

A Report of the COVID-19
Task Force Policy Translation
Working Group

Social Insurance during the Pandemic:

Successes,
Shortcomings, and
Policy Options for
the Future

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Acknowledgments

The Academy gratefully acknowledges the work of the individuals who served on the COVID-19 Task Force's Policy Translation Working Group. Their titles represent their positions at the time of the Working Group's deliberations.

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The Academy also thanks representatives of the following stakeholder organizations who were asked to provide input from their perspectives as front-line providers and advocates:

AARP
Caring Across Generations
Generations United
Liberation in a Generation
Medicare Rights Center

National Academy of Elder Law Attorneys
National Council on Aging (NCOA)
National Employment Law Project (NELP)

National Organization of Social Security Claimants' Representatives (NOSSCR)
National Healthcare for the Homeless Council
National Women's Law Center

Partnership with Native Americans
Propel
SAGE
Social Security Works

Reports of the National Academy of Social Insurance aim to assess policy options without advocating for any particular option. The options and perspectives discussed in this report do not necessarily reflect the views of individual members of the COVID-19 Task Force's Policy Translation Working Group or of the organizations with which they are affiliated.

The Academy thanks AARP, Arnold Ventures, Elevance (formerly Anthem, Inc.), Kaiser Permanente, and the RRF Foundation for Aging for their support of this project.

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Executive Summary

As the United States grappled with the COVID-19 pandemic in 2020, the National Academy of Social Insurance formed a COVID-19 Task Force consisting of two Working Groups that deliberated in two phases. The first phase was the Epidemiology Working Group. Chaired by Academy Member **Dr. Neil Powe**, Professor of Medicine at the University of California – San Francisco, the Epidemiology Working Group issued its report, *Understanding COVID-19's Outcomes and Possible Trajectory: Implications for Social Insurance Programs* in May 2021. A copy of this report is available at <https://www.nasi.org/wp-content/uploads/2021/06/COVID-19-Task-Force-Epidemiology-Working-Group-Report.pdf>.

The second phase of the COVID-19 Task Force was the Policy Translation Working Group formed in 2021. It was co-chaired by Academy Founding Board Member **Henry Aaron** of the Brookings Institution and Academy Member **Katherine Baicker**, until recently Dean of the University of Chicago's Harris School of Public Policy and now Provost of the University of Chicago. Academy Member **Louise Sheiner**, Senior Fellow and Policy Director at the Hutchins Center on Fiscal and Monetary Policy at the Brookings Institution, served as Principal Investigator. Its report, *Social Insurance during the Pandemic: Successes, Failures, and Policy Options for the Future*, follows.

The report describes and evaluates the performance of the nation's social insurance system during the pandemic and highlights its successes as well as its shortcomings. As is well known, the U.S. social insurance system helps protect individuals and families from risks to their economic well-being. Even in normal times, the social insurance system mitigates the harms caused by unemployment, illness, aging, and other forces that affect

household finances. However, in times of crisis like the pandemic, the U.S. social insurance system becomes even more important.

Overall: The U.S. social insurance system successfully mitigated the impact of the economic downturn for most individuals and families.

This report assesses the performance of pre-existing social insurance and related programs, temporary changes in those programs made in response to the pandemic, and some new federal and state policies. It addresses the following critical questions:

- What temporary measures, specifically addressing short-term crises, would have worked better to protect people?
- What changes in permanent policies or administrative practice might be considered based on the successes or failures of policies and practice in the pandemic emergency and recovery?
- What kinds of additional data collection might have produced better and more useful knowledge about the successes and failures of specific policies and administrative practices?

Key Findings

Overall: The U.S. social insurance system successfully mitigated the impact of the economic downturn for most individuals and families. Without the major

legislative and administrative changes implemented by Congress during the pandemic—including changes to Unemployment Insurance, Workers’ Compensation, Medicaid, the Affordable Care Act, and the Supplemental Nutrition Assistance Program—households would have experienced much greater financial distress and worse health outcomes. That said, the severity and abruptness of the economic slowdown stressed, and in some cases overwhelmed, the capacity of state and federal agencies to provide well-targeted assistance in a timely way. The pandemic also highlighted that the social insurance system provides different levels of protection depending on the state in which individuals and families happen to live. Lack of accurate, detailed, and timely data made it difficult to fully evaluate the performance of the social insurance system and limited the responses available.

Social Security and Medicare: The huge drop in economic activity during the pandemic did not lead to a deterioration in the finances of the Social Security and Medicare Trust Funds as was feared. However, it did highlight the sensitivity of these programs’ finances to changes in economic conditions. The closing of Social Security Administration field offices and the transition to remote work for SSA employees reduced the number of people receiving Supplemental Security Income (SSI) and Disability Insurance (DI) benefits. The pandemic underscored problems in nursing homes that had long been apparent. Medicare beneficiaries living in nursing homes were more likely to be diagnosed with COVID and more likely to die than beneficiaries living in the community, even controlling for age.

Administrative Issues: Administrative problems in the delivery of aid were particularly injurious to populations most in need. Because the federal and state governments jointly administer Unemployment Insurance and Medicaid, residents of different states received different amounts of assistance with varying degrees of administrative delay. Administrative systems that were overwhelmed by the increased demand for aid and hampered by reduced staffing delayed the delivery of aid and made accurate targeting of assistance impossible, diminishing the effectiveness of the social insurance system.

Inequities and Disparities: The pandemic highlighted and often exacerbated existing deficiencies and inequities, particularly in our health care system. It exacerbated many existing inequalities across race and ethnicity although fiscal policy responses mitigated others. Without Congressional action, many of those without health insurance would have been unable to afford COVID treatment and vaccinations. Members of different ethnic and racial groups did not have equal access to the benefits of social insurance and related programs, in part because members of different groups live in different places and in part because of other differences in access that predated the pandemic. The inequities resulting from the digital divide sharpened during the pandemic. The pandemic also exposed and magnified the inequities of the “digital divide”—the lack of access to high-speed internet and the lack of familiarity with technology.

The pandemic highlighted and often exacerbated existing deficiencies and inequities, particularly in our health care system.

Public Health Infrastructure: Analysts have long warned that our public health infrastructure is inadequate. The COVID pandemic confirmed those warnings.

Potential Income Security and Health Security Policy Options

The report of the Policy Translation Working Group identifies and assesses a broad range of Income Security and Health Security policy options in social insurance and related programs. The 44 policy options fall into three major categories.

The first consists of options that would make permanent or automatically trigger some of the new programs set up during the pandemic. These include increasing benefits and eligibility under the unemployment insurance system, automatically increasing the federal share of Medicaid spending and lowering administrative burdens for programs like SSI and SNAP during economic

downturns, and making permanent some of the changes in the regulations about telehealth and scope of practice regulations in health care, among many others.

The second category relates to the need for new policies where the pandemic uncovered a need—for example, narrowing the digital divide by ensuring high speed internet services in every community to help beneficiaries take advantage of telehealth and fixing antiquated UI administrative systems so that they are better able to respond to crises.

The third category of options includes improving data collections and research so that we are better able to understand the consequences of the pandemic and any shortcomings in the response to it. We note the significant shortcomings of the available data

on health, health insurance, housing security, and income, particularly by race and ethnicity. We also note a number of areas where more research is needed. One example concerns the question of whether the high replacement rates in the UI program during the pandemic kept the DI rolls from rising as they typically do during economic downturns.

We note the significant shortcomings of the available data on health, health insurance, housing security, and income, particularly by race and ethnicity. We also note a number of areas where more research is needed.



CHAPTER 1

Summary and Overarching Lessons

The U.S. social insurance system helps protect individuals and families from risks to their economic well-being. Even in ordinary times, the social insurance system mitigates the harms caused by unemployment, illness, aging, and other forces that affect household finances. Crises—like the pandemic—highlight the importance of the U.S. social insurance system.

This report of the National Academy of Social Insurance’s COVID-19 Task Force Policy Translation Working Group describes and evaluates the performance of the nation’s social insurance system during the pandemic. It describes the system as it existed at the start of the pandemic and the successes, shortcomings, and failures of the many changes made during the pandemic. The report also draws inferences about lessons and policy options to consider for the future. It raises the question of whether modifications made to the social insurance system during the pandemic might be made permanent, perhaps with automatic triggers that reinstate them only when the economy goes into a recession or when a public health emergency arises, or whether they might be reinstated only if Congress passes new legislation.

The U.S. social insurance system successfully mitigated the impact of the economic downturn for most individuals and families, in large part because of the significant changes made by Congress during the pandemic.

This chapter summarizes the report’s conclusions. Chapters 2–4 briefly outline each of the social insurance programs examined, summarize changes made by

Congress during the pandemic, evaluate the success of each program, and list policy options for policymakers to consider. Chapter 5 presents the policy options that are discussed throughout the report.

Broad Findings

The U.S. social insurance system successfully mitigated the impact of the economic downturn for most individuals and families, in large part because of the significant changes made by Congress during the pandemic. That said, the severity and abruptness of the economic slowdown stressed, and in some cases overwhelmed, the capacity of state and federal agencies to provide well-targeted, timely assistance. Administrative problems in the delivery of aid were particularly injurious to populations most in need. Because the federal and state governments jointly administer much of the social insurance system, such as Unemployment Insurance and Medicaid, residents of different states received different levels of assistance, with varying degrees of administrative delay. Members of different ethnic and racial groups did not have equal access to the benefits of social insurance, in part because of different residential locations and in part because of other differences in access that predated the pandemic. The inequities resulting from the digital divide widened during the pandemic because, for example, Social Security Administration (SSA) field office closures forced applicants to seek help online. Finally, the huge drop in economic activity did not, as many feared, undermine the financial positions of Social Security (Old-Age, Survivors, and Disability Insurance, or OASDI) and Medicare Hospital Insurance (HI). The remainder of this chapter elaborates on each of these summary statements.

1. The current social insurance system successfully mitigated the impact of the pandemic-induced economic downturn for most individuals and families.
 - Unemployment Insurance (UI) spared most of those who lost jobs any significant loss in income and, in fact, boosted many incomes. Many observers feared that the level of assistance would discourage the return to work, but current estimates suggest that this effect was modest during much of the pandemic.
 - Emergency legislation stipulated that states had to keep beneficiaries on the Medicaid rolls for the duration of the pandemic emergency as a condition for increased federal funding. Congress also increased the health insurance subsidies provided through exchanges established under the Affordable Care Act (ACA). As a result, there was little or no increase in the number of people without health insurance.
 - By some measures, poverty fell during the pandemic because of increased food assistance, including the Supplemental Nutrition Assistance Program (SNAP), an expanded Child Tax Credit (CTC), and the Economic Impact Payments, the checks sent by the federal government to most U.S. households.
2. Without the major legislative and administrative changes to the social insurance system implemented during the pandemic, households would undoubtedly have experienced much greater financial distress and worse health outcomes.
 - Legislation that Congress enacted during the pandemic caused a five-fold increase in UI spending. Without these changes, people losing jobs who were eligible for UI would have received less than one-half of their prior pay. Thirteen million workers—including the self-employed and those without sufficient earnings histories to qualify for UI—would have received nothing at all.
 - Similarly, without the legislated changes in the Medicaid rules and the increased ACA subsidies, many would have lost health insurance during the pandemic.
 - Without the increases in Supplemental Nutrition Assistance Program (SNAP) benefits and the rollout of the Pandemic Electronic Benefit Transfer (Pandemic EBT, or P-EBT)—a program that provided funds to purchase groceries for the value of the school meals missed due to school closures—many more children would have gone hungry during the pandemic.
 - Without the changes to Workers Compensation (WC) programs enacted in many states, many fewer workers who contracted COVID-19 at work would have qualified for benefits. Because many of these workers were not covered by health insurance from their employers and were ineligible for UI, this expanded eligibility was key in providing both wage replacement and health insurance.
 - The eviction moratorium and the \$46 billion federal Emergency Rental Assistance program helped stabilize finances and housing situations for many individuals and families, and it helped maintain incomes of property owners.
 - This aid not only helped individuals and families during the height of the pandemic slowdown, but it also left them in much better financial shape as the economy bounced back, with better credit scores and greater savings than they would have had if increased aid had not been provided.
3. Administrative systems that were overwhelmed by the increased demand for aid and hampered by reduced staffing delayed the delivery of aid and made it impossible to accurately target assistance, diminishing the effectiveness of the social insurance system.
 - The UI system buckled under the massive influx of unemployed workers, causing significant delays in benefit delivery. Antiquated computer systems that could not be reprogrammed in a

timely manner made it impossible to administer anything but the simplest benefit increases—a flat weekly increase that did not depend on previous wages.

- The closing of SSA field offices and the transition to fully remote work for SSA employees reduced the number of people receiving Supplemental Security Income (SSI) and Disability Insurance (DI) benefits.
- Confusion about whether and how the enhanced UI benefits would be treated for purposes of calculating benefits and determining eligibility under other programs led some people receiving UI to believe incorrectly that they were ineligible for other assistance.
- The first tranche of relief funds that Congress allocated to support health care providers during the pandemic was based on Medicare revenues and total patient revenues. Safety-net providers (who depend more heavily on Medicaid, which pays lower fees than private insurance) received smaller grants and suffered longer delays in receiving that assistance than did other providers. This lack of funding for safety-net providers increased existing disparities in access to quality health care.
- Families who did not file income tax returns in the year before the pandemic or whose children were born or became dependents after their last tax filing did not automatically receive the CTC. A more capable administrative system would have been able to use other administrative records to reach these families—who were likely among the neediest—more quickly.

4. The pandemic highlighted and often exacerbated existing deficiencies and inequities in our health care system.

- But for congressional action, many of those without health insurance would have been unable to afford COVID-19 treatment and vaccinations. Free vaccines and COVID-19 testing, and a temporary program to pay the treatment expenses of the uninsured,

ameliorated this problem. Without that program, many uninsured individuals would likely have faced financial distress and difficulty getting adequate treatment for COVID-19—just as many do in accessing non-COVID-19 care.

- The lack of universal paid sick leave (and, for many low-wage workers, the lack of even unpaid sick leave) threatened public health. Stopping the spread of the virus required people to quarantine. Legislation enacted during the pandemic required businesses with fewer than 500 employees to provide paid sick leave through the end of 2020 and provided tax credits for paid sick leave through September 2021. Without sick leave, many people likely would have had to continue working, thereby increasing person-to-person transmission. However, that legislation has now expired. Those with COVID-19 and other communicable diseases may once again have to go to work while sick to maintain their income and keep their jobs.

The pandemic underscored the depth of problems in nursing homes that had long been apparent. In 2020, Medicare beneficiaries living in nursing homes were 14 times more likely to be diagnosed with COVID-19 than beneficiaries living in the community, and nursing home residents who got COVID-19 were found to be more likely to die, even after controlling for age.

The pandemic underscored the depth of problems in nursing homes that had long been apparent. Low pay led to inadequate staffing, insufficient training, and high staff turnover. In 2020, Medicare beneficiaries living in nursing homes were 14 times more likely to be diagnosed with COVID-19 than beneficiaries living in the community, and nursing home residents who got COVID-19 were more

likely to die, even after controlling for age. The pandemic also highlighted a long-standing bias toward institutional care for low-income people, with Medicaid required to pay for nursing home care, but not for home- and community-based services.

- Analysts have long warned that our public health infrastructure is inadequate. The COVID-19 pandemic confirmed that assessment.
5. The pandemic demonstrated that the social insurance system provides different levels of protection depending on the state in which individuals and families happen to live.
 - Ten states have not adopted the ACA's Medicaid expansions. Non-elderly adults in these states are less likely to have health insurance and are less protected from losing insurance than residents in states that have adopted Medicaid expansions.
 - State UI systems varied widely in the capacity to process sharp increases in claims, such as occurred at the start of the pandemic, and to implement new programs quickly and efficiently.
 - The level and ease of access to UI systems and WC vary widely across states. Variations in the minimum wage across states also leads to variation in the level of UI and WC.
 - As noted above, the federal government does not require employers to offer sick leave. Some, but not all, states do.
 6. The pandemic exposed and magnified the inequities of the “digital divide”—the lack of access to high-speed internet and the lack of familiarity with technology.
 - Many of the accommodations made during the pandemic—for example, an increased use of online applications for programs like Social Security, reliance on telehealth, video-conferencing of hearings for SSDI determinations, and an online portal for families to apply for the CTC—worked well for those with access to, and knowledge of how to use, the Web. But those without access to computers with stable high-speed internet connections in private spaces and those uncomfortable with technology—including many of the elderly and residents of people in rural and low-income communities—faced serious obstacles to obtaining the benefits for which they were eligible. For example, Medicare beneficiaries' access to telehealth varied by sex, income, and U.S. Census region.
 7. The pandemic exacerbated many existing racial and ethnic inequalities, but fiscal policy mitigated others.
 - Age-adjusted COVID-19 infection rates through June 2022 were between 1.1 and 1.6 times higher for Blacks, Hispanics, and American Indian/Alaska natives than for non-Hispanic Whites. The disparity in mortality rates was even larger: Age-adjusted mortality rates were 1.7 to 2.1 times higher for Blacks, Hispanics, and American Indian/Alaska natives than for non-Hispanic Whites. These race-based disparities declined over time—even reversing themselves in some cases—as people of color became more likely than Whites to get vaccinated.
 - These disparities have many causes. They include unequal access to quality medical care and nursing homes and a long legacy of racism and discrimination. The result, even before the pandemic, was poorer health, on average, for people of color.
 - Differences in access to and knowledge of computers and differences in job profiles resulted in large differences in the availability of remote work options, likely leading to some of the differences in infection rates.
 - Food insecurity among Black and Hispanic families increased in 2020, while food insecurity among White families declined, further widening racial and ethnic disparities in food insecurity.

- Fiscal policy was more progressive during the pandemic. UI replaced a larger proportion of wages for low- than for high-wage earners during the pandemic, and the Economic Impact Payments boosted the income of low-income households proportionally far more than that of high-income households. As a result, income gaps between Black and Hispanic and non-Hispanic White households narrowed during the pandemic.¹
8. Lack of accurate, detailed, and timely data made it difficult to fully evaluate the performance of the social insurance system.
- Government poverty measures rely on the Current Population Survey (CPS), which asks respondents how much they received in benefits, including UI, SSDI, and SNAP. Administrative records, which are generally more accurate than survey responses, reveal that the CPS significantly underreports such benefits. In 2020, for example, UI payments were more than two-and-one-half times larger than reported in the CPS. Inaccurate data make it difficult to identify which policies might be changed and how. Because there is little information available about children whose parents did not file tax returns, it is unclear how many people were entitled to the CTC who did not receive it.
 - Lack of data obstructs efforts to measure exactly how much the effects of the pandemic varied by race and ethnicity. For example, some states did not report COVID-19 case rates and mortality by race and ethnicity. The SSA does not normally collect data on race or ethnicity because the categorizations are not needed for program administration. As a result, it is difficult to evaluate how the closure of field offices and the move to remote work affected different populations.
- A lack of data makes it difficult to identify whether COVID-19 rates varied by industry and occupation.
 - Lack of timely and accurate data about the spread of the virus and its effect on health outcomes greatly impaired the public health response to COVID-19.
9. The pandemic did not lead to a deterioration in the finances of the Social Security and Medicare Trust Funds, as was feared. However, it did highlight the sensitivity of these programs' finances to changes in economic conditions.
- Trust funds from which Social Security and Medicare Part A benefits are paid are projected to be depleted in the next 10–15 years. As balances decline, these programs become particularly sensitive to economic downturns. Many expected the pandemic to hasten trust fund depletion because of anticipated declines in earmarked revenues and because of rising benefit claims. In fact, the drop in revenues, although sharp, was brief, with the speedy economic recovery attributable in large part to the financial cushion that social insurance and emergency legislation provided. Neither Social Security nor Medicare spending rose more than previously expected because of the pandemic. (Medicare spending actually decreased.) As a result, the financial conditions of Social Security and Medicare Hospital Insurance were not materially affected by the pandemic.
 - Medicare spending fell in part because COVID-19 disproportionately increased mortality among Medicare beneficiaries and in part because people stayed away from doctors' offices and delayed nonemergency surgery. The Medicare program's finances were also bolstered because Medicare fees did not fully adjust to increases in hospitals' and other providers' costs.

