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Health Care Affordability Improved between 2019 and 2022 under Pandemic Health Coverage Policies

Findings from the Well-Being and Basic Needs Survey

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Each year, millions of Americans have difficulty paying for health care, leading many to delay or forgo needed care or incur medical debt (Collins, Haynes, and Masitha 2022; Rakshit et al. 2023).[1] Access to health insurance coverage can prevent these harmful outcomes and is a key determinant of health care affordability. As such, the federal response to the COVID-19 pandemic protected access to coverage through Medicaid and the health insurance Marketplaces (McMorrow et al. 2022; Tolbert, Drake, and Damico 2022). The Families First Coronavirus Response Act prohibited states from disenrolling people from Medicaid during the public health emergency in return for increased federal matching funds,[2] resulting in Medicaid enrollment growth of more than 22 million people since February 2020.[3] Additional legislation increased Marketplace premium tax credits and expanded eligibility for tax credits to families with incomes of 400 percent of the federal poverty level (FPL) or more through the end of 2025.

In this brief, we examine trends in health care affordability using data from the Urban Institute's Well-Being and Basic Needs Survey (WBNS), a nationally representative survey of adults ages 18 to 64 conducted each December. We estimate changes during the pandemic and the years leading up to it for two affordability measures: (1) the share of adults reporting they or their families had problems paying or were unable to pay medical bills in the past 12 months, and 2) the share of adults reporting they did not get needed medical care in the past 12 months because they could not afford it. We focus on how the measures changed between December 2019, just before the pandemic began, and December 2022,

the most recent round of data collection. Our analysis also examines how disparities by race/ethnicity and family income have changed during this period. Our findings include the following:

- Health care affordability improved between 2019 and 2022.
  - » Between December 2019 and December 2022, the share of adults reporting problems paying family medical bills in the past 12 months declined from 18.7 percent to 15.0 percent.
  - » The share of adults who reported forgoing needed medical care because of costs in the past 12 months declined from 18.5 percent to 13.9 percent.
  - » In the two years leading up to the pandemic, these measures showed little change.
- Racial and ethnic disparities in health care affordability narrowed.
  - » The share of Black and Hispanic/Latinx adults reporting problems paying family medical bills and forgoing needed medical care because of cost decreased sharply between 2019 and 2022. As a result, Black and Hispanic/Latinx adults reported these challenges at rates closer to those of white adults in December 2022.
- Health care affordability gains reached families with low and high incomes.
  - » Adults with family incomes between 100 and 200 percent of FPL reported the largest reduction in problems paying family medical bills (from 32.4 percent to 24.9 percent).
  - » The decrease in unmet needs for care was largest among adults with incomes below 100 percent of FPL (from 27.2 percent to 18.8 percent) and incomes between 100 and 200 percent of FPL (from 31.9 percent to 24.1 percent).
  - » Adults with incomes of 400 percent FPL or more reported significant declines in both problems paying medical bills (from 10.1 percent to 6.1 percent) and unmet needs for care (from 9.3 percent to 6.3 percent).

Improvements in affordability between 2019 and 2022 emerged after temporary new policies protected and expanded access to public or subsidized coverage. Because of the Medicaid continuous coverage requirement, millions of adults and children have remained enrolled in Medicaid during the past three years, even if they experienced changes in their family income or other circumstances that would have previously made them ineligible. By eliminating the need for periodic renewals, the requirement has also prevented wrongful terminations of Medicaid for people who remain eligible but have trouble navigating those complex administrative processes. In addition, the expansion of Marketplace premium tax credits likely contributed to rising Marketplace enrollment while reducing out-of-pocket premiums for current enrollees.[4]

Pandemic-era changes in the health insurance policy landscape have expired or are scheduled to expire in the coming years, however, which may halt recent progress in making health care more affordable. As of April 2023, some states have started Medicaid eligibility redetermination and renewal processes. An estimated 18 million people are expected to lose Medicaid by 2024 because they are no

longer eligible for the program or because administrative barriers will cause eligible people to lose coverage (Buettgens and Green 2022).

State actions to prevent coverage losses among those who remain eligible for Medicaid will be needed to reduce the number who become uninsured. The extent to which losses of Medicaid result in higher uninsurance rates also depends on how many people who lose eligibility will successfully transition to the Marketplace or employer-sponsored insurance and how many were already covered by employer-sponsored insurance before the continuous coverage requirement ended, even if they remained enrolled in Medicaid during the public health emergency. Federal legislation would also be needed to expand Marketplace premium subsidies beyond 2025. In the sections below, we present results from the WBNS, discuss the implications of these and other policy changes, and describe the data, methods, and limitations of our analysis.

