrollment Trends amidst a Pandemic-Era,” Mark Farrah Associates, April 30, 2021, <https://www.markfarrah.com/mfa-briefs/year-over-year-health-insurance-enrollment-trends-amidst-a-pandemic-era/>.
- <sup>10</sup> “Mid-Year Trends in Health Insurance Enrollment and Segment Performance,” Mark Farrah Associates, September 30, 2020, <https://www.markfarrah.com/mfa-briefs/mid-year-trends-in-health-insurance-enrollment-and-segment-performance/>.
- <sup>11</sup> “Health Insurance Membership Reaches over 300M at 2Q21,” Mark Farrah Associates, October 4, 2021, <https://www.markfarrah.com/mfa-briefs/health-insurance-membership-reaches-over-300m-at-2q21/>.
- <sup>12</sup> The American Community Survey estimates the number of nonelderly adults ages 18 to 64 in 2019 was 201,197,710.
- <sup>13</sup> Centers for Medicare & Medicaid Services, “CMS Releases August Medicaid and CHIP Enrollment Trends Snapshot Showing Continued Enrollment Growth,” news release, December 21, 2020, <https://www.cms.gov/newsroom/press-releases/cms-releases-august-medicaid-and-chip-enrollment-trends-snapshot-showing-continued-enrollment-growth>; and Centers for Medicare & Medicaid Services, “New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 Million Americans Enrolled in Coverage during the COVID-19 Public Health Emergency,” news release, June 21, 2021, <https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during>.
- <sup>14</sup> Premium contributions for a benchmark silver plan for people with incomes below 150 percent of the federal poverty level (FPL) were reduced to zero; required premium contributions were significantly reduced for people with incomes between 150 and 400 percent of FPL; and premium contributions were capped at 8.5 percent of income for people with incomes above 400 percent of FPL, who were previously ineligible for any subsidies. The law also made people receiving unemployment compensation eligible for enhanced subsidies.
- <sup>15</sup> The 2021 special enrollment period ran from February 15 to August 15, 2021, in the 36 states that use the HealthCare.gov platform. Special enrollment period dates varied for the 15 states that use state-based

Marketplaces. HealthCare.gov implemented the enhanced subsidies from the American Rescue Plan Act on April 1, 2021. See “2021 Final Marketplace Special Enrollment Period Report,” Centers for Medicare & Medicaid Services, accessed February 7, 2022, <https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf>.

- <sup>16</sup> US Department of Health and Human Services, “Biden-Harris Administration Announces Record-Breaking 12.2 Million People Are Enrolled in Coverage through the Health Care Marketplaces,” news release, September 15, 2021, <https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html>.
- <sup>17</sup> Centers for Medicare & Medicaid Services, “Fact Sheet: Marketplace 2022 Open Enrollment Period Report, Final National Snapshot,” news release, January 27, 2022, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>.
- <sup>18</sup> CMS, Center for Medicaid and CHIP Services, Medicaid and CHIP Learning Collaboratives, “July 2021 Medicaid and CHIP Enrollment.”
- <sup>19</sup> “Health Insurance Coverage: Information from the Household Pulse Survey,” Centers for Disease Control and Prevention, National Center for Health Statistics, last reviewed January 19, 2022, <https://www.cdc.gov/nchs/covid19/pulse/health-insurance-coverage.htm>.
- <sup>20</sup> Megan Messerly, “Next Big Health Crisis: 15M People Could Lose Medicaid When Pandemic Ends,” *Politico*, February 2, 2022, <https://www.politico.com/news/2022/02/02/medicaid-states-pandemic-loss-00004153>
- <sup>21</sup> Tricia Brooks, “A Few Key Data Points Are Essential in Monitoring Medicaid Enrollment When the Continuous Enrollment Requirement Is Lifted,” *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center For Children and Families, December 6, 2021, <https://ccf.georgetown.edu/2021/12/06/a-few-key-data-points-are-essential-in-monitoring-medicaid-enrollment-when-the-continuous-enrollment-requirement-is-lifted/>.
- <sup>22</sup> Katie Keith, “House Passes Build Back Better Act,” *Health Affairs Blog*, November 23, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20211123.122022/full/>.