1 Comparing median after-tax income from 2019 to 2021 from the Census table “Post-Tax Household Income Summary Measures” by race and ethnicity. See <https://www.census.gov/data/tables/2022/demo/income-poverty/p60-276.html>.



CHAPTER 2

Income Security during the Pandemic

How well did income security programs perform during the pandemic? How did the pandemic affect their financial status? What do the changes made to social insurance programs during the pandemic suggest about potential permanent reforms?

This chapter explores how the pandemic affected major income-support programs: Social Security, Supplemental Security Income (SSI), Unemployment Insurance (UI), and Workers Compensation (WC). It also examines changes to the Child Tax Credit (CTC).

2.A Social Security

The Social Security system—formally the Old-Age, Survivors, and Disability Insurance (OASDI) program—is a central pillar of the U.S. social insurance ecosystem. It is composed of two parts: Old-Age and Survivors Insurance (OASI), which provides monthly benefits to retirees and their spouses, survivors of deceased workers, and other dependents; and Social Security Disability Insurance (SSDI), which provides monthly benefits to disabled workers and their dependents.

Social Security retirement benefits account for about 30 percent of the income of the elderly, and about 40 percent of elderly households rely on it for half or more of their income (Dushi and Trenkamp 2021).² SSDI benefits are an even more important source of income for covered workers with disabilities. About 80 percent of beneficiaries receive at least one-half of their income from SSDI; 37 percent rely on SSDI as their sole source of income (O’Leary, Walker, and Roessel 2015). Poverty

among the disabled and elderly would be significantly higher absent the SSDI program (Engelhardt and Gruber 2004; Vallas 2015).

By law, retirement and survivors and disability benefits for Social Security must be paid out of the OASI and SSDI Trust Funds, respectively. These trust funds receive most of their income from contributions by employees, their employers, and the self-employed. Smaller amounts of trust fund income come from income taxes on Social Security benefits and interest earnings on trust fund assets. The two trust funds are legally distinct, but Congress may shift revenues between the funds and has done so in the past based on the programs’ respective needs (Ruffing and Van de Water 2014). For that reason, the financial status of OASI and SSDI are considered jointly. Projected spending on these programs significantly exceeds projected revenues. Before the pandemic, official projections indicated that the combined SSDI and OASI Trust Funds would be depleted in 2035.

How did the pandemic affect the long-range outlook for the Social Security system?

In spring 2020, many analysts predicted that the pandemic would hasten trust fund depletion.³ They anticipated a long and deep recession that would reduce revenues far more than any decreases in costs resulting from increased mortality. In fact, the COVID-19-induced recession turned out to be briefer and the

2 These estimates are lower than those based solely on the CPS because that survey significantly understates non-Social Security household income. See Dushi and Trenkamp (2021) for a discussion.

3 See, for example, Gladstone and Akabas (2020).

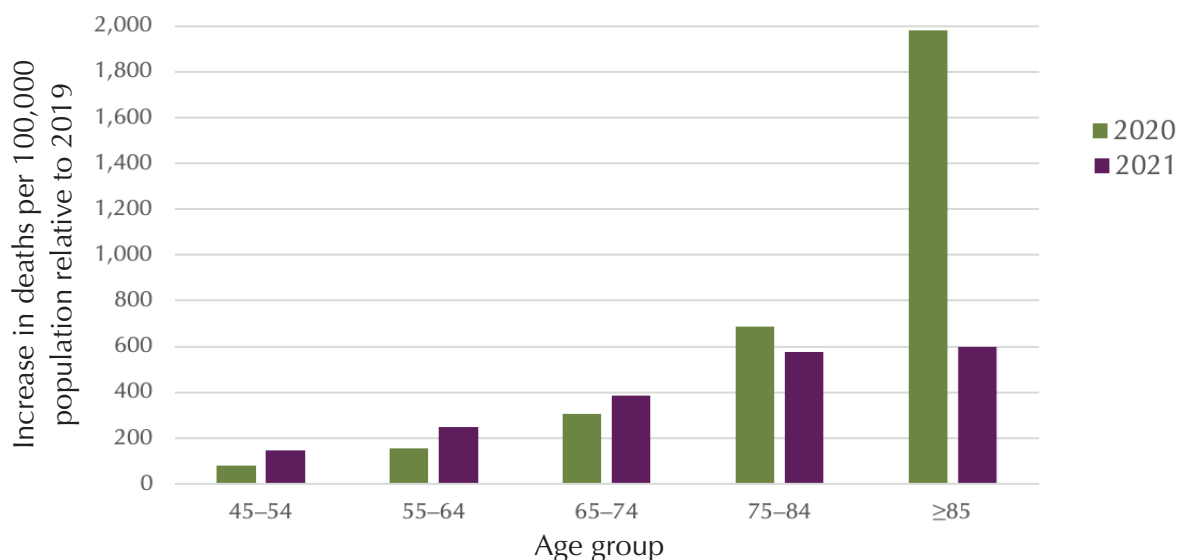
The COVID-19-induced recession turned out to be briefer and the economic recovery stronger than anticipated. As a result, the reduction in revenues has been much smaller than was expected. The health effects of the pandemic . . . have been far more dire.

economic recovery stronger than anticipated. As a result, the reduction in revenues has been much smaller than was expected. The health effects of the pandemic, in contrast, have been far more dire than initially expected. To date, there have been about 1.3 million excess deaths from the pandemic. (See chapter 3 for more details about mortality during the pandemic (National Center for Health Statistics n.d.)) The increase in deaths was concentrated among older persons (see Figure 2-1). In both 2020 and 2021, for example, about 1 percent more of those 65 and over died than would have been expected based on 2019 mortality rates.⁴ Looking

forward, the Social Security Trustees assume that death rates will continue to be elevated in 2022 and 2023, but then revert to the pre-pandemic baseline.⁵ As a result, the number of beneficiaries is projected to be lower for many years than pre-COVID-19 projections indicated. Furthermore, during the pandemic, claims for SSDI fell, while claims for OASI benefits were largely as expected. (Claims are discussed in detail below.)

In 2021, Social Security Trust Fund revenues, adjusted for inflation, were about 7 percent lower than expected before the pandemic and are projected to be about 3 percent lower in 2022. Revenues are then expected to return to the levels projected before the pandemic.⁶ In contrast, inflation-adjusted costs were about 4 percent lower than projected in 2021 and are projected to be lower through 2030, reflecting higher mortality during the pandemic.⁷ On balance, these changes in projected revenue and costs resulting from the pandemic have little effect on the financial status of the OASDI program. The projected reserve depletion date is 2035, the same as in

Figure 2-1: Increase in deaths during pandemic, by age group



- 4 Similar statistics are not available for the disabled, a problem noted by the National Council on Disability (2021) in its “2021 Progress Report: The Impact of COVID-19 on People with Disabilities.”
- 5 This assumption is consistent with a scenario in which death rates continue to be elevated because of COVID-19 (either new infections or the lingering effects of older infections) but that effect is offset by decreased deaths that happened earlier because of COVID-19. Put another way, the population that survived COVID-19 is healthier and thus deaths will be lower.
- 6 Comparison of the 2020 Trustees’ projection with actual revenues as reported in May 2022 Trustees report.
- 7 These comparisons reflect all the changes made to the Trustees’ assumptions between 2020 and 2022, some of which may not be pandemic related.

the 2020 pre-pandemic projection, and the program's long-range status is similarly little affected.

2.A.1 Effects of the Pandemic on the Social Security Retirement Program: Labor Force Participation and Employment of Older Workers, Social Security Claiming, and Benefit Levels

Participation and Employment of Older Workers:

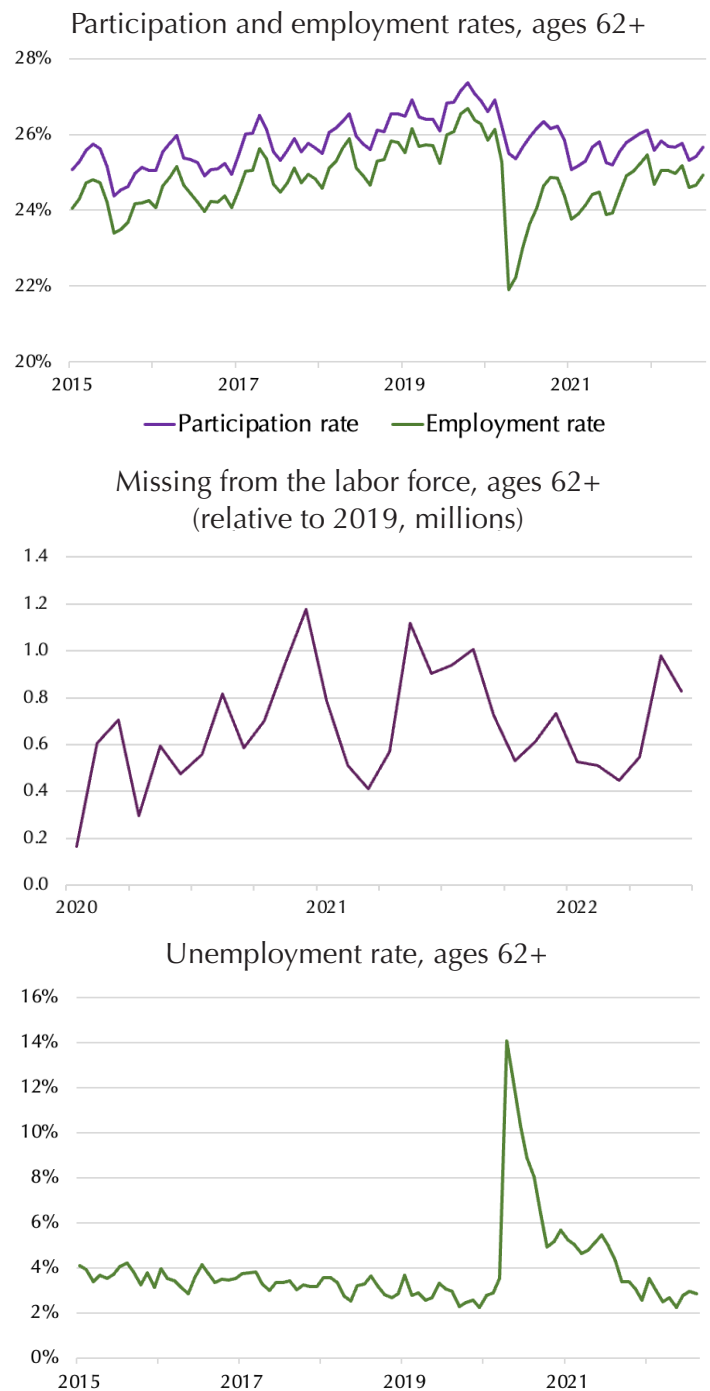
Workers: Labor force participation—the share of people who are working or looking for a job—for people ages 62 and over fell sharply at the onset of the pandemic and remains below the pre-pandemic level (Figure 2-2, top left).⁸ In August 2022, for example, participation was 1.2 percentage points below its level in August 2019.⁹

In the first months of the pandemic, about 700,000 workers ages 62 and older dropped out of the labor force (Figure 2-2, top right). That number continued climbing over the first year of the pandemic; at its peak, the reduction in participation was about 1.2 million workers. By August 2022, participation of older workers was still lower than before the pandemic, leaving the labor force deficit at about 800,000.

More older workers left the workforce during the pandemic because of involuntary unemployment than did younger workers. After reaching a high of 14 percent in April 2020, however, the unemployment rate for older workers dropped sharply and nearly returned to its pre-pandemic level by June 2022 (Figure 2-2, bottom left). By August 2022, the age-adjusted share of workers 62 and older who were employed was 1 percentage point below its pre-pandemic level (Figure 2-2, top left). The remaining shortfall in employment reflects the reduction in labor force participation.

Social Security Claiming: Reductions in labor force participation during the pandemic

Figure 2-2: Labor force statistics individuals ages 62 and over



Source: Working Group calculations from the Current Population Survey. All series are age adjusted.

- 8 Calculated from the Current Population Survey. Changes in the age distribution of the population are accounted for by calculating what the labor force participation rate would have been had the age structure of the population been the same as it was in 2019.
- 9 Participation had been on a rising trajectory that began in about 2016, meaning that the shortfall from trend (i.e., from the participation rate that would have been observed had the trend continued) is even larger, about 1.5 percentage points. It is unclear whether the trend would have continued.

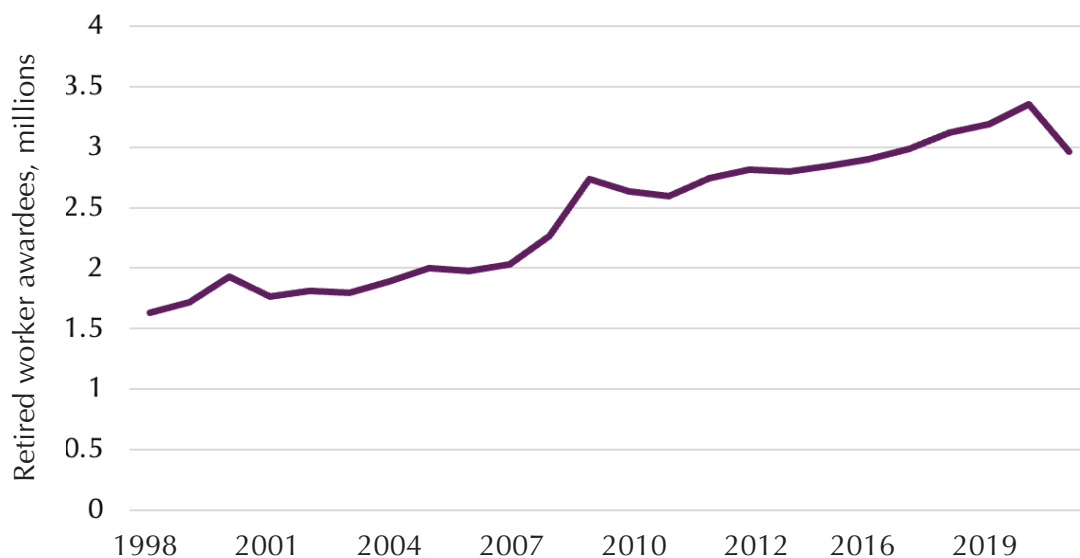
stand in contrast to applications for Social Security retirement benefits. With reductions in employment and labor force participation, one might have expected applications for Social Security retirement benefits to increase, but they did not. Instead, the number of new retired-worker beneficiaries rose by just 200,000 in 2020 and then fell back in 2021 (Figure 2-3).

One reason that claims did not increase is that many of those who left the labor force had already claimed benefits while working in order to supplement earnings. In 2021, for example, over one-half of the missing labor force participants were ages 70 or older, and one-third were older than 66 (Figure 2-4).¹⁰ Most of these workers were likely already receiving benefits while working.¹¹

The level of fiscal relief during the pandemic (including the three rounds of Economic Impact Payments that totaled \$3,200 per adult and \$2,500 per child for most families, plus the UI expansions) may be a second reason why new benefit applications did not increase. Because of this assistance, as well as the strong housing and stock markets, people who left the labor force early could afford to delay claiming benefits, thereby earning higher monthly benefits when they eventually applied.¹²

Finally, closure of SSA field offices because of the pandemic may also help explain why the number of new applications for benefits fell (see Box 2-1). If so, people may have been blocked from applying, which suggests that awards will increase in future years since most SSA field offices reopened in April 2022. Any deferral of

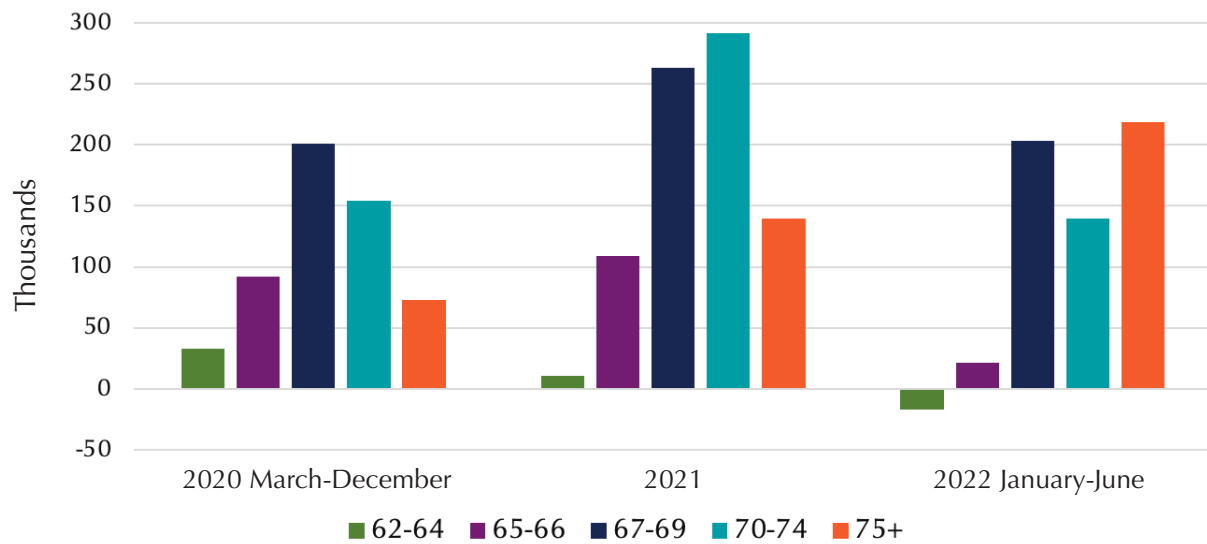
Figure 2-3: Annual retired worker awardees (millions), 1998-2021



Source: Social Security Statistical Supplement Table 6.B5.1.

- 10 Figure 2-4 assumes that in the absence of the pandemic, participation by age would have been the same as it was in 2019.
- 11 Davis (2021) found that 70 percent of those who retired during the pandemic had worked part time, supporting the notion that many of those who retired were older workers who supplemented Social Security with earnings from part-time work. Coile and Zhang (2022) found that retirements were unrelated to local labor market conditions, suggesting a role for health concerns and stronger balance sheets from government stimulus checks and strong stock and housing markets.
- 12 Two trends might also be going on at once, obscuring the relationship between COVID-induced retirements and Social Security claiming. It is possible that many of those who exited the labor force earlier than anticipated (and who were not already Social Security recipients) *did* apply for benefits, while others who retired during the pandemic as planned (i.e., did not change their retirement date) nonetheless delayed Social Security claiming, because of higher-than-anticipated income or wealth. This might lead to declines in Social Security claiming on average, with some claiming earlier than expected and others claiming later.

Figure 2-4: Missing from the labor force, by age and year



Source: Working Group calculations based on Current Population Survey.

benefits will slow the depletion of the SSA Trust Funds but somewhat increase the long-term funding gap since the Social Security benefit formula increases monthly payments somewhat more on average than the delay in benefits would justify.

Effect of the Economic Downturn and Recent Inflation on Average Social Security Benefits

Recessions affect benefits of different age groups differently (Van de Water 2020). Social Security retirement benefits are based on a person’s highest 35 years of earnings, with earnings indexed to the average wage index (AWI) in the year a worker turns 60. The AWI is intended to reflect the general increases in wages that occurred during a worker’s years of employment (SSA 2022a). It is calculated as the ratio of total wages paid in a year to the total number of workers who did any work in that year—and may therefore be affected by business-cycle variation in hours of work and unemployment. For example, those who worked in the pre-pandemic months of January 2020 and February 2020 are included in the calculation, even if they became unemployed in April 2020 and, as a consequence, had low average earnings over the calendar year.