Results

Health Care Affordability Improved between 2019 and 2022

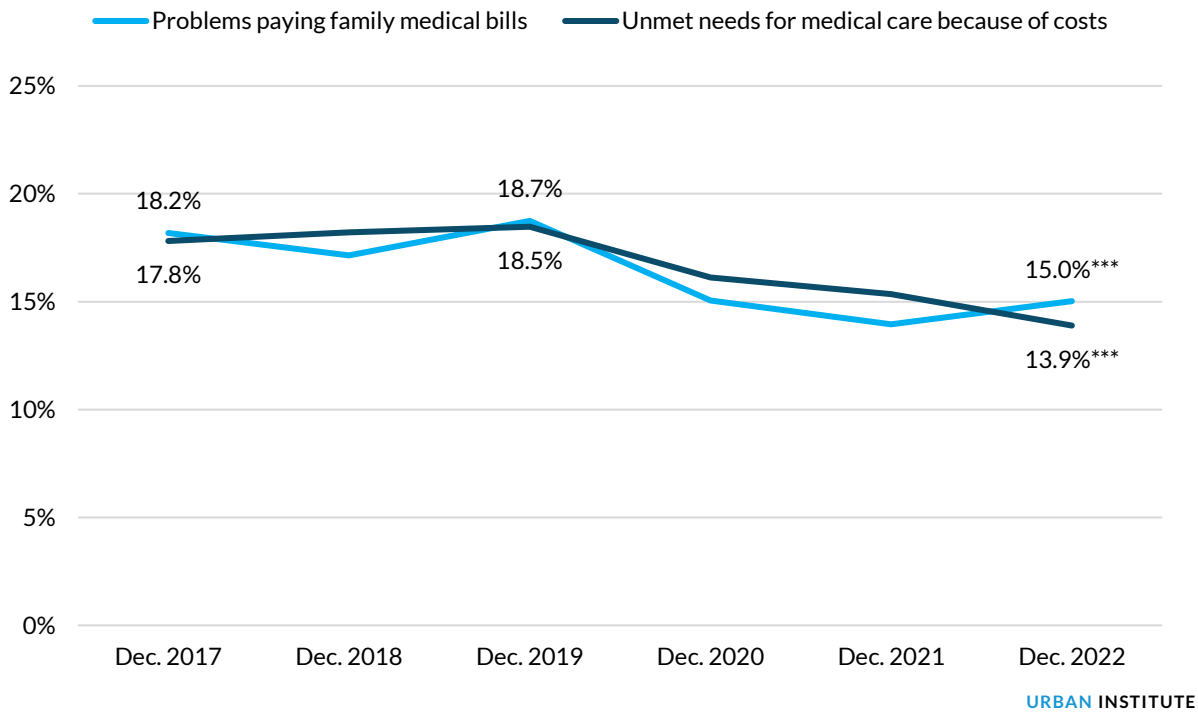
Federal surveys have found that the share of nonelderly adults without health insurance coverage declined between 2019 and 2022, after enactment of federal coverage protections.[5] In the WBNS, we found that health care affordability also improved during this period.[6]

Between December 2019 and December 2022, the share of adults reporting problems paying family medical bills in the past 12 months declined from 18.7 percent to 15.0 percent (figure 1). This decrease represented a break from the previous trend in the years just before the pandemic. The share of adults with problems paying medical bills was essentially unchanged between 2017 and 2019 (18.2 percent versus 18.7 percent).

We observed a similar pattern in the share of adults who reported needing medical care in the past 12 months but not getting it because they could not afford it. Between December 2019 and December 2022, the share of adults reporting unmet needs for medical care because of costs declined from 18.5 percent to 13.9 percent, representing a 25 percent reduction. Between 2017 and 2019, the two years leading up to the pandemic, the share of adults reporting unmet needs had held steady at approximately 18 percent.

FIGURE 1

Share of Adults Ages 18 to 64 Reporting Health Care Affordability Challenges in the past 12 Months, December 2017 to December 2022



Source: Urban Institute Well-Being and Basic Needs Survey, December 2017–December 2022.
Notes: Estimates are regression adjusted.
*/**/*** December 2022 estimate differs significantly from December 2019, at the 0.10/0.05/0.01 level, using two-tailed tests.