## References

- Banthin, Jessica. 2021. “Fewer People May Have Become Uninsured in 2020 Than Feared.” *JAMA Health Forum* 2 (9): e212255. <https://doi.org/10.1001/jamahealthforum.2021.2255>.
- Banthin, Jessica, Matthew Buettgens, Michael Simpson, and Robin Wang. 2021. “What If the American Rescue Plan’s Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022.” Washington, DC: Urban Institute.
- Banthin, Jessica, and John Holahan. 2020. “Making Sense of Competing Estimates: The COVID-19 Recession’s Effects on Health Insurance Coverage.” Washington, DC: Urban Institute.
- Banthin, Jessica, Michael Simpson, Matthew Buettgens, Linda J. Blumberg, and Robin Wang. 2020. “Changes in Health Insurance Coverage Due to the COVID-19 Recession: Preliminary Estimates Using Microsimulation.” Washington, DC: Urban Institute.
- Banthin, Jessica, Michael Simpson, and Andrew Green. 2021. “The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress.” New York: Commonwealth Fund. <https://doi.org/10.26099/4gyx-ry85>.
- Blumberg, Linda J., Michael Simpson, John Holahan, Matthew Buettgens, and Clare Wang Pan. 2020. “Potential Eligibility for Medicaid, CHIP, and Marketplace Subsidies among Workers Losing Jobs in Industries Vulnerable to High Levels of COVID-19-Related Unemployment.” Washington, DC: Urban Institute.
- Buettgens, Matthew, and Andrew Green. 2021. *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?* Washington, DC: Urban Institute.

- Bundorf, M. Kate, Sumedha Gupta, and Christine Kim. 2021. "Trends in US Health Insurance Coverage during the COVID-19 Pandemic." *JAMA Health Forum* 2 (9): e212487. <https://doi.org/10.1001/jamahealthforum.2021.2487>.
- Cohen, Robin A., and Amy E. Cha. 2020. "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January–December 2019." Hyattsville, MD: National Center for Health Statistics.
- . 2021. "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2020–March 2021." Hyattsville, MD: National Center for Health Statistics.
- . 2022. "Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2020–September 2021." Hyattsville, MD: National Center for Health Statistics.
- Collins, Sara R., Gabriella N. Abouafia, and Munira Z. Gunja. 2021. "As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.?" New York: Commonwealth Fund. <https://doi.org/10.26099/6w2d-7161>.
- Corlette, Sabrina, Linda J. Blumberg, Megan Houston, and Erik Wengle. 2022. "Preparing for the Biggest Coverage Event since the Affordable Care Act: Perspectives from State Health Officials on the End of Medicaid's Continuous Coverage Requirement." Washington, DC: Urban Institute.
- Dague, Laura, Nicolas Badaracco, Thomas DeLeire, Justin Sydnor, Alyssa Shell Tilhou, and Donna Friedsam. 2022. "Trends in Medicaid Enrollment and Disenrollment during the Early Phase of the COVID-19 Pandemic in Wisconsin." *JAMA Health Forum* 3(2): e214752. <https://doi.org/10.1001/jamahealthforum.2021.4752>.
- Dahlhamer, James M., Matthew D. Bramlett, Aaron Maitland, and Stephen J. Blumberg. 2021. "Preliminary Evaluation of Nonresponse Bias Due to the COVID-19 Pandemic on National Health Interview Survey Estimates, April–June 2020." Hyattsville, MD: National Center for Health Statistics.
- Dorn, Stan. 2020. *The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History*. Washington, DC: Families USA.
- Dvorkin, Maximiliano A. 2020. "Which Jobs Have Been Hit Hardest during COVID-19?" St. Louis: Federal Reserve Bank of St. Louis.
- Gangopadhyaya, Anuj, Michael Karpman, and Joshua Aarons. 2020. "As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured." Washington, DC: Urban Institute.
- Garfield, Rachel, Gary Claxton, Anthony Damico, and Larry Levitt. 2020. "Eligibility for ACA Health Coverage Following Job Loss." San Francisco: Kaiser Family Foundation.
- Garrett, Bowen, and Anuj Gangopadhyaya. 2020. "How the COVID-19 Recession Could Affect Health Insurance Coverage." Washington, DC: Urban Institute.
- Karpman, Michael, and Sharon K. Long. 2015. "QuickTake: HRMS Benchmarks Well against Gallup-Healthways and NHIS on Changes in Health Insurance Coverage between 2013 and 2015." Washington, DC: Urban Institute.
- Karpman, Michael, and Stephen Zuckerman. 2021. "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased." Washington, DC: Urban Institute.
- Ruhter, Joel, Ann B. Conmy, Rose C. Chu, Christie Peters, Nancy De Lew, and Benjamin D. Sommers. 2021. "Tracking Health Insurance Coverage in 2020-2021." Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy.
- Schpero, William L., and Chima D. Ndumele. 2022. "Medicaid Disenrollment after the COVID-19 Pandemic." *JAMA Health Forum* 3 (2): e214743. <https://doi.org/10.1001/jamahealthforum.2021.4743>.
- SHADAC (State Health Access Data Assistance Center). 2020. "Comparing Federal Government Surveys That Count the Uninsured." Princeton, NJ: SHADAC.
- Stewart, Andrea. 2021. "Changes in Federal Surveys Due to and during COVID-19." Minneapolis: State Health Access Data Assistance Center.

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