In summer 2020, Social Security’s Chief Actuary testified that the AWI in 2020 was likely to decline about 6 percent, rather than increase 3.5 percent as had been projected in 2019 (Goss 2020a). As a result, the lifetime benefits of about 4 million people who turned 60 in 2020 would be about 9 percent lower.

This projection turned out to be unduly pessimistic. The AWI in 2020 was 2.8 percent higher than in 2019, just slightly lower than the 2019 projection (SSA 2022b).

However, the high inflation experienced in 2021 and 2022 did significantly reduce the real benefits of cohorts turning 60 in 2020 and 2021 because there is no indexing of either wages or benefits from ages 60 to 62. The cohort turning 60 in 2020, for example, did not receive the 1.3 percent cost of living adjustment (COLA) in 2021 or the 5.9 percent COLA in 2021; their real lifetime benefits are about 2.5 percent lower than if inflation had been a more typical 2.4 percent in each year. People turning 60 in 2021 received a relatively large increase in the AWI but did not receive the 8.7 percent COLA in 2022 and will not receive the COLA this year. It seems likely that their real lifetime benefits will be significantly lower as a result of the combination of higher-than-expected inflation and wages.

The experience demonstrated the pitfalls of the formulas used to calculate benefits: The lifetime benefits of

different cohorts can be significantly affected by short-term macroeconomic fluctuations like unemployment or inflation.

Effect of Earlier-than-Expected Retirement on Social Security Retirement Benefits

As discussed above, there was no net increase in Social Security claiming during the pandemic, although it is possible that some claimed early because of unemployment, while others delayed claiming in response to the financial support provided.

Early claiming has two effects. First, even if earlier claiming was actuarially fair (i.e., expected lifetime benefits were unaffected by early claiming), claiming early would lead to lower monthly payments (because monthly payments are reduced actuarially to offset the fact that benefits are received for longer). The reduction in monthly benefits increases the risk of poverty at older ages (Coile and Levine 2011).

Second, the adjustments to the benefit are not actuarially fair. Munnell and Chen (2019), for example, estimated that, given the decline in interest rates and increases in life expectancy over time, the reduction in benefits for early claiming is too large on average—that is, it leads to lower expected lifetime benefits. Older workers who cannot find work—or who face health risks from working—and need to claim Social Security early are penalized. Furthermore, older workers who face time out of the labor force may have a harder time than other workers finding jobs during the recovery (Farber 2017).

Policy Options

Many options to address Social Security’s long-run imbalances have been discussed in the past, including

by the SSA (SSA 2020) and the Congressional Budget Office (“Social Security Policy Options, 2015”). This report focuses on addressing issues that were highlighted by the pandemic.

POLICY OPTION 2.A.1: Modify formulas used to calculate the national average wage index.

Several changes might protect retiring workers from a permanent reduction in benefits when the wage index is depressed by high unemployment. The simplest solution is to bar reductions in the AWI when unemployment is high or rising.¹³ Such a change might be limited to retirees with low lifetime earnings.

POLICY OPTION 2.A.2: Modify formulas used to calculate benefits when inflation is high.

Several changes might protect retiring workers from a permanent reduction in benefits when inflation is high in the years before they are eligible for benefit indexation. For example, benefits could be increased over those years when inflation exceeds some threshold. Such a change also might be limited to retirees with low lifetime earnings.

POLICY OPTION 2.A.3: Make adjustments for early or delayed claiming actuarially fair. Workers who claim Social Security early face a lifetime of lower benefits. One option to prevent workers from having to claim early during periods of unemployment is to ensure that UI replaces a sufficiently large share of earnings (a policy option described below), as it did during much of the pandemic, thus lessening the need for early claiming. Another is to modify the formula used to calculate benefits so that the average worker does not receive lower lifetime benefits when they claim early. Given that early claimants are disproportionately low earners, this change would be progressive (Biggs, Chen, and Munnell 2021).

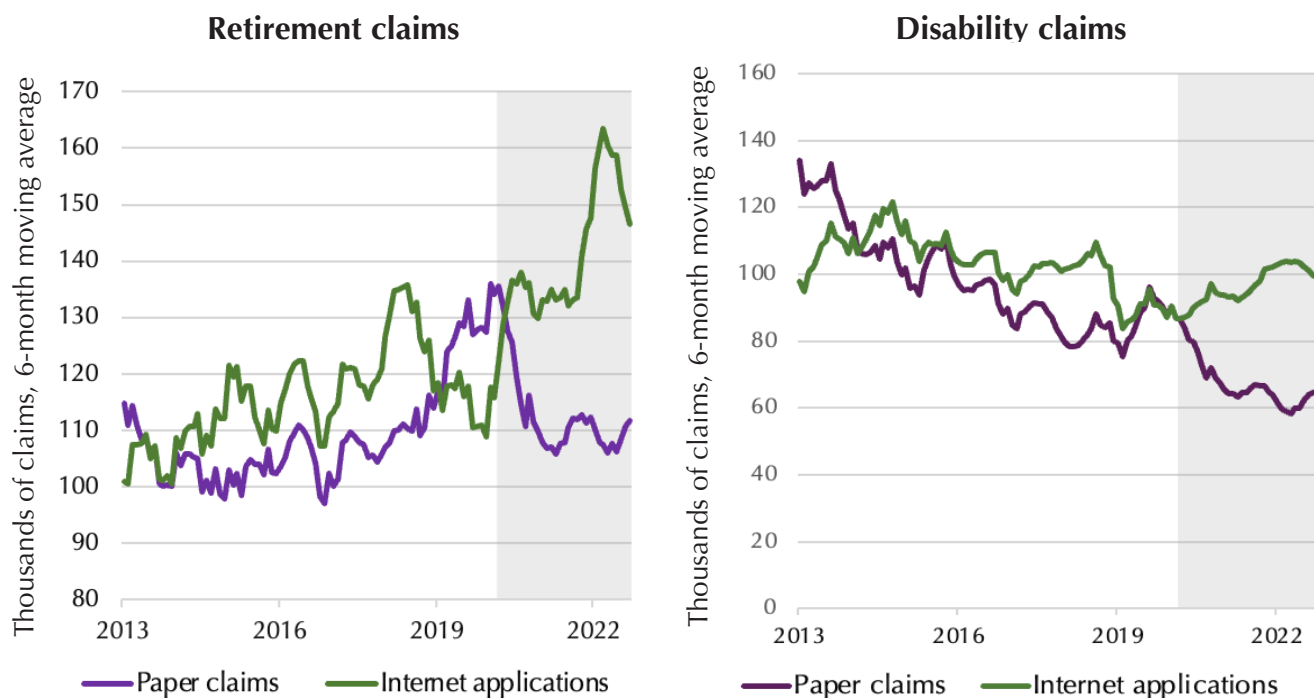
13 The “Protecting Benefits for Retirees Act,” introduced in July 2020 by Senators Tim Kaine (D-VA) and Bill Cassidy (R-TX), stipulates that if, in a given year, the standard formula leads to a reduction in the AWI, the AWI should be left unchanged. This would provide only partial protection against variations due to business cycle conditions; a reduction in aggregate earnings because of higher unemployment might still lead to a smaller increase in the AWI.

BOX 2-1 Social Security Field Office Closures during COVID-19 Pandemic

SSA field offices provide many services, including help with applications for Social Security retirement, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), and Medicare. (SSI, SSDI, and Medicare are examined below.) One may apply for Social Security and Medicare online, and help is also available by phone.

During the pandemic, SSA largely closed its field offices to protect workers and claimants. SSA employees worked remotely for nearly two years until April 2022. The proportion of all applications filed online for both SSDI and Social Security retirement benefits increased from about 50 percent pre-pandemic to 60 percent to 65 percent in mid-2022 (Figure 2-5). For retirement benefits, this reflected a large increase in internet applications; for SSDI, this shift mostly reflected a decline in paper claims (filed by mail during the pandemic).

Figure 2-5: Social Security retirement and Disability Insurance, online vs. paper claims, Oct. 2014–Aug. 2022



Despite the increase in online applications, the closing of field offices likely dissuaded people from applying for benefits.¹⁴ The application is confusing for some—particularly SSDI and SSI applicants—and difficult to complete online or without in-person assistance; others may not have access to the internet. Furthermore, with field offices closed, applicants needed to submit important documents—like passports or birth certifications—through the mail or in boxes placed outside the field offices, without any guarantee as to when or if they would be returned (Rein 2021).

The shift to remote work for SSA employees also led to problems processing applications. There were reports of large backlogs of unopened mail at SSA offices (SSA 2022c). These difficulties suggest that claims may rise sharply in the months ahead as backlogs are worked through; because field offices reopened only in April 2022, it is too soon to know how significant an issue this will be.

14 In particular, Deshpande and Li (2019) showed that the closing of some SSA field offices (while, unlike during the pandemic, others stayed open) led to a persistent 16 percent decline in the number of disability recipients in surrounding areas.

2.A.2 Effect of the Pandemic on the SSDI Program: Changes in Applications and Number of Beneficiaries

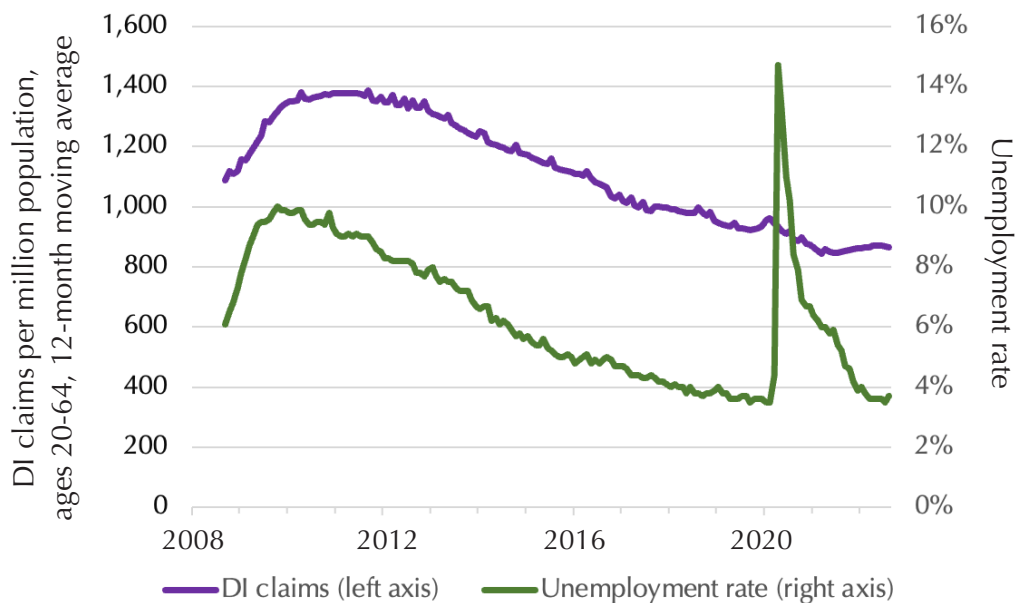
SSDI applications usually vary over the business cycle: When unemployment rises, so too do disability claims (Maestas et al. 2022). SSDI applications rose during the Great Recession and fell as unemployment subsequently declined (see Figure 2.6).¹⁵

This pattern did not repeat itself in 2020. Despite a dramatic rise in unemployment, SSDI claims did not increase, although they did flatten relative to the

pre-pandemic trend.¹⁶ Still, given the size of the unemployment increase, SSDI applications appear lower than expected, particularly in 2020 when the unemployment rate was quite elevated.

Various factors may explain why fewer SSDI applications were filed during the pandemic than expected: (1) The SSA closed field offices (see Box 2-1); (2) people who became unemployed and could be eligible for SSDI chose not to apply because of special UI benefits and other COVID-19-related assistance¹⁷; and (3) the unemployment rate came down quickly.

Figure 2-6: SSDI claims per million population, ages 20–64 and unemployment rate



Note: SSDI (Social Security Disability Insurance).

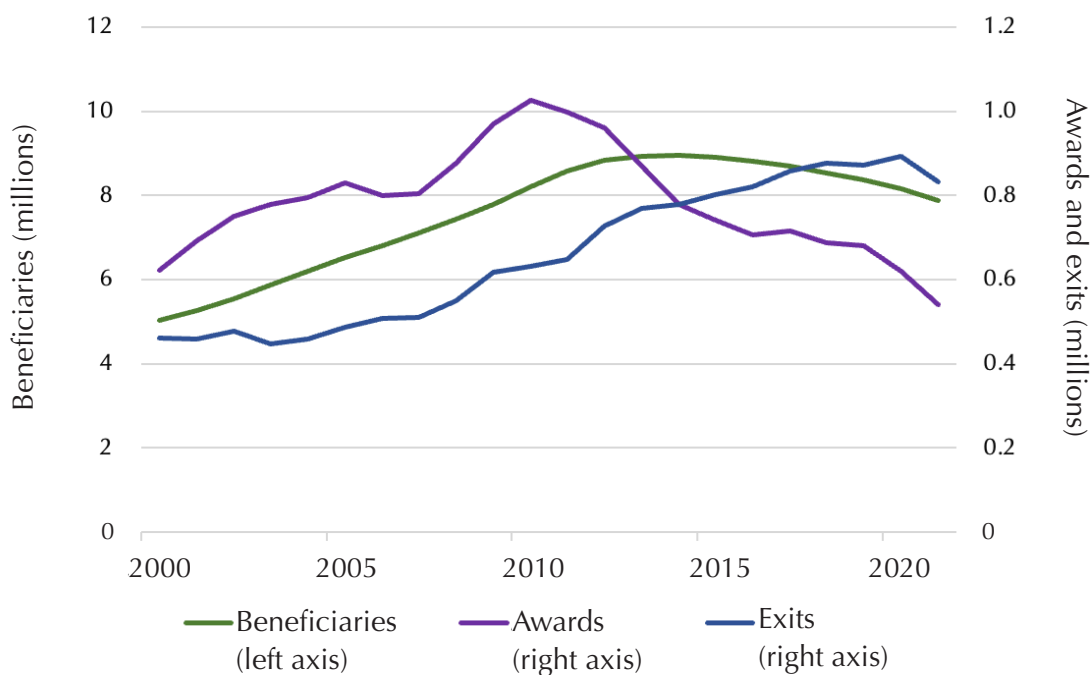
- 15 There has been much research into the causes of the decline in SSDI since the Great Recession, which had been unexpected by the SSA. In addition to cyclical factors, researchers have pointed to changes in appeals approval rates, the availability of health insurance through the ACA exchanges, the closing of SSA field offices, and changes in the nature of work (Miller 2021; Trends in Social Security Disability Insurance 2019).
- 16 SSDI applications fell 2 percent in 2020, after declining 4 percent in 2018 and 2019. Whether SSDI applications were lower or higher than expected depends on the counterfactual—that is, on what would have happened to applications in the absence of the pandemic. The SSA has been assuming that the very low rates of SSDI incidence in recent years are temporary and that SSDI incidence will rise over time. Relative to projections, SSDI applications were lower than expected in 2020 and 2021.
- 17 Although previous research has found little relationship between UI extensions and SSDI applications (see Mueller, Rothstein, and von Wachter 2016), the expansion of UI during the pandemic was unprecedented. People who lost their jobs were more likely to receive UI than in past downturns and received much higher benefits than ever before, particularly March–July 2020, when benefits were increased \$600 per week for everyone, regardless of previous earnings. Many workers received more in UI than they had earned while working (Ganong et al. 2022a), and so were likely better off receiving UI than they would have been if found eligible for SSDI. In addition, assistance in the form of Economic Impact Payments helped supplement household incomes.

Changes in the Number of SSDI Awards, Exits, and Beneficiaries during the Pandemic

SSDI awards dropped in 2020 and 2021 (Figure 2-7). Although SSDI awards had been declining since 2011, the drop during the pandemic was larger than would have been suggested by pre-pandemic trends and the increase in the unemployment rate.¹⁸ Determining whether someone is eligible for SSDI may take a long

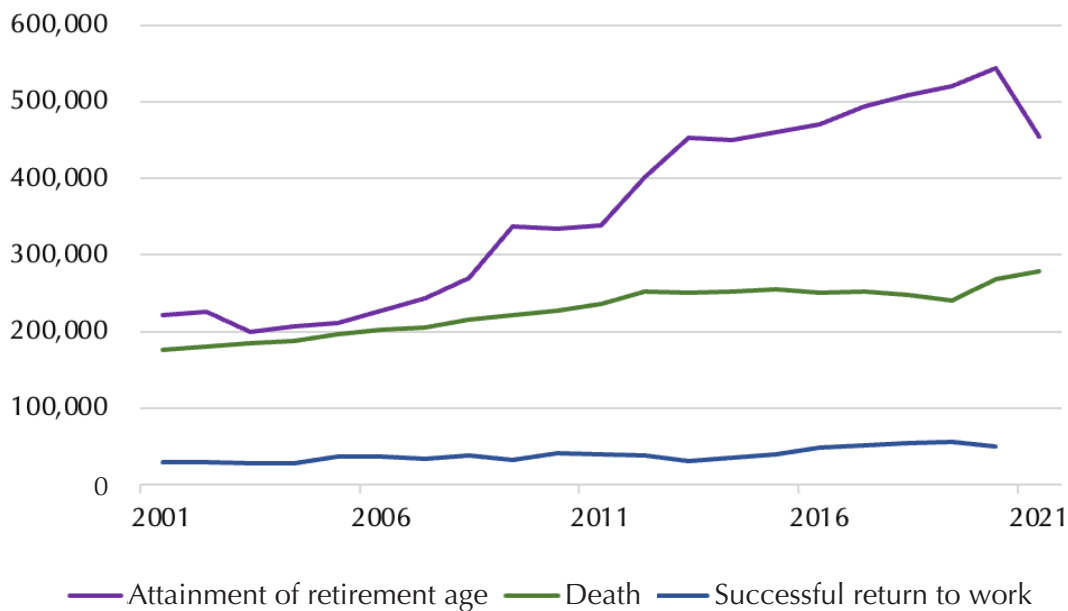
time, so the drop in applications in 2020 and 2021 will affect awards over a number of years and likely had only modest effects in 2020.¹⁹ It seems likely that the decrease in SSDI awards during the pandemic was also related to difficulties associated with the suspension of in-person hearings, the move to remote work for SSA employees, and the difficulty obtaining medical evidence during the pandemic. The number of daily SSDI hearings also fell sharply during the first seven months of the pandemic (“COVID-19: Urgent Actions Needed” 2022).

Figure 2-7: Disabled workers: beneficiaries, awards, and exits



- 18 Analysts have been somewhat puzzled by the reduction in applications over the past decade and the even sharper reduction in new awards, both of which have exceeded expected declines from the Boomer cohort aging into OASI. Part of the reason for the decrease results from fewer applications. Other factors have also played a role, including—notably—the training of administrative law judges, some of whom had unusually high award rates (Lubbers and Ray 2015).
- 19 The initial step is to apply for benefits through a local SSA field office. The field office then forwards the application to the state disability agency, which may request additional medical evidence and/or consult medical experts to make a decision. This process took 4.3 months on average in 2020. Just over one-third of applicants are determined to be eligible for benefits at this stage. Those who are denied at the first stage may ask that their denial be reconsidered by the same state agency. This process took an average of four months in 2020. Approximately 13 percent of those who ask for reconsideration are approved at this stage. Those denied eligibility at reconsideration may appeal their denial to an administrative law judge. The delay before such appeals are heard and decided is long and highly variable, currently averaging just over 12 months but ranging from 6 to 19 months across regional hearing offices. Approximately one-half of appeals are approved at the hearing level, which is the end of the process for most applicants. A small fraction of applicants denied benefits by administrative law judges appeal to the Social Security Appeals Council, and if denied there, to federal court. Applicants who are denied benefits at any stage may reapply at a later date. Approximately 47 percent of initial applicants in 2010–2014 were ultimately awarded benefits by 2018 (Hoynes, Maestas, and Strand 2022).