Racial and Ethnic Disparities in Health Care Affordability Narrowed

Most of the racial/ethnic groups we examined reported having fewer affordability challenges between 2019 and 2022 (figure 2). During this period, the share of Black adults reporting problems paying medical bills declined from 24.4 percent to 15.9 percent and the share reporting unmet needs for care because of costs fell from 20.4 percent to 12.6 percent. Hispanic/Latinx adults, who have among the nation's highest uninsurance rates (Branch and Conway 2022), also experienced far fewer problems paying medical bills (from 22.7 percent to 17.0 percent) and unmet needs for care (from 21.8 percent to 16.2 percent). White adults reported declines of approximately 3 to 4 percentage points for each measure.

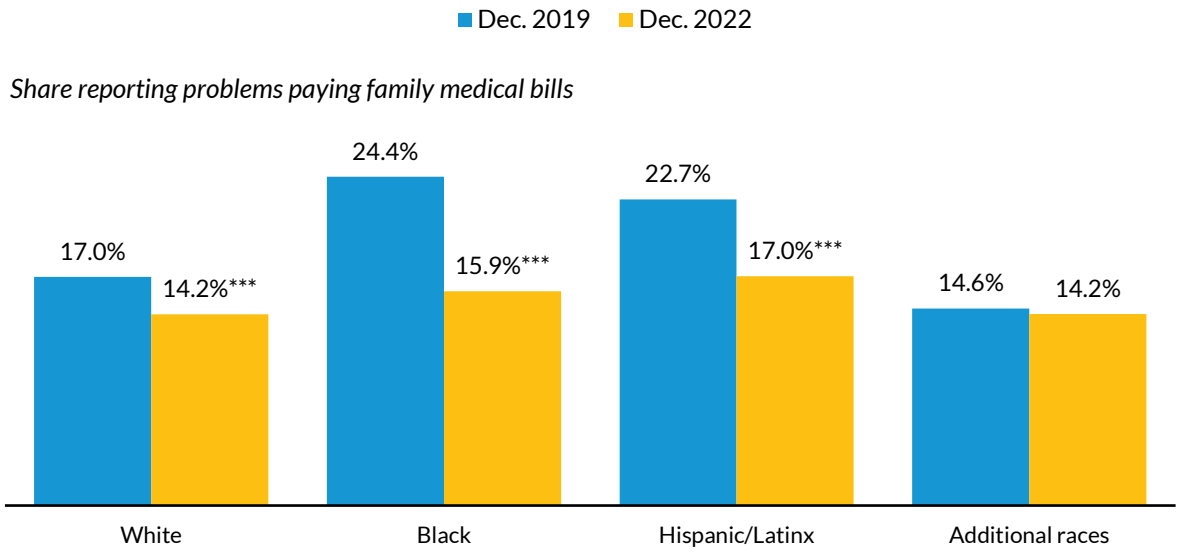
These changes reduced estimated disparities in affordability, as Black and Hispanic/Latinx adults reported affordability challenges at rates closer to those reported by white adults in 2022. For instance, Black adults were 7.4 percentage points more likely than white adults to report problems paying medical bills in 2019 (24.4 percent versus 17.0 percent) but were almost equally likely to report experiencing these problems in 2022 (15.9 percent versus 14.2 percent). However, because of small sample sizes, estimates of disparities between white adults and adults in most other racial and ethnic

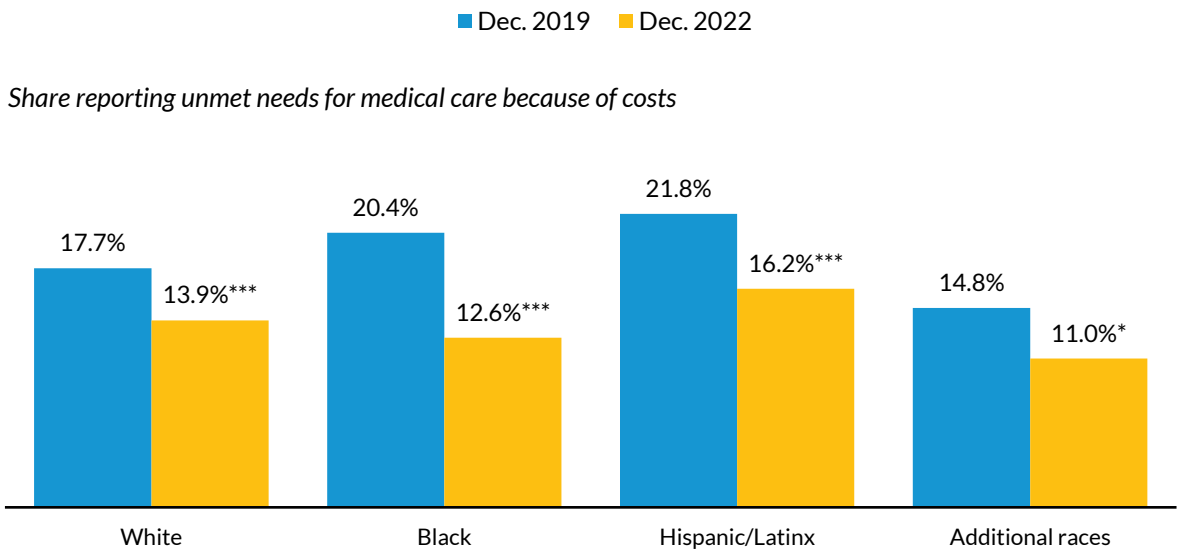
subgroups were relatively imprecise. Federal surveys with larger sample sizes and higher response rates will be needed to confirm these findings.

We did not observe a statistically significant change in problems paying medical bills among non-Hispanic/Latinx adults of additional races, a diverse group that includes adults who are American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, more than one race, or some other race. These adults, however, reported a decline in unmet needs for care (from 14.8 percent to 11.0 percent). Though sample size limitations prevented us from further disaggregating the data to provide precise estimates, federal surveys have found significant variation in affordability challenges between and within these groups, and it will be important to monitor their experiences when data from those surveys become available (Cohen and Cha 2023).

FIGURE 2

Share of Adults Ages 18 to 64 Reporting Health Care Affordability Challenges in the past 12 Months, by Race/Ethnicity, December 2019 to December 2022





Source: Urban Institute Well-Being and Basic Needs Survey, December 2017—December 2022.

Notes: Estimates are regression adjusted. The terms "white," "Black," and "additional races" in this brief refer to adults who do not identify as Hispanic/Latinx. "Additional races" includes adults who are American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, more than one race, or some other race.

*/**/*** December 2022 estimate differs significantly from December 2019, at the 0.10/0.05/0.01 level, using two-tailed tests.

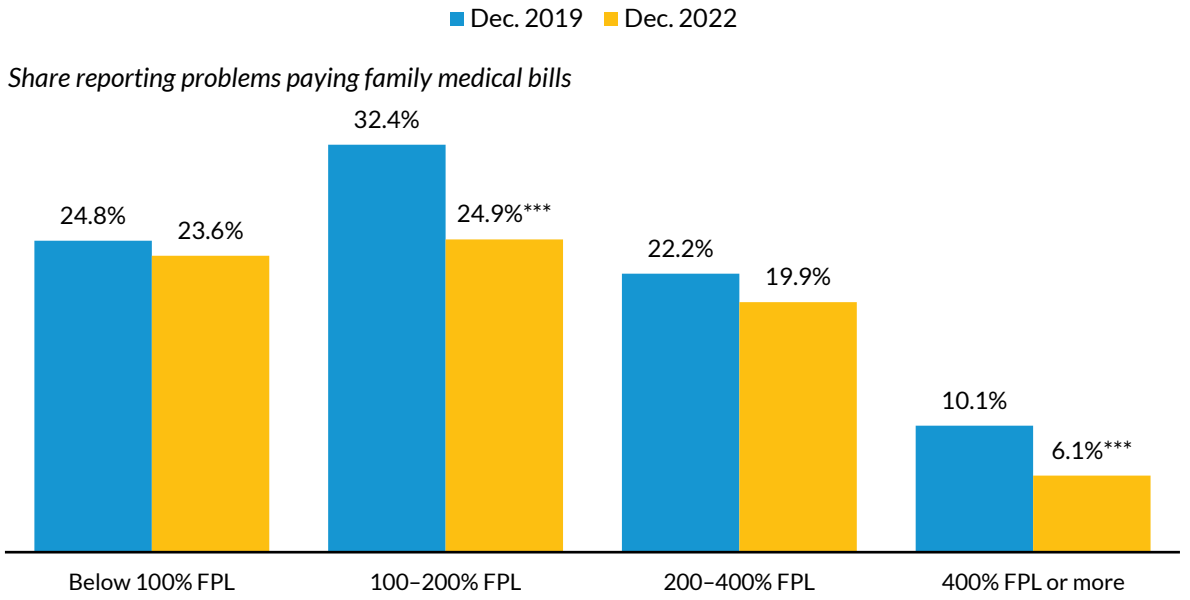
Affordability Gains Reached Families with Low and High Incomes