Figure 2-8: Annual SSDI exits by reason



The most recent observations are for 2021, except for “Successful Return to Work,” which ends in 2020.

Note: SSDI (Social Security Disability Insurance).

SSDI program exits increased slightly in 2020, driven by an increase in SSDI beneficiaries reaching the normal retirement age for Social Security and transferring out of SSDI into OASI, and by the sharp increase in mortality because of COVID-19. The number of people leaving SSDI to return to work decreased slightly from an already very low level (Figure 2-8). Overall, the number of SSDI beneficiaries continued to decline in 2020 and 2021 at about the same pace as in recent pre-pandemic years.

The Potential for Long COVID-19 to Increase Disability

Some who seem to have recovered from COVID-19 experience health problems, known as “long COVID.” These problems include fatigue, fever, respiratory and heart problems, neurological problems, digestive problems, and others (CDC 2022). Much remains unknown about the incidence and persistence of long COVID-19. According to the Centers for Disease and Prevention (CDC), an estimated 13.3 percent of those infected by COVID-19 experience post-COVID-19 conditions extending one month or more after infection, and 2.5 percent experience symptoms after three

months. Thirty percent of hospitalized COVID-19 patients experience symptoms continuing six months or more after infection. Other surveys suggest that long COVID-19 occurs even more frequently. According to the Census Household Pulse Survey, for example, roughly 30 percent of adults who ever had COVID-19 had symptoms that lasted three months or longer (CDC 2022).

Thirty percent of hospitalized COVID-19 patients experience symptoms continuing six months or more after infection. Other surveys suggest that long COVID-19 occurs even more frequently.

Even if only a small fraction of the estimated 60 percent of the U.S. population who had been infected as of February 2022 are debilitated by long COVID-19, disability might increase sharply (Clarke 2022). Evidence of the effects of long COVID-19 on labor market participation is mixed. Sheiner and Salwati (2022) estimated that about 420,000 workers have left the labor

force because of long COVID-19. Similarly, Gopi Shah Goda estimated the shortfall at about 500,000 people. Other estimates are much higher, up to 4 million (Bach 2022). Whether long COVID-19 ultimately affects SSDI depends on how severe it turns out to be and on whether the program deems workers with long-COVID symptoms to be eligible for benefits.

Remote Work and Labor Force Participation of People with a Disability

The increasing feasibility of remote work since the start of the pandemic may help those with a disability remain in the labor force (Klipfel 2020). Laws have long required businesses to make reasonable accommodation for workers with disabilities. Even so, the difficulty and cost of commuting, the stigma suffered by people with disabilities, and less-than-ideal work environments may discourage participation (Altiraifi 2019). With the increasing acceptability and feasibility of remote work, labor force participation by people with disabilities might increase. On the other hand, fear of COVID-19 might dissuade people with disabilities from working.

The Federal Reserve’s 2021 Survey of Household Economics and Decisionmaking suggested that fear of COVID-19 restrained employment more for those with a disability than for those without. For example, among nonworkers with a bachelor’s degree, 19 percent of those with a disability reported that concern about contracting COVID-19 was a reason they were not working, almost twice the share of those without a disability (“Economic Well-Being” 2022). On the other hand, that survey also showed that workers with a disability were more likely to work from home during the pandemic—and thus may have benefited more from employers’ increased acceptance of remote work.²⁰ Examining changes in labor force participation of people with disabilities, Sheiner and Salwati (2022) concluded that it is unclear whether remote work has increased participation, but

if it has, the effect is quite small. It is possible that the effect might increase over time.

Lessons Learned and Policy Options

POLICY OPTION 2.A.4: Ensure that administrative challenges do not impair access to SSDI. Closure of SSA field offices hampered applications for benefits, particularly by those without access to the internet or those who have difficulty using it. While a shift to online services may reduce administrative costs and improve customer service for many applicants, ensuring high-speed internet access, improving phone services, and providing virtual visits for people who need more help filling out forms will guarantee that no one is left behind.

Now that field offices have reopened, the SSA might consider taking steps to meet the pent-up demand by extending hours and increasing the number of appointment slots, particularly in areas where applications declined most during the pandemic (Stein and Weaver 2021). Because the SSA’s administrative budgets have been falling, after adjustment for inflation and rising caseloads, service expansion will be possible only if Congress boosts those budgets (Romig 2022).

POLICY OPTION 2.A.5: Investigate the relationship between higher UI benefits and SSDI. To what extent government financial assistance reduced SSDI applications remains unclear. Because most people who are awarded SSDI never return to the workplace, the provision of substantial but temporary UI benefits during any future epidemics might cause fewer people to leave the labor force and therefore have better long-term consequences for workers than reliance on SSDI as a means of weathering economic downturns. The relationship between household support and SSDI merits extensive future research.

POLICY OPTION 2.A.6: Ensure that people who cannot work because of long COVID are covered by

20 According to data from the Bureau of Labor Statistics, employment rates of those with a disability increased sharply in 2021. However, this rise is difficult to interpret. As discussed by Sheiner and Salwati (2022), disability rates also increased during the pandemic. If those who were newly disabled (perhaps because of long COVID) were more likely to work, this could explain the rise in employment among the disabled, rather than an increase in participation among those who were previously disabled.

SSDI. It will be important for the SSA to be able to provide SSDI benefits to people who are suffering from long COVID and unable to work. Some have suggested that the SSA should include long COVID as one of the medical conditions listed in the Disability Evaluation Under Social Security guidance document (also known as the Blue Book), arguing that such a listing would ensure that long-COVID sufferers with conditions that prevent them from working actually receive the support they need (Petrie-Flom Center Staff 2022). While it is too soon to know whether such a listing is necessary or whether the current guidelines about what constitutes a qualifying disability will be sufficient to address long COVID, this is an important area for policymakers to address.

2.B Supplemental Security Income

SSI provides cash assistance to adults and children with disabilities and people ages 65 and over who meet the program’s income and resource limits. It is funded through general revenues.

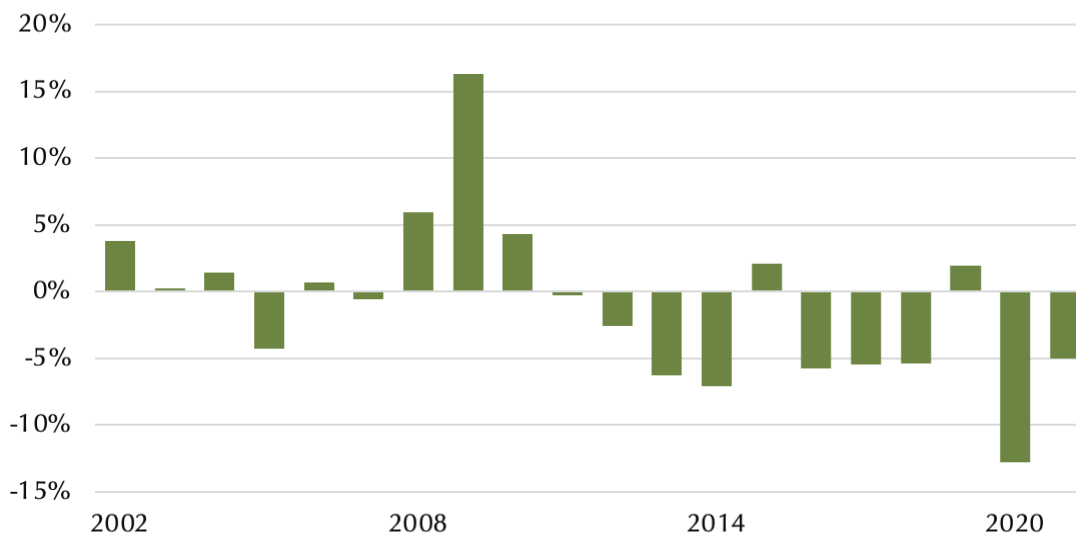
SSI guarantees a minimum income level for its recipients. For people on OASDI, SSI helps to support those with very low benefits. In 2022, the guaranteed minimum monthly income was \$841 for an eligible individual and \$1,261 for an eligible couple. Some states supplement federal SSI benefits. Most SSI recipients in most states are also eligible for Medicaid.

Unlike OASDI, SSI is available only to people with few assets—less than \$2,000 for an individual or \$3,000 for a couple, excluding a car, home, household goods, and various other items. In 2020, 29 percent of SSI recipients were elderly, 14 percent were under age 18, and 57 percent were non-elderly adults with disabilities (Giefer 2021).

Changes in SSI Applications during the Pandemic

As with SSDI, SSI applications normally rise when unemployment increases and fall when unemployment drops. Figure 2-9 shows annual changes in SSI applications.²¹ The figure shows the rise in SSI

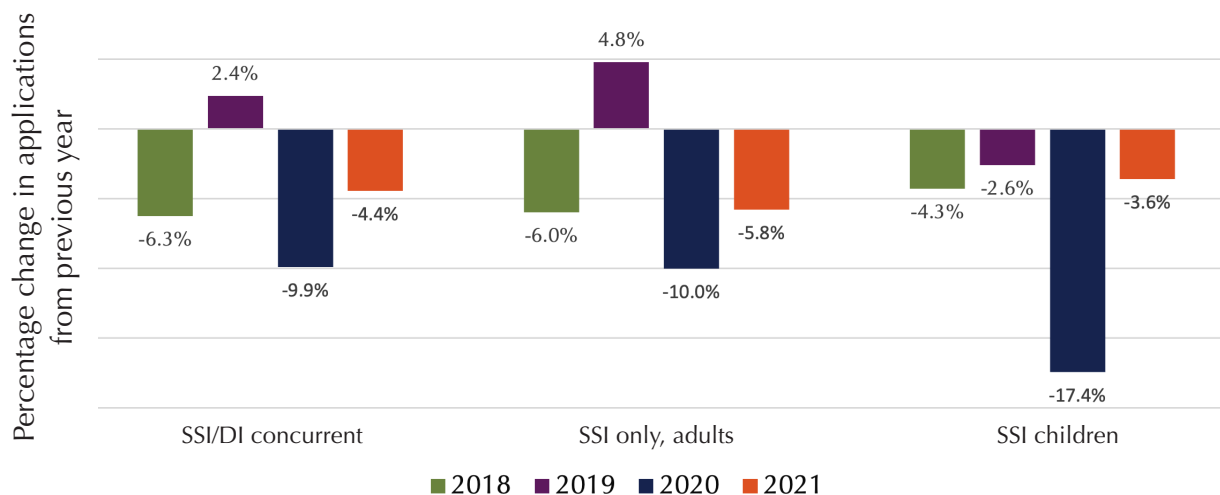
Figure 2-9: Percentage change in SSI applications



Note: SSI (Supplemental Security Income).

²¹ To spotlight the pandemic, the data are summed by year, where years begin in April. For example, “2017” is April 2016 to April 2017.

Figure 2-10: Percentage change in SSI applications by type of applicant



Note: SSI (Supplemental Security Income), DI (Disability Insurance).
Source: Social Security Administration.

applications during the Great Recession years of 2008 and 2009. It also shows that the increase in SSI applications did not occur during the pandemic: Instead, applications plummeted in 2020 and fell even further in 2021. The decline in applications was largest for children, but was also very large for adults applying for SSI alone and adults applying for SSI/SSDI concurrently (Figure 2-10).

The possible explanations for the decline in SSI applications mirror those for SSDI applications. SSA field office closures and the move to fully remote work for SSA employees made it harder for many to apply for payments. Because of these changes, SSI applications and supporting documents had to be submitted primarily by mail.

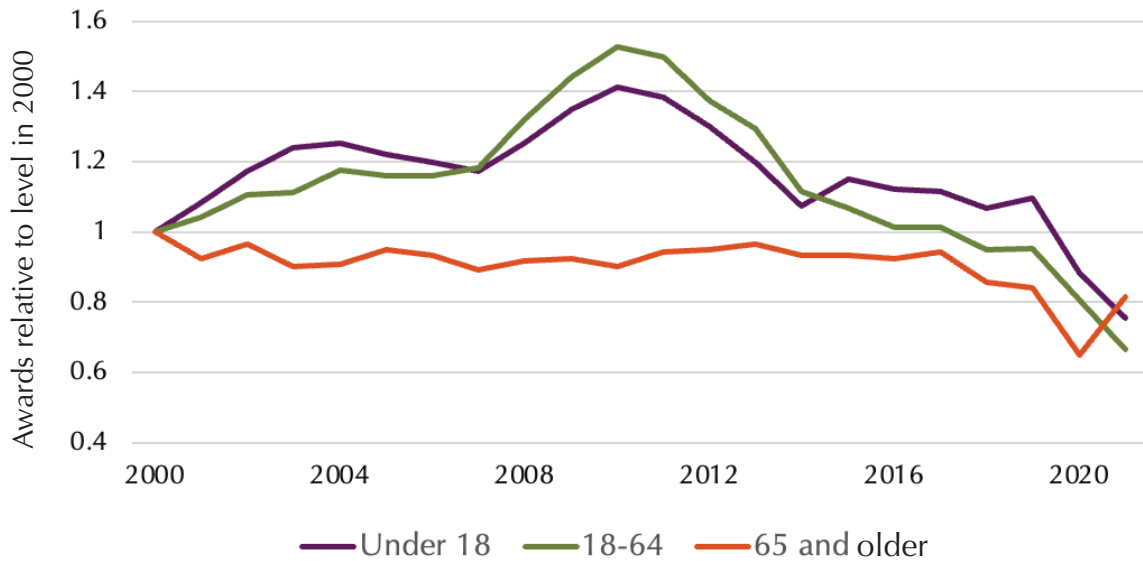
The possible explanations for the decline in SSI applications mirror those for SSDI applications. SSA field office closures and the move to fully remote work for SSA employees made it harder for many to apply for payments.

As with SSDI, the fiscal support provided to most individuals and families may have spared many the need to seek help through SSI. Households may also have believed, incorrectly, that these payments disqualified them for SSI because of that program's income and asset tests. The treatment of UI and Economic Impact Payments (EIPs) during the pandemic differed from usual practice in that Congress explicitly excluded UI and EIPs from the SSI asset or income test. The SSA was slow to make this determination, and initial guidance suggested that these programs would affect SSI eligibility and benefits.

SSI Awards, Exits, and Total Beneficiaries during the Pandemic

SSI awards rose steeply during the Great Recession for children and adults younger than 65, reflecting high unemployment's impact on SSI applications. In 2020, awards fell sharply for all age groups, despite the large increase in unemployment.

Figure 2-11: New SSI recipients, 2000-2021



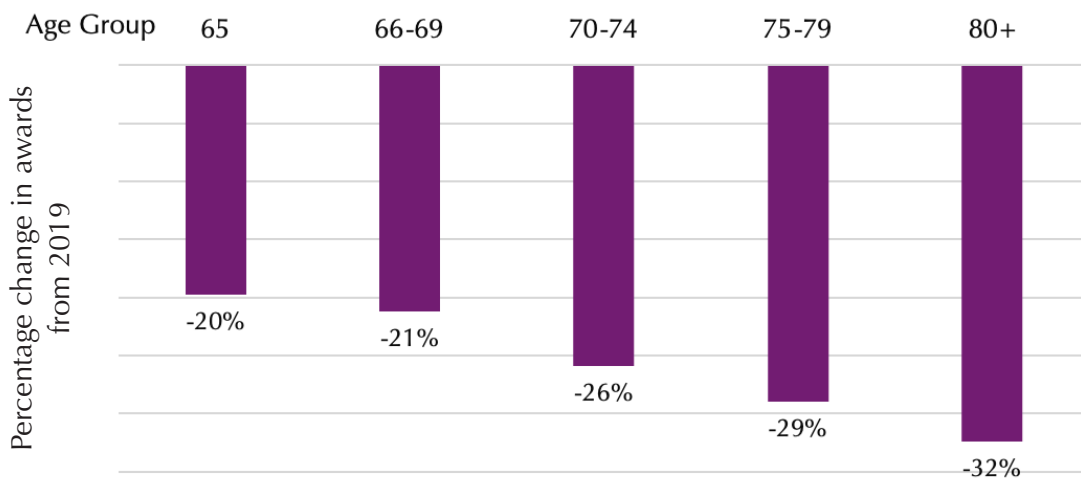
Note: SSI (Supplemental Security Income).
Source: Social Security Administration.

Part of the decline in awards in 2020 reflected SSA field office closings’ effects on applications. As shown in Figure 2-12, for example, among those 65 and older, awards declined more for older applicants who likely needed the most help applying. In 2021, awards for the non-elderly continued to decline, but rebounded for the elderly.

SSI Terminations

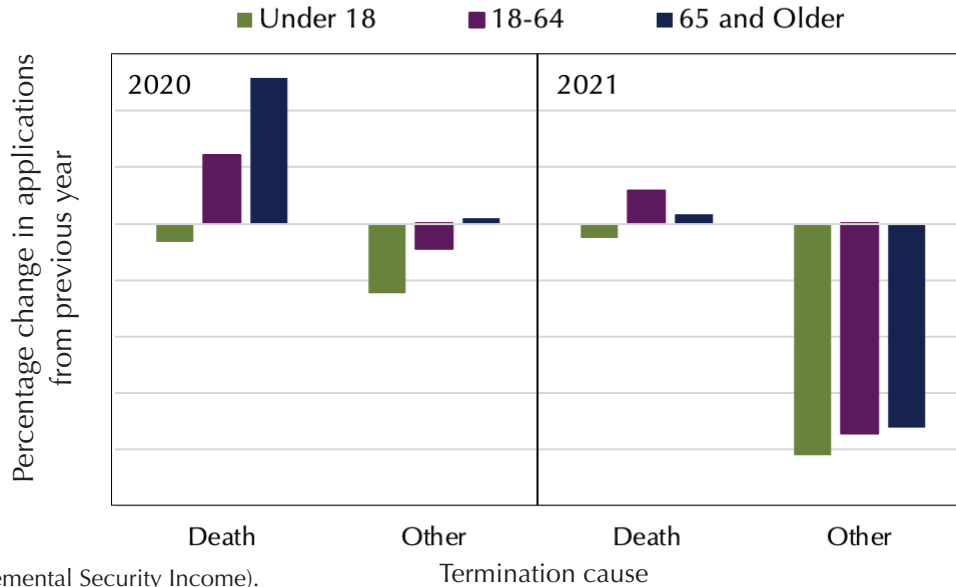
Terminations increased 3 percent in 2020, reflecting a sharp rise in the mortality of adult and aged SSI beneficiaries, but a decline in terminations for other reasons (Figure 2-13). The decline in other terminations likely reflects the decision by the SSA to “reprioritize

Figure 2-12: Decline in SSI new recipients ages 65+ by age group, 2020



Note: SSI (Supplemental Security Income).
Source: Social Security Administration.

Figure 2-13: Change in SSI terminations by year, cause, and age



Note: SSI (Supplemental Security Income).
Source: Social Security Administration.

certain manual workloads to stop actions that could, under normal circumstances, have resulted in a reduction, suspension, or termination of benefits or payments” during the initial six months of the pandemic (SSA 2020). This reprioritization included suspending reviews of income and resources for SSI eligibility.

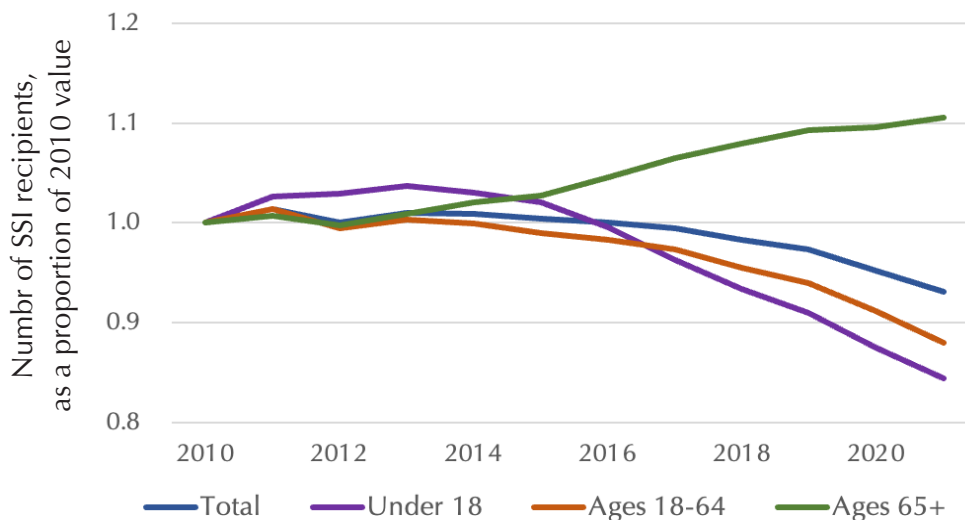
extent that SSA field office closings explain the drop in applications during the height of the pandemic, SSI participation is likely to increase in the near future, although terminations might also increase as SSA works through its backlogs.

Even if the decline in applications was the result of EIPs, there is likely to be some “catch up” in applications as those resources are spent.

SSI Recipients

As SSI applications fell and terminations increased in 2020, the number of SSI recipients declined. To the

Figure 2-14: SSI recipients by age relative to 2010, 2010-2021



Note: SSI (Supplemental Security Income).

Lessons Learned and Policy Options

Flaws in the SSI program were widely recognized before the pandemic. Benefits are too low to keep people out of poverty: 52 percent of SSI beneficiaries still lived in poverty in 2016 (Messel and Trenkamp 2022). Similarly, the asset tests are restrictively low, \$2,000 in countable assets for single beneficiaries, \$3,000 for couples.

These resource limits, which have not been changed since 1989, prevent many beneficiaries from having any reasonable cushion for unforeseen circumstances, and they discourage saving.²² SSI also discourages work because SSI benefits are reduced by 50 cents for every \$1 in earnings after a \$65 per month disregard. For a discussion of policy options to address these longstanding issues with SSI, see Romig and Washington (2022) and Altman (2020).

This pandemic highlighted other deficiencies with the system that merit consideration of policy changes.

POLICY OPTION 2.B.1: Ensure that administrative changes do not impair access to SSI. SSI participation declined during the pandemic, and changes in the SSA's operating procedures were a significant factor. To the extent that the SSA will maintain some level of remote work going forward, it needs to ensure adequate support for those who need help navigating the application process.²³ As SSI beneficiaries have few assets and little or no income, delays in processing SSI applications will contribute to protracted hardship.

POLICY OPTION 2.B.2: Simplify the eligibility and reporting requirements for SSI. One of the factors that makes it difficult for people to navigate the system is the complexity of SSI and its burdensome eligibility requirements (Altman 2020). Congress might consider revamping and simplifying eligibility and benefit rules so that they do not needlessly impede access to benefits. For example, SSI's "in-kind support and maintenance" rules require beneficiaries to disclose any non-financial help they receive from family and friends. These rules are complicated and, according to some analysts, impose

administrative costs on the SSA that far exceed any savings they might generate (Altman 2020; Romig 2021).

POLICY OPTION 2.B.3: Improve clarity in communication when fiscal policy changes have the potential to affect SSI eligibility. In normal times, UI benefits count as unearned income for the purpose of calculating OASI benefits and eligibility, and the EIPs are excluded from countable resources for only one year. The SSA changed the treatment of both of these programs during the pandemic—specifying a permanent exclusion of pandemic-related UI benefits and EIPs for the purpose of determining SSI eligibility or benefit levels ("Special Processing Instructions" 2022).

The fact that sources of income that are usually counted in determining eligibility were not counted during the COVID-19 crisis led to confusion that might have dissuaded people from applying. News reports suggested that, in some cases, SSA employees did not treat the EIPs correctly (Delaney 2021).

The interaction of different forms of financial support is complicated, and, in the future, (1) deciding early on what the treatment will be and (2) communicating that decision might be high priorities for Congress and the SSA. The exclusion of previously counted income and assets became a problem in part because the cap on allowed assets in the SSI program is so low. With EIPs averaging \$3,200 per adult during the pandemic, EIP receipt might have resulted in many beneficiaries losing SSI benefits.

2.C Workers Compensation

State WC laws require employers to buy insurance that provides state-mandated benefits to injured workers, including wage replacement, first-dollar coverage for medical treatment associated with a work-related injury or illness, and some compensation for permanent loss of function or loss of wages. In return for carrying such insurance, employers are shielded from negligence suits, including, in most states, lawsuits arising from injuries caused by gross negligence or reckless disregard for safety.

22 If it had been adjusted for inflation using the consumer price index, the limit would be over \$5,600 today.

23 While SSA field offices have reopened, employees have more opportunity to telework than they did before the pandemic (Friedman 2022).

As with other state-based programs, including UI, income support provided by WC programs varies by jurisdiction. In general, weekly benefit amounts are linked to the state's average weekly wage (SAWW), which varied in 2021 from a low of \$865 in Mississippi to a high of \$2,157 in the District of Columbia (U.S. Bureau of Labor Statistics 2022). Workers who are temporarily disabled from performing their pre-injury job most commonly receive two-thirds of their pre-injury earnings as tax-free income support, although that replacement rate varies. For example, Massachusetts sets its replacement rate at 60 percent of pre-injury earnings. The programs also generally set a weekly benefit maximum at 100 percent of the average weekly wage, although the maximum may be set as low as two-thirds of the SAWW, as in Mississippi. These temporary benefits are paid until the worker reaches maximum medical improvement, is able to return to work, or reaches the maximum number of weeks the state sets for temporary benefits. Higher wage earners—including those in jobs with significant safety risk—are unlikely to receive the full two-thirds of earnings, particularly in states with low weekly wage averages and low maximum caps. States' treatment of workers who continue to be impaired or disabled after their right to temporary benefits ends varies. As a result, benefit adequacy (defined as two-thirds replacement) is generally considered to be low (Hunt 2004).

The WC system has significant problems. It is highly adversarial, with claimants needing lawyers in most states, and there are considerable barriers to receiving benefits. Estimates suggest that in many states only 40 percent to 60 percent of potential claims are ever filed (Boden and Ozonoff 2008; Bonauto et al. 2010; Rosenman et al. 2006). For workers to receive benefits, they must be able to show that the illness or injury arose out of, and in the course of, employment—a difficult burden to meet when the illness is an infectious disease that is not limited to the workplace. In an environment of very limited sick leave coverage and without universal health insurance, WC may play an important role in providing income support and medical care coverage for active workers who contract occupational diseases.

During the pandemic, a key question was whether COVID-19 would be considered an occupational disease and covered by WC. Conditions at some

workplaces—meatpacking, for example—led to widespread transmission of COVID-19 and ultimately many deaths (“Coronavirus Infections and Deaths” 2021). State WC programs differ widely in their treatment of occupational diseases, however, and the treatment of COVID-19 infections has varied across states and among occupations. Twenty-eight states amended their laws or regulations so that COVID-19 infections would be presumed to be work related, most often for first responders and health workers, and sometimes for other workers (Cunningham 2022).

Twenty-eight states amended their laws or regulations so that COVID-19 infections would be presumed to be work related, most often for first responders and health workers, and sometimes for other workers (Cunningham 2022).

COVID claims have been filed and approved in all 45 states for which data are available (National Council on Compensation Insurance 2022). The number of claims has been small, however, and the average cost of a claim has been low. In 2020, COVID-19 claims accounted for just 7 percent of total WC claims in the median state and only 2 percent of the total dollar value of benefits. Some of these claims may turn out to involve long COVID and become more expensive over time. Insurers saw profitability margins increase on WC during the early phases of the pandemic, in large part because overall claims fell as a result of the closing of many workplaces in 2020. It seems unlikely that long-COVID costs will offset the savings resulting from the overall reduction in claims that might have involved higher costs. As a result, the pandemic left the financial health of WC insurance carriers strong.

Lessons Learned and Policy Options

States that have created clearly delineated presumptions for compensability of COVID-19 under their WC laws have decreased the amount of uncertainty for workers, employers, and insurers and have increased efficiency in

the processing of claims. At the same time, the COVID-19 pandemic has highlighted a primary weakness of WC in dealing with occupational disease. Unless there are special laws or regulations for compensating a disease, it may be extremely difficult for a worker to demonstrate that it is work related. In addition, because there are more than 50 WC jurisdictions in the U.S., consistency is difficult to attain.

POLICY OPTION 2.C.1: Clarify the treatment of pandemic-related illnesses under state WC programs.

States might make clear which illnesses and which workers will be covered for pandemic-related illnesses, as was done by the State of California, which created a rebuttable presumption of compensability for all workers who contracted COVID-19, and by the State of Alaska, which created an irrebuttable presumption of compensability for first responders. The expansion of these efforts to provide guidance for all pandemic-related illnesses might improve transparency in the system for workers, employers, and insurance carriers.

POLICY OPTION 2.C.2: Increase WC wage replacement rates to achieve benefit adequacy, which is generally thought to be a replacement rate equal to two-thirds of pre-injury earnings.

POLICY OPTION 2.C.3: Increase eligibility for WC benefits for infectious occupational diseases.

States might consider developing more inclusive rules, including presumptions for diseases, that enhance the availability of benefits to workers who contract an occupational disease.

POLICY OPTION 2.C.4: Improve data collected regarding WC benefits paid for COVID-19-related conditions. Requirements for reporting COVID-19 as an occupational disease were relaxed by the federal government during the pandemic. Sound data, including by race and ethnicity, are essential for the development of WC policies that are fair and equitable.

POLICY OPTION 2.C.5: Consider federal guidelines for WC to increase consistency and fairness across the states.

2.D Unemployment Insurance

UI is a joint federal–state program that temporarily replaces a portion of wages, typically 50 percent up to a weekly maximum that varies widely from state to state, for workers who have been laid off and are available for work. Benefits in most states terminate after 26 weeks for workers who have not found a job (Whittaker and Isaacs 2019).

Congress changed the UI program during the pandemic in many ways, which are described below. These changes expired in September 2021, returning the UI program to where it was in 2019. In 2019, the levels of UI benefits varied greatly across the states. In December 2019, average weekly benefits ranged from \$213 in Mississippi to \$549 in Massachusetts because statutory benefit formulas differed and average earnings varied (U.S. Department of Labor, Employment & Trading Administration 2022a). The share of a worker’s wage that was replaced by UI benefits varied from 37 percent in Arizona to 54 percent in Hawaii (U.S. Department of Labor, Employment & Trading Administration 2022b).

Not all unemployed workers are eligible for benefits. To qualify for UI, workers must have minimum earnings from a single employer during the base period (typically the first four of the last five completed calendar quarters preceding the claim) ranging from \$1,000 to \$5,000.²⁴ The self-employed are not eligible. Over the past year, many states have further tightened eligibility and shortened the duration of benefits (Gwyn 2022).

Eligibility restrictions disproportionately reduce coverage for low-income workers. Some estimates suggest that during the Great Recession, only one-quarter of low-wage unemployed workers received UI benefits (Zipperer and Gould 2020). A smaller proportion of Black than White workers is eligible for UI benefits. One study reported that 61 percent of unemployed Black workers were eligible for UI benefits from 2002 to 2018 compared to 76 percent of unemployed White workers (Skandalis, Marinescu, and Massenkoff 2022). Part of that gap reflects tighter rules in states where Black workers comprise a higher-than-average proportion of

24 <https://oui.doleta.gov/unemploy/pdf/uilawcompar/2019/monetary.pdf>.

employees and part reflects differing UI-relevant work histories for White and Black workers.

Changes to the UI System during the Pandemic

The federal government financed a dramatic but temporary expansion of the UI system during the pandemic. The CARES Act increased UI benefits by \$600 a week from March 2020 through July 2020. In September 2020, the Lost Wages Assistance program was created to increase benefits by \$300 a week for about six weeks, from September 2020 to October 2020.²⁵ Legislation enacted in December 2020, and extended by the American Rescue Plan, again raised weekly UI benefits by \$300. Twenty-six states ended the \$300 supplement in June or July 2021 (Zeballos-Roig and Kaplan 2021).

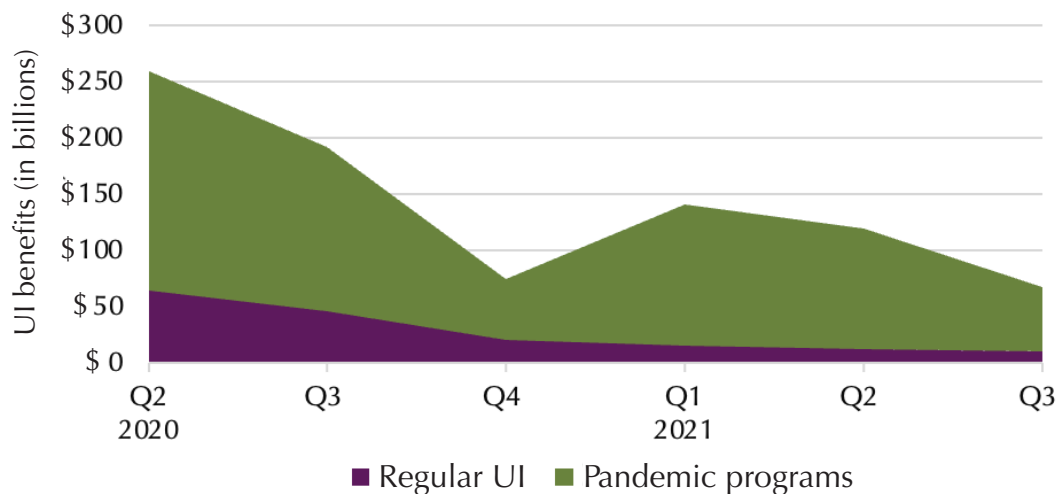
The Pandemic Unemployment Assistance (PUA) program, also originally enacted by the CARES Act, expanded eligibility for UI benefits to workers who were self-employed or who would be ineligible for regular

UI because of irregular or insufficient work histories, because of a health risk at work or because of dependent care responsibilities. The PUA program was extended by the American Rescue Plan and then expired in September 2021 (unless states ended it early). Legislation enacted during the pandemic also provided 53 weeks of additional benefits for workers who exhausted their regular UI benefits. This provision also expired in September 2021.²⁶

The changes in UI benefit amounts were larger than any made in previous recessions. In the Great Recession, for example, Congress increased UI benefits by \$25 per week and did not broaden eligibility. Extending benefits during recessions is common, however; in the Great Recession, for example, benefits were available for up to 99 weeks.

The legislative changes made during the pandemic boosted UI expenditures to \$840 billion from the second quarter of 2020 through the third quarter of 2021 (Figure 2-15) (“Federal Recovery Programs” 2022). Only 20 percent of the UI expenditures were from regular UI. The pandemic programs increased benefits five-fold.

Figure 2-15: Unemployment insurance benefits



Note: UI (Unemployment Insurance).
Source: Bureau of Economic Analysis.

25 The federal government also created the Paycheck Protection Program, or PPP, which gave forgivable loans to businesses in order to keep people employed. See Chodorow-Reich et al. (2022) for an analysis of the effects of this program.
26 Congress enacted the PPP, which gave forgivable loans to businesses that kept workers on payroll. This report does not evaluate this program. Interested readers may refer to Chodorow-Reich et al. (2022) and Hubbard and Strain (2020).

Distributional Impact of Benefits: The UI expansion was very progressive. The flat benefit increase was larger relative to earnings for low- than for high-wage workers. The expansion of eligibility to those whose earnings histories would have been insufficient to qualify them for UI under past law also helped low-wage workers more than high-wage workers (Ganong et al. 2022a). The patterns of COVID-19 job loss increased this effect because unemployment was concentrated among low-wage workers (Sheiner 2022). Benefits exceeded previous earnings for about three-quarters of the unemployed when the supplement was \$600, and about half of workers when it was \$300 (Figure 2-16; Ganong, Noel, and Vavra 2020).

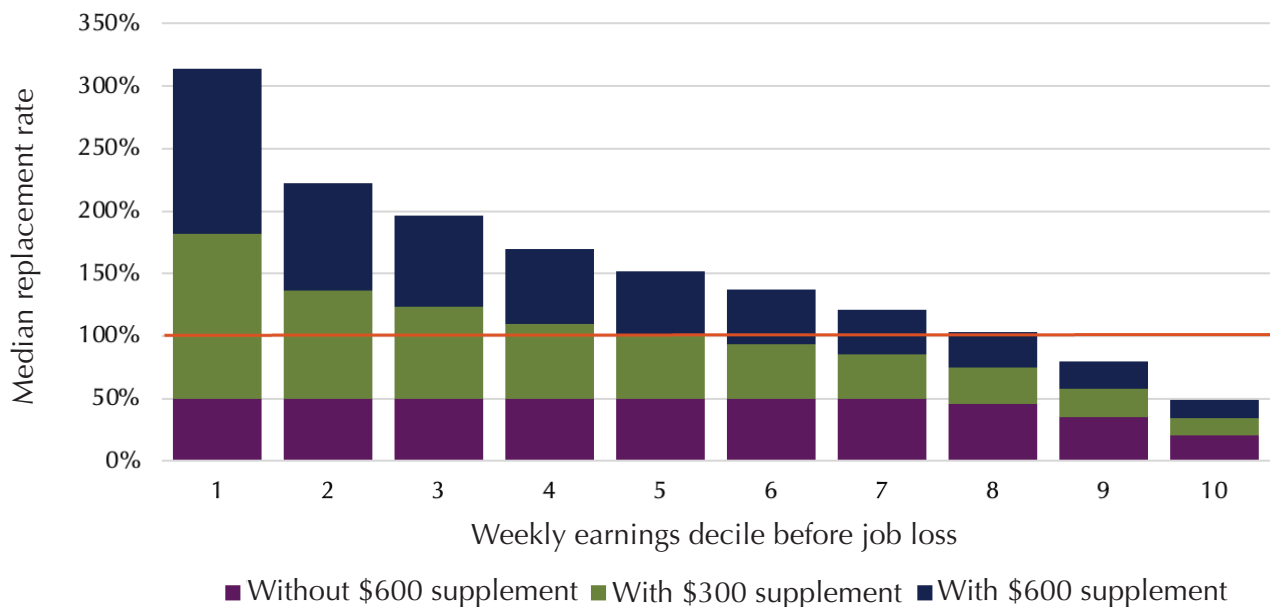
The PUA program (which expanded eligibility to the self-employed, those without sufficient earnings histories, and others unable to work for reasons related to COVID-19) was also progressive. The median 2019 income of people receiving PUA benefits was 25 percent lower than the median income of those receiving only regular UI benefits (Ganong, Noel, and Vavra 2022).

Data on the distribution of UI benefits across race and ethnicity are available from the Census Bureau’s Annual Social and Economic Supplement to the Current

Population Survey (CPS). However, surveys like this tend to understate UI benefits. The data problem worsened during the pandemic: The reported value of UI benefits in 2020 in the CPS was less than half of the value of the benefits that administrative records indicated that households actually received (Larrimore, Mortenson, and Splinter 2022). Using these potentially unreliable data from the CPS, Figure 2-17 shows that reciprocity rates for unemployed workers by race and ethnicity in 2020 resembled that in the Great Recession: Black, Hispanic, and other non-White unemployed workers were less likely to report receiving UI benefits than White unemployed workers. Using data from the Household Pulse Survey, Mar, Ong, and Lawson (2022) also found that unemployed Black and Hispanic workers were less likely to receive UI benefits during the pandemic. The reasons for these disparities are unclear and deserving of more research.