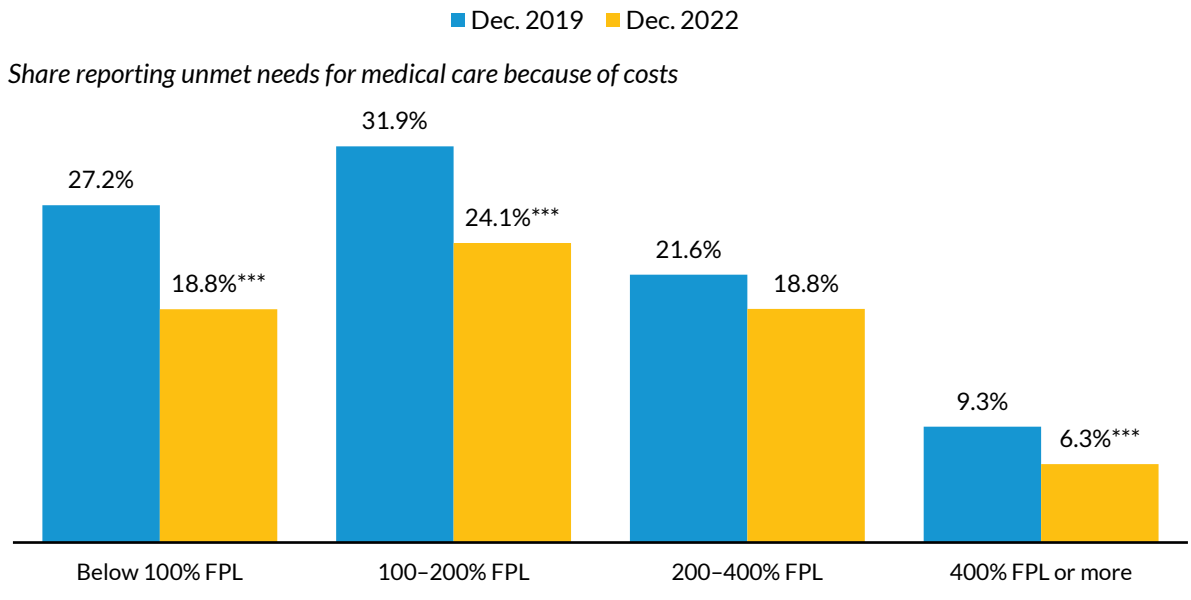
Changes in health care affordability between 2019 and 2022 varied widely across levels of family income as a percentage of FPL. The share of adults with incomes below 100 percent of FPL who reported problems paying medical bills did not change significantly during this period, but the share of adults in this income group who went without needed care because of costs fell sharply, from 27.2 percent to 18.8 percent (figure 3). Adults with incomes just above that level—between 100 and 200 percent of FPL—experienced some of the largest reductions in both measures: the share with problems paying medical bills fell from 32.4 percent to 24.9 percent and the share with unmet needs for care fell from 31.9 percent to 24.1 percent.

Adults with incomes between 200 and 400 percent of FPL reported a decrease in both types of affordability challenges, but those changes were not statistically significant. Adults with the highest incomes (i.e., 400 percent of FPL or more) reported a 4 percentage point decline in problems paying medical bills (from 10.1 percent to 6.1 percent) and a 3 percentage point decline in unmet needs for care (from 9.3 percent to 6.3 percent).