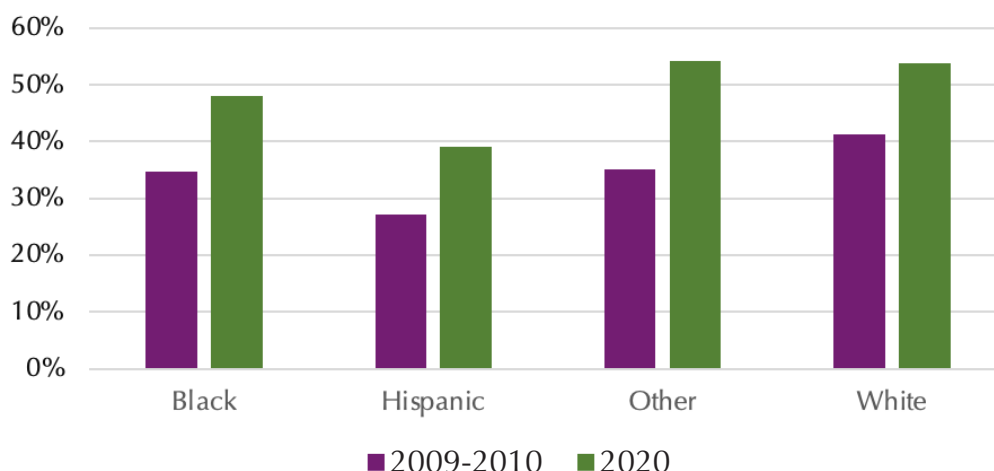
Effects on Household Spending: Using administrative data from the bank accounts of Chase customers, Ganong et al. (2022) found that the UI benefits resulted in large increases in household spending. Comparing workers who received benefits to those who did not receive any because of administrative delays at the start of the pandemic, for example, the authors found that

Figure 2-16: Median Unemployment Insurance replacement rates by earnings decile



Source: Chart created by the Working Group using data from Ganong et al. (2022a).

Figure 2-17: Share of unemployed workers reporting UI receipt, by race and ethnicity



Note: UI (Unemployment Insurance).

Source: Panel calculations using the Census Bureau's Annual Social and Economic Supplement to the Current Population Survey.

nearly half of unemployment benefits are spent in the first month after receipt. Examining the expiration of the \$600 supplement and the onset of the \$300 supplement, they found that about 30 percent of benefits were spent in the first month of receipt. The large increases in UI benefits during the pandemic meant that workers who lost their jobs actually increased their consumption rather than reduced it, as is typical after job loss (Gruber 1997).

Effects on Job Search and Labor Force Participation:

Policymakers face a tradeoff when deciding how much of past earnings UI should replace. The larger the share, the better UI protects workers from financial loss, but the weaker are incentives to find work and accept a job if offered. Replacement rates were much higher during the pandemic than ever before. This “natural experiment” provided the first direct evidence of how very high replacement rates affect work incentives during an economic downturn. Analyses of the resulting data show that the substantial UI benefits did affect employment, particularly in 2021 after COVID-19 vaccines had been widely disseminated and labor demand was strong. For example, Holzer, Hubbard, and Strain (2022) found that the unemployment rate for workers ages 25 to 54 in July and August of 2021 would have been 0.75 percentage point lower had all states chosen to terminate federal benefits early; Coombs et al. (2021) found broadly similar results. The estimated effects over the entirety

of the pandemic were smaller than estimates based on previously available data would have predicted (Ganong et al. 2022a). The smaller disincentive effects likely reflect a number of factors, including the fact that the supplements were temporary (recipients knew that they could not count on them for long), as well as pandemic-specific factors, like fear of COVID-19 and lack of childcare (Ganong et al. 2022b).

The studies did show that workers were much worse off when the UI supplements expired. Termination of UI benefits was associated with an increase in the proportion of the unemployed who found jobs, but the increase in earnings associated from added work was much less than the reduction of income from lower UI benefits (Coombs et al. 2021). Some research indicates that those who search longer for a job because of UI end up finding better jobs with higher wages, suggesting that improvements in match quality must be weighed against longer unemployment spells (Nekoei and Weber 2017).

Administrative Challenges

At the start of the pandemic, more than half of states were running their UI systems with 1980s technology, using outdated hardware and software (Kelly 2020; Simon-Mishel 2020). Pennsylvania Department of Labor and Industry Secretary Kathy Manderino (2017) described that state's UI system as being held together by “chewing gum and duct tape.” Outdated technology

forced Congress to offer every UI recipient a flat \$600 per week supplement “because the antiquated state UI administrative capacity could not handle more tailored ways to increase UI benefit generosity” (Bivens 2020).

Even with more up-to-date systems, UI agencies would have been challenged during the pandemic: The unemployment rate nearly tripled between March and April 2020—a larger monthly increase than ever observed before.²⁷ Furthermore Congress enacted major changes to UI rules, which states had to implement quickly (Ganong et al. 2022a).

These challenges caused significant delays in benefit issuance. Only 14 percent of pandemic UI claims had been paid by the end of March 2020, 47 percent by the end of April, and 56 percent by the end of August (Novello and Stettner 2020).²⁸ In 2020, workers receiving regular UI had to wait about three weeks to get their first payment, but workers receiving PUA (the system for workers ineligible for regular UI) had delays of six or seven weeks (Ganong, Sullivan, and Anderson 2022). Delays subjected recipients to economic hardship that modernized administrative systems could have avoided (Farrell et al. 2020). These hardships would have been worse had not the federal government also distributed EIPs (rebate checks) to most households in the spring of 2020 (“Consumption Effects of UI” 2020).

Outdated UI systems contributed to . . . fraud. . . . Modernized . . . technology would have improved payment accuracy while reducing processing time.

Outdated UI systems contributed to fraud. States relaxed anti-fraud efforts, such as third-party verification, in order to process applications more quickly. The share of improper payments doubled during the pandemic—from about 9 percent to 18 percent, which Ganong et al. (2022a) attribute to a mix of weaker agency control activities in the face of a huge volume of claims and an increase in crime. Modernized technology would have

improved payment accuracy while reducing processing time.

Lessons Learned and Policy Options

Despite genuine administrative problems, the expansions of UI during the pandemic were highly successful in avoiding sustained economic hardship. The reforms protected tens of millions of job losers financially, while discouraging reemployment only modestly. Furthermore, the large spending trend resulting from UI payments demonstrated that UI benefits can be an effective tool to boost consumption during economic downturns.

POLICY OPTION 2.D.1: Increase replacement rates for UI. UI replaces at most 50 percent of previous earnings, often much less, significantly below replacement rates in many other countries (Organisation for Economic Co-operation and Development [OECD] 2016). Replacement rates could be raised for all UI recipients (Ganong et al. 2022a) or for those with low earnings histories (Dube 2021). Both replacement rates and UI duration might be automatically increased when a state’s unemployment rate rises, if not permanently.

POLICY OPTION 2.D.2: Increase eligibility for UI. In normal times, many unemployed workers are ineligible for UI, including low-wage and part-time workers without sufficient earnings histories, the self-employed, new labor force entrants, and workers who leave their jobs voluntarily. The expansions during the pandemic showed that broadening eligibility is feasible. One analyst proposed lowering earnings thresholds and allowing workers who quit for good cause to be eligible for UI, where good cause might include changes in work circumstances (e.g., wage cuts or shortened hours) and extenuating family circumstances (e.g., poor health or the relocation of a spouse) (Dube 2021). Another analyst proposed a federal Jobseeker’s Allowance—a small, short-term allowance to support workers who are ineligible for UI because they lack a recent work history, including the self-employed and new entrants to the labor force (West et al. 2016).

27 Since 1929, when monthly data first became available.

28 These numbers are probably a lower bound, as they include only those receiving regular UI benefits.

Despite genuine administrative problems, the expansions of UI during the pandemic were highly successful in avoiding sustained economic hardship. . . . Furthermore, the large spending trend resulting from UI payments demonstrated that UI benefits can be an effective tool to boost consumption during economic downturns.

POLICY OPTION 2.D.3: Increase federal financing of UI. These reforms would raise UI costs and necessitate additional funding. One option would be for the federal government to pay a share of UI costs for states that meet some minimum replacement rates and eligibility standards—just as it did for states that expanded Medicaid under the Affordable Care Act. Alternatively, UI might become a fully federal program, like Social Security (Dube 2021). Federalization and uniform national rules might reduce current inequities, including the fact that UI is currently less adequate for Black than for White workers. A third option could be federal legislation that might encourage states to raise the UI payroll tax base, which currently is as low as \$7,000.

POLICY OPTION 2.D.4: Address UI technology before the next downturn. The experience during the pandemic demonstrated the importance of having adequate administrative capacity. Some states have worked on modernizing their systems over the past 10–20 years, and the American Rescue Plan provided grants to states that might lead to further improvements. State policymakers might consider moving quickly to modernize their UI systems to ensure that unemployed workers can access UI benefits easily, without undue administrative burdens, while also ensuring that the system has checks to prevent fraud and the flexibility to adjust replacement rates or other rules if desired.

2.E The Pandemic Child Tax Credit

The Child Tax Credit (CTC) was first enacted as a part of the 1997 Taxpayer Relief Act. It was originally a modest nonrefundable tax credit (\$400 per child) for middle-income families with children. Successive legislative changes increased the credit and made it partially refundable and fully available to families with income up to \$400,000.²⁹

Before the pandemic, this credit was equal to 15 percent of earnings above \$2,500, up to \$2,000 per qualifying child. Only \$1,400 per child was refundable. For low-income families, the credit was tied to earnings: The higher the earnings, the higher the credit.³⁰

The tying of the credit to wages and the limit on refundability resulted in children in the lowest-income families receiving the lowest credit. In 2022, an estimated 18.7 million children—28 percent of all eligible children—received less than the full credit or no credit at all because their families lacked earnings or their earnings were too low (Tax Policy Center 2022). The shares of Black and Latino children receiving less than the full credit was even larger, with over 40 percent likely not receiving it.³¹

Changes to the CTC during the Pandemic

Because of the structure of the CTC, low-income families who experienced periods of unemployment during the pandemic might have received a smaller credit. The Taxpayer Certainty and Disaster Tax, enacted in December 2020, allowed filers to use either 2019 or 2020 earnings to calculate the 2020 credit to safeguard the credit for poor families.

The American Rescue Plan made additional temporary changes to the CTC for 2021. It increased the maximum credit for families with income below a certain threshold

29 The credit phases out at a 5 percent rate for heads of households with income above \$200,000 and for married filers with income above \$400,000. See <https://sgp.fas.org/crs/misc/R45124.pdf> for the legislative history of the Child Tax Credit.

30 These provisions were legislated in the Tax Cuts and Jobs Act (TCJA), which doubled the Child Tax Credit but also made several other changes to the tax code—for example, eliminating the personal exemption for dependents, which on the whole kept the tax treatment of families roughly constant (Maag 2019). These provisions are set to expire in 2025.

31 This is a rough estimate based on Marr (2022).

to \$3,000 per child (\$3,600 for children 0–5 years old)³²; it made the credit fully refundable regardless of earnings—meaning that low-income families would receive the entire credit—and it provided half the amount of the credit in monthly advance payments (with the remaining half claimed on the 2021 tax return.) It also made 17-year-old children eligible for the credit, whereas the maximum age of eligibility had been 16. These provisions expired at the end of 2021.

Effects of the Expanded CTC on Children’s Well-Being

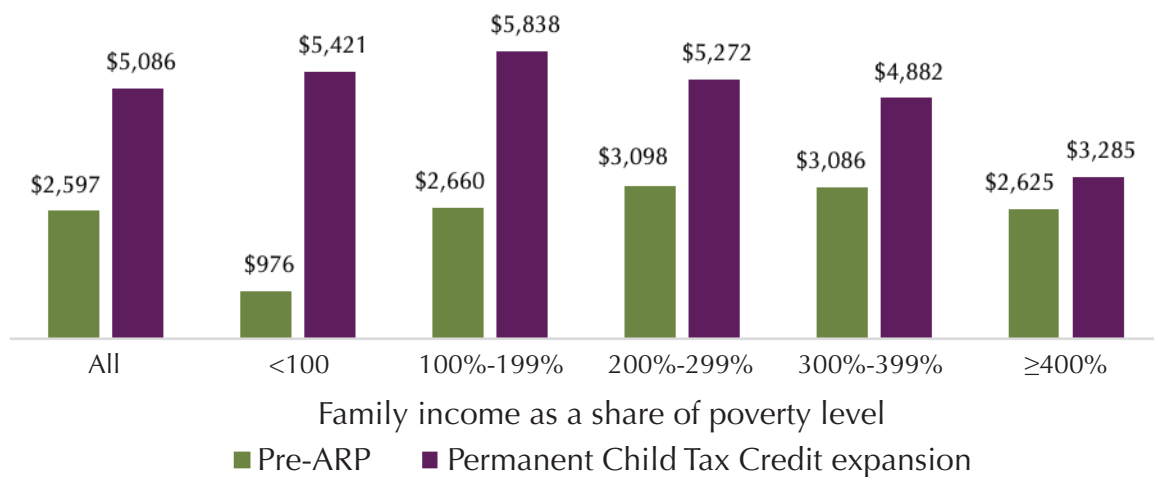
The Congressional Research Service estimated that the shift to full refundability and the temporary increase in the CTC under the American Rescue Plan—if made permanent—would increase the average credit for families with incomes below federal poverty thresholds from \$976 to \$5,421 and for those with more than four times the federal poverty thresholds from \$2,625 to \$3,285 (Figure 2-18) (Crandall-Hollick, Carter, and Boyle 2021).³³ As a result, child poverty rates would

decline by almost 50 percent.³⁴ Black and Hispanic households with children would see the largest declines in poverty rates, if the credit were reinstated on a permanent basis—from 18 percent to 10 percent and from 20 percent to 12 percent, respectively (Figure 2-19).

Estimates from 2021 suggest that the expansion of the CTC reduced household food insufficiency in families with children by 26 percent (Shafer et al. 2022). Families with low incomes reported that they spent most of the credit on basic needs and educational expenses (Center on Budget and Policy Priorities 2022).

The net effect of the fiscal support provided to families with children during the pandemic—including UI, the EIPs, and the expanded CTC in 2021—was a sharp drop in childhood poverty.

Figure 2-18: Average monthly Child Tax Credit with and without ARP CTC expansion, by income



Note: ARP (American Rescue Plan), CTC (Child Tax Credit).

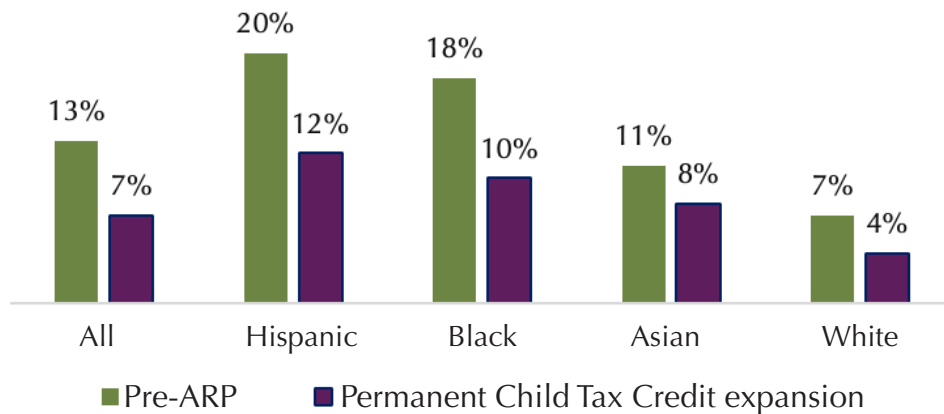
Source: Working Panel Chart based on data from Congressional Research Service (2022).

32 The phaseout of the additional CTC amount began at \$75,000 for single filers, \$112,500 for heads of household, and \$150,000 for joint filers.

33 These estimates are simulated for a non-recessionary economy under the assumption that take-up is complete.

34 (Crandall-Hollick, Carter, and Boyle 2021).

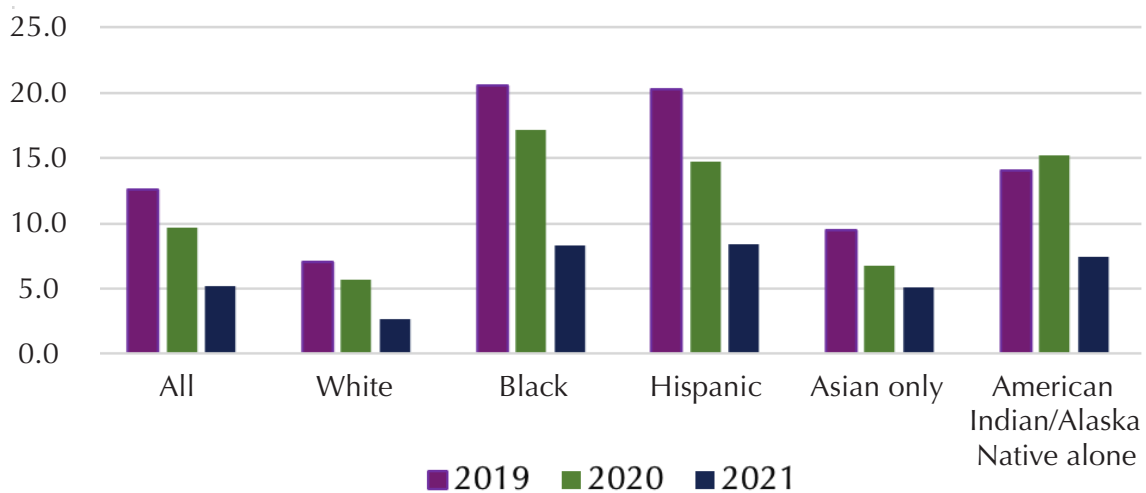
Figure 2-19: Child poverty rates with and without ARP CTC expansions



Note: ARP (American Rescue Plan), CTC (Child Tax Credit).

Source: Working Panel Chart based on data from Congressional Research Service (2022).

Figure 2-20: Child poverty (Supplemental Poverty Measure)



The net effect of the fiscal support provided to families with children during the pandemic—including UI, the EIPs, and the expanded CTC in 2021—was a sharp drop in childhood poverty, as measured by the Census Bureau’s Supplemental Poverty Measure (Figure 2-20).

Effects of the CTC on Parents’ Labor Force Participation

The previous CTC provided low earners an incentive to work because the value of the credit increased with

earnings. The flat American Rescue Plan Act credit eliminated this incentive. To the extent that the shift in the credit formula reduced work, total family income would increase by less than the added credit. One study that addressed this question found that the expanded credit had no significant immediate impact on employment or participation in the labor force (Ananat et al. 2022). These effects might not occur immediately, and the response during the pandemic might be different from the effect in ordinary times. One simulation found that a permanent credit would cause an estimated 1.46

million workers (2.6 percent of working parents) to leave the labor force, offsetting half of the poverty-reducing effect of the credit and completely eliminating the reduction in deep poverty (Corinth, Meyer, and Wu 2022). Another study argued that this estimate of withdrawal from work was too high because it was based on historical labor supply responses, whereas women have become a greater part of the labor force than in the past and less likely to withdraw from work because of the credit (Goldin, Maag, and Micheltore 2022).

Administrative Challenges with the Monthly Advanced CTC

Any benefit administered through the tax system misses many people because millions of households do not file tax returns. That problem affected the CTC. Families who did not file returns (or did not have children on their last tax filing) did not automatically receive the credit. The IRS tried to deal with this problem by creating a portal through which non-filers could claim the credit, but some families without access to or comfort with computers likely failed to receive the intended benefit.

Exactly how many fell through the cracks is uncertain because information about children whose parents do not file tax returns is scarce. Overall, estimates suggest that by the end of 2021, 90 percent to 95 percent of eligible children were receiving the monthly credit—a much higher rate of take-up than in most other programs (Parolin et al. 2021). The take-up rate was likely lower by very-low-income families who are not required to file taxes. A survey of very-low-income families with children who use an app to manage their SNAP benefits found that about 20 percent of children in these families were not receiving the credit (Pilkaukas and Micheltore 2021); if these families were more likely than other poor families to be aware of benefits, then the overall share of children in poor families not receiving the credit might be higher than 20 percent. As noted above, surveys tend to underestimate receipt of public benefits, so the share might be lower.