FIGURE 3

Share of Adults Ages 18 to 64 Reporting Health Care Affordability Challenges in the past 12 Months, by Family Income, December 2019 to December 2022





Source: Urban Institute Well-Being and Basic Needs Survey, December 2017—December 2022.
FPL = federal poverty level.
Notes: Estimates are regression adjusted.
*/**/*** December 2022 estimate differs significantly from December 2019, at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

We observed sustained improvements in health care affordability between 2019 and 2022 despite the economic disruptions caused by the COVID-19 pandemic. The results from our analysis complement recent findings from the National Health Interview Survey showing fewer people had problems paying medical bills and cost-related barriers to care between 2019 and 2021 and suggesting these trends continued in 2022 (Cohen and Cha 2023; McGough, Amin, and Cox 2023).[7] These findings are also consistent with estimated declines in medical debt (Karpman, Martinchek, and Braga 2022). We found that Black and Hispanic/Latinx adults reported especially large affordability gains. Given the relatively small sample sizes of racial and ethnic subgroups in the WBNS, it will be important to use federal survey data to further examine changes in racial and ethnic disparities in the ability to pay for care.

The Pandemic Policy Response May Have Contributed to Affordability Gains

Affordability gains occurred during a period of rapid change in federal safety net policy and the health insurance coverage landscape. The Medicaid continuous coverage requirement prevented states from disenrolling beneficiaries during the public health emergency. This requirement temporarily stopped the churning enrollment characteristic of Medicaid before the pandemic, which led to frequent uninsurance spells and disruptions in health care access for Medicaid enrollees (Sommers et al. 2016; Sugar et al. 2021). Because Medicaid requires little or no cost sharing for covered services, the continuous coverage requirement may have protected many families from the higher out-of-pocket costs they would have faced with private insurance, which frequently imposes cost sharing for services and high deductibles before coverage begins (Johnston et al. 2020). Further, the American Rescue Plan Act made Marketplace coverage more affordable by providing enhanced premium subsidies to people already eligible and expanding eligibility to people with incomes above 400 percent of FPL.[8] However, further research is needed to assess whether these policies caused the affordability changes we observed.

Other factors possibly bolstering health care affordability include federal relief programs, such as expanded unemployment insurance benefits, COVID-19 economic impact payments, and the expanded child tax credit. The No Surprises Act, which protects insured patients from receiving larger-than-expected medical bills from out-of-network providers, also took effect in January 2022 (Hoadley et al. 2023). Reductions in the share of adults reporting cost-related access barriers and medical bill problems may also be related to reductions in health care use. Many people delayed care because of fear of COVID-19 exposure or provider decisions to limit or postpone services following the onset of the pandemic in 2020, though pent-up demand led to a partial rebound in health care use in 2021 (Birkmeyer et al. 2020; Gonzalez, Karpman, and Haley 2021; Martin et al. 2022; McGough, Amin, and Cox 2023; Mehrotra et al. 2021).

The relative importance of different policies and factors in explaining recent improvements in health care affordability is unknown, but the reduction in uninsurance during the COVID-19 pandemic suggests that policies protecting insurance coverage can mitigate the impact of future economic downturns or public health crises.

The Expiration of Pandemic Coverage Protections Could Place Consumers at Greater Financial Risk

The end of the Medicaid continuous coverage requirement could halt or reverse recent progress in health care affordability. The Consolidated Appropriations Act of December 2022 delinked this requirement from the public health emergency and allowed states to begin resuming Medicaid redetermination and renewal processes in April 2023. As these processes restart, 18 million adults and children are at risk of losing Medicaid, with up to 4 million expected to become uninsured (Buettgens and Green 2022). The impact on the number of uninsured will depend on state efforts to avoid wrongful terminations of Medicaid and help those no longer eligible transition to other sources of coverage (i.e., through employers or the Marketplaces). It will also depend on the number of people already covered by private insurance even though they have remained enrolled in Medicaid during the public health emergency. Enhanced Marketplace premium subsidies will lower the cost of coverage for many people who lose Medicaid and lack access to affordable employer-sponsored insurance, but these enhanced subsidies will expire after 2025 without congressional action.

Additional Federal and State Policies Could Affect Trends in Health Care Affordability

Fewer people reported challenges paying for care under the Medicaid continuous coverage requirement, suggesting that other strategies to ensure coverage continuity may improve health care affordability. The Consolidated Appropriations Act will require states to maintain 12-month continuous eligibility for children under age 19, regardless of changes in their family income or other circumstances, beginning in January 2024.[9] This provision reduces the risk that children will lose Medicaid and CHIP (Children's Health Insurance Program) coverage during the year because of administrative barriers associated with recertifying eligibility. The law also makes permanent a state option to provide 12 months of postpartum Medicaid and CHIP coverage.

Some states will also use Medicaid demonstration waivers to provide multiyear continuous Medicaid coverage for children from birth through age 5.[10] States are taking additional actions to expand coverage and affordability by facilitating automatic transitions between Medicaid and the Marketplaces; providing coverage to immigrants excluded from public insurance programs; and using state funding to increase subsidies for premiums and cost sharing (Levitis and Pandit 2021; Manatt Health 2021).[11]

Data and Methods

This brief draws on data from the Urban Institute's Well-Being and Basic Needs Survey, a nationally representative internet-based survey of adults ages 18 to 64 designed to monitor changes in individual and family well-being as policymakers consider changes to federal safety net programs. The survey is fielded annually in December. For this analysis, we used data from all survey rounds between 2017 and 2022. For each round, we draw a stratified random sample (including a large oversample of adults in low-income households) of approximately 7,500 adults from the KnowledgePanel, a probability-based

internet panel maintained by Ipsos that includes households with and without internet access. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of nonelderly adults based on benchmarks from the Current Population Survey Annual Social and Economic Supplement and the American Community Survey. Participants can complete the survey in English or Spanish. For further information about the survey design and content, see Karpman, Zuckerman, and Gonzalez (2018).[12]

We estimated changes over time in two measures of health care affordability: (1) the share of adults reporting they or someone in their family had problems paying or were unable to pay medical bills in the past 12 months and (2) the share of adults reporting there was a time in the past 12 months when they did not get needed medical care because they could not afford it. We assessed trends in affordability between 2017 and 2022, with an emphasis on changes between 2019 and 2022, both overall and by race/ethnicity and family income as a percentage of FPL.

Estimated changes were regression adjusted to control for any changes in the demographic and socioeconomic characteristics of the adults participating in each survey round not fully captured in the survey weights. We controlled for a respondent's gender, age, race/ethnicity, primary language, educational attainment, family size, family income, chronic health conditions, residence in an urban or rural area, internet access, homeownership status, family composition, and census region; the presence of children under age 19 in the respondent's household; whether the respondent participated in multiple survey rounds; and how long the respondent has been a member of the KnowledgePanel. In presenting the regression-adjusted estimates, we used the predicted rate of each outcome in each year for the same nationally representative population. For this analysis, we based the nationally representative sample on respondents to the 2021 and 2022 survey rounds.

The WBNS has several limitations, including a low cumulative response rate. The survey weights and regression adjustment mitigate, but do not eliminate, potential nonresponse bias. However, studies assessing recruitment for the KnowledgePanel have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008), and WBNS estimates are generally consistent with benchmarks from federal surveys (Karpman, Zuckerman, and Gonzalez 2018). The sampling frame for the WBNS also excludes or underrepresents certain groups of adults, including those who are homeless, have low literacy levels, and are not proficient in English or Spanish. Sampling error is larger for estimated changes over time for racial/ethnic and income subgroups that have smaller sample sizes. There may also be recall bias or other sources of measurement error in self-reported health care affordability challenges. Finally, trends in affordability may partially reflect temporary changes in care-seeking behavior during the COVID-19 pandemic.

Notes

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Census Bureau, April 7, 2021, https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

[2] States could disenroll Medicaid enrollees during the public health emergency if they moved out of state or voluntarily requested to have their coverage terminated.

[3] CMS (Centers for Medicare and Medicaid Services), "January 2023 Medicaid and CHIP Enrollment Trends Snapshot," accessed May 1, 2023, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/january-2023-medicaid-chip-enrollment-trend-snapshot.pdf.

[4] Centers for Medicare and Medicaid Services, "Biden-Harris Administration Announces Record-Breaking 16.3 Million People Signed Up for Health Care Coverage in ACA Marketplaces during 2022–2023 Open Enrollment Season," press release, January 25, 2023, https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-record-breaking-163-million-people-signed-health-care-coverage, "Marketplace 2022 Open Enrollment Period Report: Final National Snapshot," January 27, 2022, https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.

[5] The National Health Interview Survey found a decline between July–December 2019 and July–December 2022 in the share of 18- to 64-year-olds who were uninsured (from 15.6 percent to 12.3 percent), a rise in the share reporting any private coverage (from 65.9 percent to 67.5 percent), and a moderate increase reporting any public coverage (from 20.4 percent to 22.2 percent). National Center for Health Statistics, "Interactive Biannual Early Release Estimates," accessed May 1, 2023, https://wwwn.cdc.gov/NHISDataQueryTool/ER_Biannual/index_biannual.html.