Any benefit administered through the tax system misses many people because millions of households do not file tax returns. . . . The IRS tried to deal with this problem . . . but some families without access to or comfort with computers likely failed to receive the intended benefit.

Lessons Learned and Policy Options

The expanded CTC effectively reduced poverty and improved child well-being. Policymakers might consider several options to build on this success.

POLICY OPTION 2.E.1: Make the credit permanent.

This option would reinstate the credit as formulated under the American Rescue Plan Act and make it permanent.

POLICY OPTION 2.E.2: Amend the Act to maintain some of the connection of the CTC to earnings while still increasing the value of the credit to poor families by increasing the credit faster as income rises or faster for large families.

POLICY OPTION 2.E.3: The IRS and state agencies might take measures to increase tax filing. When filing increases, so does participation in the Earned Income Tax Credit and the CTC (Goldin et al. 2021). The IRS might do more to inform the public of the value of filing. It might send potential filers prepopulated tax returns using data from administrative records and continue the “simplified filing” process that allows families with very low incomes to provide a limited set of data to establish tax benefits without having to file full tax returns (Code for America 2022). In addition, states might be provided with funding to identify non-filers by comparing their SNAP and Medicaid rolls to the tax rolls. They might then reach out to non-filers and provide them with help filling out their tax forms.

2.F The Eviction Moratorium and Rental Assistance³⁵

Although there are a number of federal housing assistance programs for low-income renters—including the Housing Choice Voucher program, the Section 8 project-based rental assistance program, and public housing—there is no federal guarantee to housing assistance, and only about one in every four eligible low-income renters is served (Barnes et al. 2021). As a result, the majority of low-income renters in large metropolitan areas are considered severely cost burdened, meaning that they spend 50 percent or more of their income on rent. The share of cost-burdened households is particularly high among Black, Asian, and Hispanic households (Joint Center for Housing Studies 2021).

The federal government expanded aid to renters during the pandemic. In particular, it established a moratorium on evictions and provided \$46 billion in Emergency Rental Assistance (ERA) for certain low-income borrowers: \$25 million enacted in December 2020 and an additional \$22 billion in March 2021.³⁶

The eviction moratorium appears to have been a helpful policy response during the pandemic, although a lack of data on the prevalence of renter distress before the pandemic makes this conclusion somewhat tentative. Still, the evidence that is available suggests that the moratorium yielded important health benefits (including lower infection rates and mortality from COVID-19) and provided a valuable safety net to renters—particularly those who were already housing insecure before the pandemic (Goodman and Wachter 2022). An eviction moratorium only allows people to delay paying rent; it does not forgive it, and overdue rent continues to accrue. It is also costly for small landlords who lose income (perhaps only temporarily).

The ERA program appears somewhat less successful. It was not established until the end of 2020—nine months after the pandemic began—and money was very slow to be distributed. By June 2021, for example, only \$3 billion had been distributed (Goodman and Wachter

2022). In part this reflects the difficulty of rolling out new programs: Funds were distributed to state, local, and tribal governments, and each had to set up its own procedures and eligibility criteria. Some of the procedures were quite onerous themselves, slowing down the process even further. The second tranche of ERA funding was intended to eliminate some of the obstacles and speed up the distribution of funds (Goodman and Wachter 2022).

Evidence to date suggests that the funds, once distributed, benefited the lowest-income renters, many of whom likely were distressed even before the pandemic (Goodman and Wachter 2022). Other renters benefited from the EIPs, the expanded UI benefits, and the enhanced CTC. The combination of all these factors led evictions nationwide to fall by about 3 million during the pandemic, with evictions falling most notably in majority-Black and low-income areas (Hepburn et al. 2022).

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Lessons Learned and Policy Options

POLICY OPTION 2.F.1: Consider a national eviction moratorium—combined with rental assistance—during a future public health emergency or economic downturn. Eviction moratoriums during public health emergencies save lives, and so they are particularly valuable. To protect small landlords, however, such moratoriums might be combined with rental assistance programs.

POLICY OPTION 2.F.2: Expand current housing assistance programs. The decline in evictions during

35 This section draws heavily on Goodman and Wachter (2022).

36 See Goodman and Wachter (2022) for a detailed timeline about the eviction moratoriums and a description of the eligibility requirements for the ERA funds.

the pandemic demonstrates that substantial financial support may improve the lives of the most disadvantaged families. Under our current social insurance system, fewer than one in four eligible households actually receives support due to lack of program funds. Increasing the amount of aid available would help bolster our social insurance system.

POLICY OPTION 2.F.3: Improve data collection about renters. There is a great need for more comprehensive data on the rental market and renters. Because of a paucity of pre-pandemic data, it was hard to determine whether renters were facing unusual financial distress during the pandemic and hard to gauge exactly how much rental assistance was necessary.

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CHAPTER 3

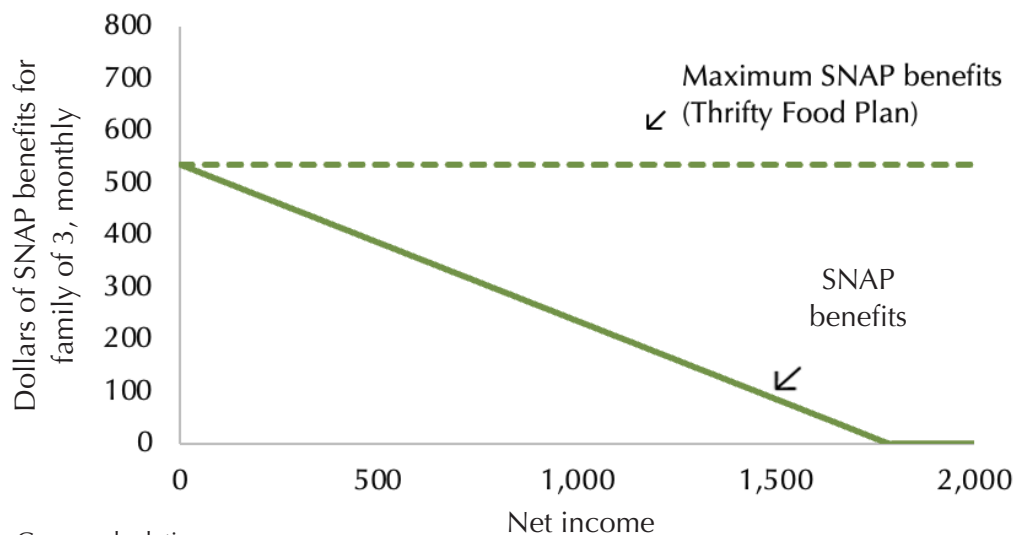
Food Assistance during the Pandemic

Several programs provide nutrition assistance to low-income families, including the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch and School Breakfast programs, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Adequate nutrition is especially important for children because an insufficient quantity of nutritious food can permanently blight their health, impair educational achievement, and lower lifetime earnings (Hall and Neuberger 2021).

3.A Supplemental Nutrition Assistance Program (formerly known as Food Stamps)

SNAP provides assistance to families with low income to support improved diets.³⁷ SNAP support may enable recipients to shift some of the funds the family formerly spent on food to other family needs, so SNAP is actually a form of general income support. SNAP reduces poverty, improves long-run outcomes for children,

Figure 3-1: SNAP benefits: pre-pandemic



Source: Working Group calculations.

37 States have some discretion over income and asset tests for SNAP eligibility for people deemed categorically eligible for SNAP (an eligibility pathway through which applicants participating in other means-tested programs are automatically eligible for SNAP). In most states, the income limit is 185 percent to 200 percent of the poverty level for most households. The majority of states have also eliminated or greatly eased the federal asset limits (“Supplemental Nutrition Assistance Program” 2022).

and helps families weather temporary losses in income (Hoynes and Schanzenbach 2019).

The federal government finances the benefits; states share in the administrative costs. In ordinary times, the benefit is equal to the maximum SNAP benefit (based on household size and the cost of a “thrifty diet”) minus 30 percent of a household’s net income—total income minus certain deductions, including those for a portion of earnings and excess shelter costs, as shown in Figure 3-1.³⁸

SNAP spending increases automatically and without delay during recessions—no congressional action is needed. As income and assets fall, more people become eligible, and for many already on the rolls, benefits increase. Furthermore, program integrity is high, with low rates of administrative error and fraud (Rosenbaum 2014).

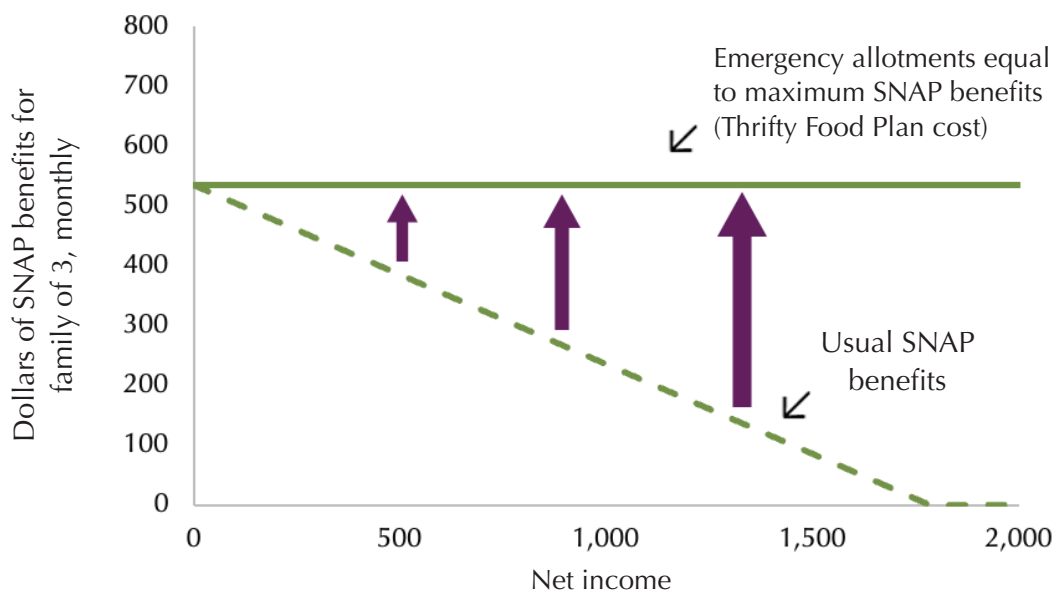
Congress liberalized SNAP during the pandemic through the Family First Coronavirus Response Act (FFCRA), enacted on March 18, 2020:

- States were given broad discretion—through the end of the public health emergency—to ease

access to the program by extending certification periods, waiving in-person interviews, moving more application and related procedures online, and making them more available by phone. Virtually all states took advantage of this flexibility. (The public health emergency was in effect from January 27, 2020 through May 11, 2023.)

- Congress increased federal support for state costs in administering SNAP.
- Congress suspended a provision applicable in normal times that limits SNAP payments to no more than three months every three years for childless adults ages 18–49 who are not disabled and who are not working or enrolled in a qualifying work or training program at least half time. The suspension will end in July 2023.
- Congress also authorized “emergency allotments,” under which all households received the maximum benefit for their household size, as illustrated in Figure 3-2. The emergency allotments required both a federally declared national health emergency and a

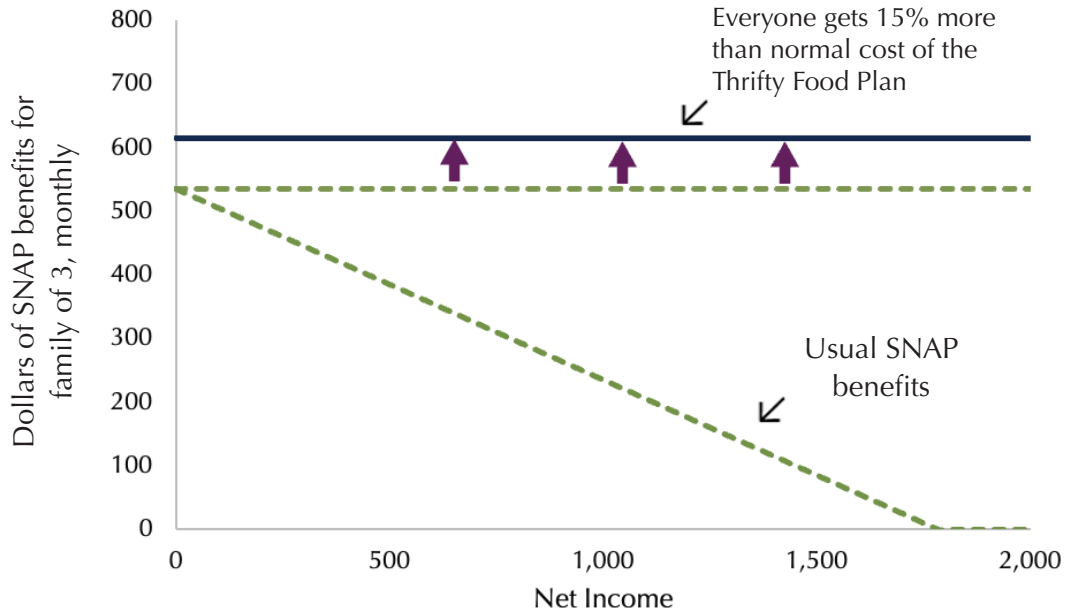
Figure 3-2: SNAP benefits: Families First Coronavirus Response Act, March-April 2020



Note: SNAP (Supplemental Nutrition Assistance Program).

38 See <https://www.fns.usda.gov/snap/recipient/eligibility> for a description of deductions from income (U.S. Department of Agriculture Food and Nutrition Service 2021).

Figure 3-3: SNAP benefits: Families First Coronavirus Response Act, March-April 2020



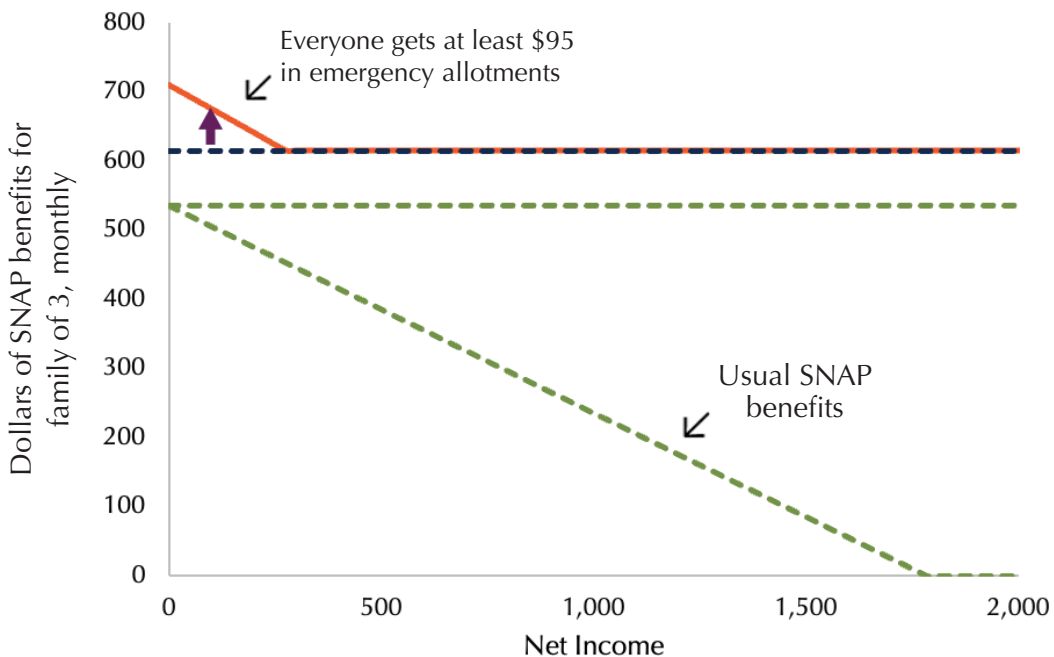
Note: SNAP (Supplemental Nutrition Assistance Program).

state-declared health emergency to be in effect. As of September 2022, 30 states and the District of Columbia still had emergencies in effect, but some states had reverted to the normal SNAP benefits schedule (U.S. Department of Agriculture Food and Nutrition Service 2022a).

The maximum SNAP allotment was increased 15 percent in the Coronavirus Response and Consolidated Appropriations Act (2021); this increase was extended through September 2021 in the American Rescue Plan (Figure 3-3).

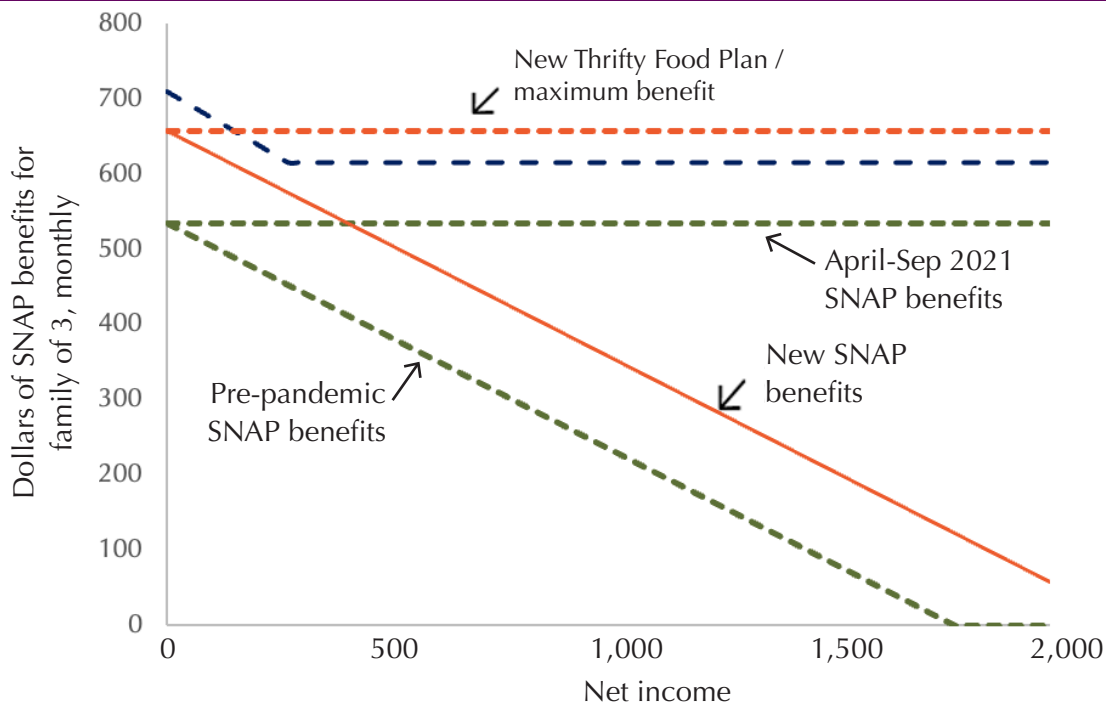
One issue with the emergency allotments is that they provided the largest increase in benefits to those with

Figure 3-4: SNAP benefits: COVID-19



Note: SNAP (Supplemental Nutrition Assistance Program).

Figure 3-5: SNAP benefits: October 2021 onwards*



* In many states, the lowest-income beneficiaries continued receiving the extra emergency allotments through February 2023.

Note: SNAP (Supplemental Nutrition Assistance Program).

the highest net income. In April 2021, the federal government modified the emergency allotments so that families received a minimum increase of \$95 per month (Figure 3-4).³⁹

Although the official emergency has ended, benefits have risen permanently because the federal government in October 2021 increased the estimated cost of the Thrifty Food Plan, and the associated needs standard, by roughly 21 percent above pre-pandemic levels (Figure 3-5).