The American Community Survey (ACS) found a moderate decrease between 2019 and 2021 in the share of 19- to 64-year-olds who were uninsured (from 12.9 percent to 12.2 percent), no change in the share with private coverage, and an increase in the share with public coverage (from 17.7 percent to 19.1 percent). ACS data for 2022 will be available Fall 2023. "2021 ACS: Estimates Show Declining Uninsurance Rates Across 28 States, Driven by Rise in Public Coverage and Fall in Private Coverage," SHADAC Blog and News, September 15, 2022, https://www.shadac.org/news/2021-acs-data-release.

[6] Pre-pandemic coverage estimates in the Well-Being and Basic Needs Survey aligned with benchmarks from the ACS (Karpman, Zuckerman, and Gonzalez 2018), which asks about coverage in a similar format. Our estimates of the trend in coverage during the pandemic differ slightly from those of other federal surveys. Consistent with the National Health Interview Survey and the ACS, we found an increase between December 2019 and December 2022 in the share of 18- to 64-year-olds with public coverage (from 14.8 percent to 17.4 percent). However, we also observed a decline in the share with employer-sponsored coverage (from 63.8 percent to 60.8 percent) not found in those surveys. Our sample size was not large enough to detect statistically significant changes in uninsurance. In addition, each of these surveys appears to understate the increase in the number of adults with Medicaid when compared with administrative enrollment data.

[7] National Center for Health Statistics, "Interactive Quarterly Release Estimates: Percentage of Adults Aged 18 and Over Who Did Not Get Needed Medical Care Due to Cost in the Past 12 Months, United States, 2019 Q1, Jan.–Mar.—2022 Q3, Jul.–Sep.," accessed March 29, 2023, https://wwwn.cdc.gov/NHISDataQueryTool/ER_Quarterly/index_quarterly.html.

[8] The American Rescue Plan Act also established other temporary coverage protections for unemployed people in 2021. See Pollitz (2021) and US Department of Labor, "FAQs about COBRA Premium Assistance under the American Rescue Plan Act of 2021," April 7, 2021, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-premium-assistance-under-arp.pdf.

[9] Edwin Park, Anne Dwyer, Tricia Brooks, Maggie Clark, and Joan Alker, "Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained," Georgetown University Center for Children and Families, January 5,

2023, https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

[10] Joan Alker and Elisabeth Wright Burak, "Oregon Leads the Nation by Covering Children in Medicaid from Birth to Kindergarten—Which State Will Be Next?" *Say Ahhh!* (blog), Georgetown University Center for Children and Families, September 28, 2022, https://ccf.georgetown.edu/2022/09/28/oregon-leads-the-nation-by-covering-children-in-medicaid-from-birth-to-kindergarten-which-state-will-be-next/.

[11] Emma Oppenheimer, "Health Insurance Affordability Enterprise," October 5, 2021, Connect for Health Colorado, https://ckf.cchn.org/wp-content/uploads/Health-Insurance-Affordability-Enterprise-Overview.pdf; Adam Beam and Don Thompson, "California First to Cover Health Care for All Immigrants," Associated Press, June 30, 2022, https://apnews.com/article/health-california-immigration-gavin-newsom-medicaid-b09edcb2b89ab041b520f431f8aab4b6; Washington Healthplanfinder, "Washington Health Benefit Exchange Announces CascadeCare Savings," news release, October 4, 2022, https://www.hca.wa.gov/assets/hbe-cascade-care-savings-announcement.pdf; New York State Department of Health, "New York State Department of Health Will Ask Federal Government to Expand Essential Plan to Further Reduce Rate of Uninsured and Improve Health Equity," press release, last updated February 2023, accessed March 2, 2023, https://www.health.ny.gov/press/releases/2023/2023-02-10_expand_essential_plan.htm; Rachel Lorenz, "Lightening the Load: Costs to Drop for Those Using NM's Health Care Exchange This Year," *Albuquerque Journal*, October 22, 2022, https://www.abqjournal.com/2542474/lightening-the-load-costs-to-drop-for-those-using-nms-health-care-exchange-this-year.html.

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