Coordination with other forms of fiscal relief during the pandemic: As noted in chapter 2, the SSA ruled that the Economic Impact Payments (EIPs) and Unemployment Insurance (UI) should not be treated as assets or income in determining eligibility for Supplementary Security Income. No such changes were made with respect to SNAP at first. In 2020, the greatly expanded UI benefits counted as income for purposes of calculating SNAP benefits. The payments were treated as other tax refunds: They were excluded from assets for 12 months. Legislation enacted in December 2020, however, excluded the \$300 per week boost to

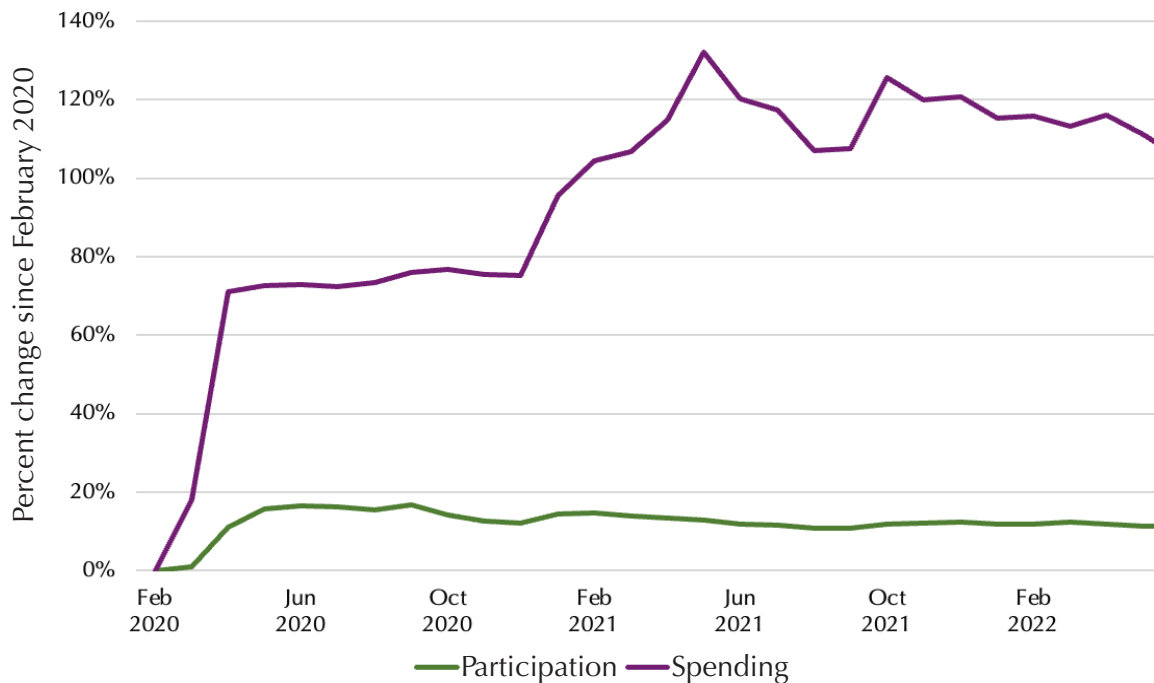
UI benefits as income for purposes of calculating SNAP benefits.

Who Benefited from SNAP during the Pandemic?

The increases in SNAP benefits resulting from revised regulations and legislation triggered by the COVID-19 crisis increased monthly benefits by approximately 88 percent, on average (Bitler, Hoynes, and Schanzenbach 2021). Benefits increased most for those on the rolls who were on the upper parts of the SNAP income eligibility scale. Because White households receiving SNAP typically have higher incomes on average than Blacks and Hispanic households, White individuals and families likely received bigger “bumps” in benefits than did Blacks and Hispanics. Bitler, Hoynes, and Schanzenbach (2022) estimated, based on 2019 administrative data, that monthly SNAP benefits increased by 95 percent for Whites, compared with 84 percent and 78 percent for Blacks and Hispanics, respectively.

39 This modification was a reinterpretation of the statute (Reiley 2021).

Figure 3-6: SNAP participation and spending during the pandemic



Note: SNAP (Supplemental Nutrition Assistance Program).

SNAP Participation during the Pandemic

Participation in SNAP increased about 16 percent in the spring of 2020—adding 6 million people to the program—and remained 12 percent above pre-pandemic levels through March 2022, the latest month for which data are available (Figure 3-6).

The increased participation reflects the removal of administrative barriers, by waiving in-person interviews and extending certification periods, as well as suspending the three-month limit on the duration of payments for certain beneficiaries. Additional federal funding for administrative costs may have also helped states deal with the increased demand and change in procedures. Increasing unemployment also contributed to increased SNAP participation, as documented by Bitler, Hoynes and Schanzenbach (2021).

SNAP spending increased much more than participation—benefits were 73 percent, or about \$3.2 billion, higher in May 2020 than in February 2020, and

in 2021 they were more than double the pre-pandemic level.

Lessons Learned and Policy Options

POLICY OPTION 3.A.1: Lower administrative barriers to SNAP take-up. The increase in SNAP participation during the pandemic appears related to changes in administrative procedures that made it easier to enroll in and stay on SNAP. These included the extension of certification periods, reduced paperwork and interview burdens, telephonic signatures, and electronic filing of paperwork. Administrative burdens reduce SNAP participation among eligible individuals, and reforms that simplify recertification may increase retention (Gray 2019; Homonoff and Somerville 2021). To boost SNAP take-up, some or all of the pandemic changes might be made permanent (or at a minimum, be designed to take effect automatically, if unemployment rises sufficiently) to ensure that administrative burdens are not preventing some families from accessing vital nutrition assistance.⁴⁰

40 See Hoynes and Schanzenbach (2019) for a review of the evidence on SNAP and well-being.

While Congress did take action to increase SNAP benefits during the downturn, some worry that relying on future Congresses puts these important benefits at risk. Several options are worth considering that would automatically increase SNAP benefits during downturns and guarantee availability of funds for SNAP.

POLICY OPTION 3.A.2: Enact triggers that would loosen SNAP requirements and raise benefits during recessions. Legislation might be passed to temporarily amend the SNAP program as a function of economic circumstances—for instance, the national unemployment rate or even state-specific unemployment rates. The changes might include increases in the maximum SNAP benefit (which would be more progressive than simply providing every household with the maximum benefit), a suspension of the three-month time limit (which is particularly problematic during times of high unemployment), the easing of rules related to recertification and verification, and an increase in the federal share of administrative costs. This policy would help both from a macroeconomic perspective, because SNAP benefits are an effective fiscal stimulus, and would help prevent families from going hungry during downturns if UI is inadequate.

POLICY OPTION 3.A.3: Allow the U.S. Agriculture Secretary the authority to make such modifications in the event of a recession or public health emergency. Congress might provide broad authority to the Secretary to modify SNAP requirements. A more limited option would be to modify the Stafford Act, which allows the Secretary to modify various SNAP rules in the case of a natural disaster, to include federally declared national health emergencies.

POLICY OPTION 3.A.4: Change appropriations language for SNAP funding. Although SNAP is typically viewed as an “entitlement,” its funding comes through the regular annual appropriations process, in which it receives a fixed dollar appropriation instead of an appropriation for “such sums as may be necessary.” SNAP does have an appropriated contingency reserve, but the reserve equals only a fraction of one month’s benefits.

Under SNAP’s authorizing law, across-the-board benefit cuts are triggered if funding is insufficient to

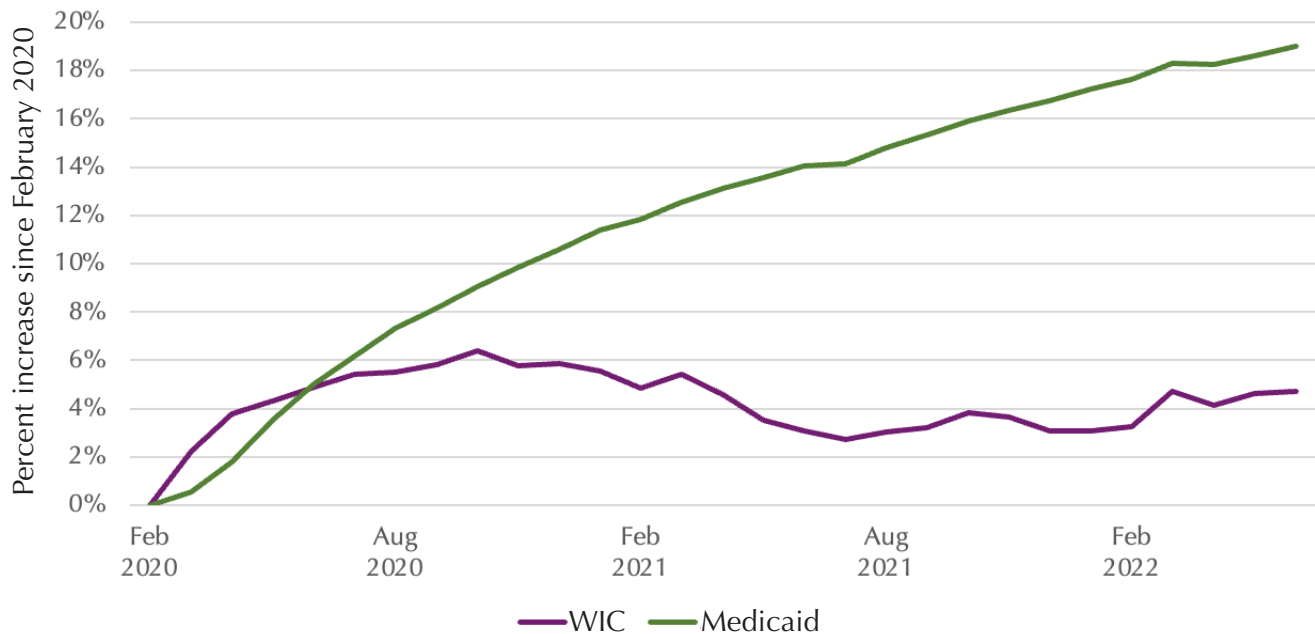
pay full benefits. This has never occurred, and during the pandemic SNAP benefits were successfully raised a number of times. The possibility that benefit cuts could be triggered by insufficient funding might be addressed by replacing the fixed dollar amounts provided for SNAP in appropriations bills with “such sums as may be necessary” or by combining a fixed dollar amount in appropriations bills with language in those bills that provides “such sums as may be necessary” for the fourth quarter of the fiscal year.

3.B Special Supplemental Nutrition Program for Women, Infants, and Children

The WIC program provides nutritious foods, nutrition education, breastfeeding support, and referrals for health services to low-income pregnant women and postpartum women with children under age five. The program has been shown to improve birth outcomes—increasing average birthweight and reducing the incidence of low birth weight (Hoynes and Schanzenbach 2016). The program is a federal grant program: Each year, Congress gives each state a specific sum to operate the program. The size of each grant depends on the number of infants and children in the state below age five who are living at or below 185 percent of the federal poverty level. States have some discretion over eligibility and other program rules. Children enrolled in Medicaid, SNAP, or Temporary Assistance for Needy Families (TANF) meet WIC’s income requirement in all states. As with SNAP, state agencies were provided with flexibility during the pandemic that allowed them to provide benefits without in-person visits to WIC offices.

WIC participation has been declining for years. . . . Many children eligible for WIC are not receiving it. In 2019, for example, just 57 percent of eligible children were receiving WIC. Most eligible infants received benefits, but take-up rates for older children and mothers were much lower.

Figure 3-7: Pandemic changes in enrollment of children: WIC vs. Medicaid



Note: WIC (Special Supplemental Nutrition Program for Women, Infants, and Children).

WIC participation has been declining for years. Some of that decline may reflect the improving economy and falling birth rates. But many children eligible for WIC are not receiving it. In 2019, for example, just 57 percent of eligible children were receiving WIC. Most eligible infants received benefits, but take-up rates for older children and mothers were much lower (U.S. Department of Agriculture 2022c).

Even accounting for pre-pandemic trends, WIC participation increased by much less than SNAP or Medicaid participation during the pandemic (Hall and Neuberger 2021) (Figure 3-7). Given that children under age five and pregnant and postpartum women who are enrolled in Medicaid and SNAP are eligible for WIC, the smaller increase in WIC suggests at a minimum some lost opportunities for states to enroll WIC-eligible families (Figure 3-7).

Examining WIC participation for children, Hall and Neuberger (2021) noted that changes in participation varied widely across states, with participation increasing 20 percent in some states while declining 20 percent in others. They noted the importance of administrative

factors. States that were unable to remotely load WIC benefits onto electronic benefit cards—requiring participants to travel to the WIC clinic or drop off their card to receive benefits—experienced a decline in WIC participation between February 2020 and February 2021.

POLICY OPTION 3.B.1: Establish performance metrics for cross-enrollment in WIC of eligible SNAP and Medicaid participants. WIC is an extremely important program that provides health and food support at a crucial time in children’s lives. Increasing WIC take-up might help improve outcomes for children and reduce racial disparities in maternal and child health and food insecurity (Hall and Neuberger 2021).⁴¹ While not fully understood, the much larger increase in SNAP and Medicaid participation and the higher take-up rates for children in those programs suggest that many who might have been eligible for WIC did not receive benefits. Measuring and establishing performance metrics for cross-enrollment of eligible SNAP and Medicaid participants into WIC, similar to the performance metrics for the National School Lunch Program, might in turn provide needed attention to

41 As discussed by Hoynes and Schanzenbach (2016), there is little evidence of the effects of WIC on children’s health, so definitive conclusions are difficult; however, at a minimum, WIC increases the resources available to families.

WIC take-up and an additional incentive for states to conduct the crucial outreach and institute the appropriate reforms in application and related processes needed to get people signed up for the program.

According to one study, the Pandemic EBT rollout led to a 17 percent reduction in the share of SNAP households reporting that the children did not have enough to eat and a 28 percent reduction in the share of families reporting that their children sometimes or often did not have enough to eat.

3.C School Lunch and Breakfast Programs during the Pandemic

The National School Lunch Program and the School Breakfast Program help states provide meals to roughly 30 million low-income children. School closures during the pandemic blocked the direct provision of these meals. In response, a new program, the Pandemic

Electronic Benefit Transfer (Pandemic EBT, or P-EBT) was established, under which families received electronic debit cards to purchase groceries for the value of the school meals missed due to school closures.

This program served a vital role in preventing hunger, perhaps as important as the EIPs and SNAP. According to one study, the Pandemic EBT rollout led to a 17 percent reduction in the share of SNAP households reporting that the children did not have enough to eat and a 28 percent reduction in the share of families reporting that their children sometimes or often did not have enough to eat (Bauer, Ruffini, and Schanzenbach 2021). These effects were significantly larger in states that had particularly high school-closure rates.

POLICY OPTION 3.C.1: Make Pandemic EBT permanent to address food insecurity during summer and holiday school closures. The pandemic demonstrated the importance of school meals to families and the dire consequences of school closures. Pandemic EBT was a successful program that efficiently and effectively addressed food insecurity stemming from school closures (but did not address the deep learning losses associated with those closures). The program

Figure 3-8: Share of adults ages 18-64 reporting household charitable food use in the past 12 months

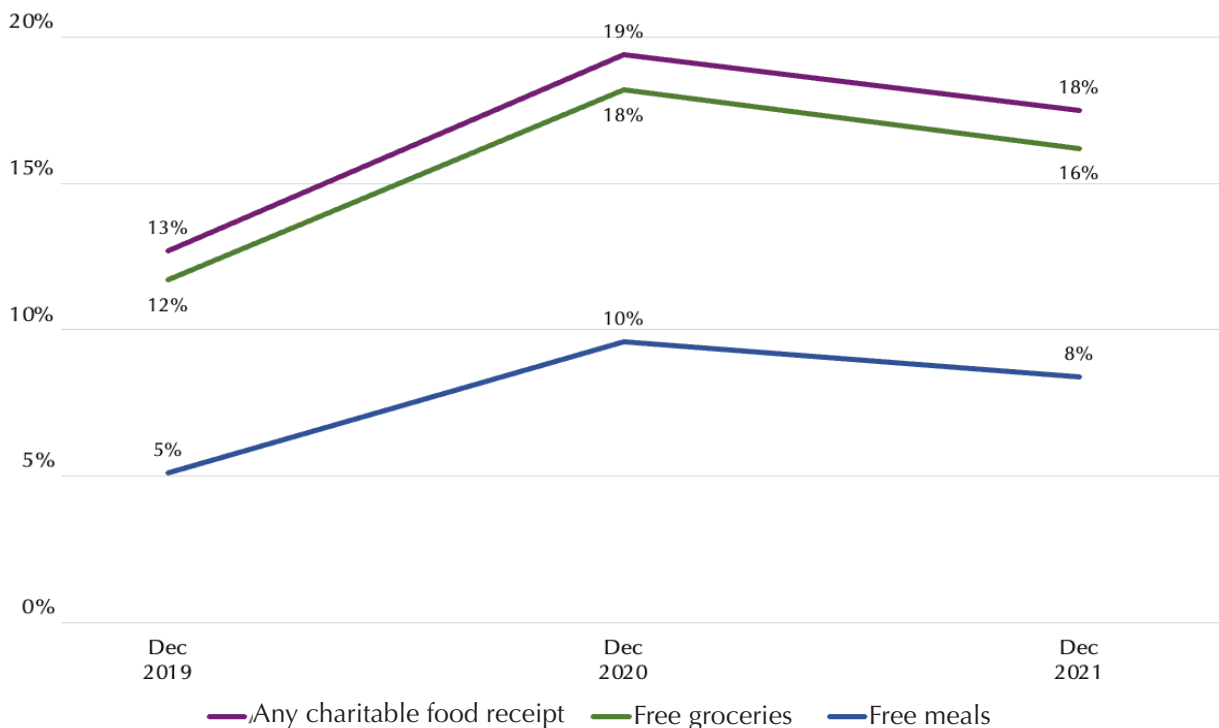
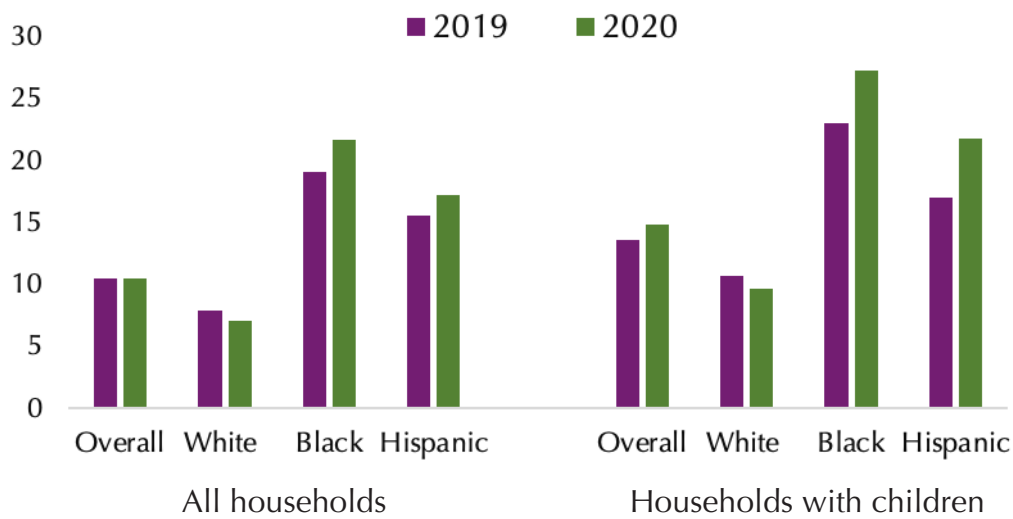


Figure 3-9: Annual food insecurity, by race/ethnicity and presence of children, 2019-2020



Source: Working Group chart based on data in Coleman-Jensen et al. (2020) and Coleman-Jensen (2021).

might be made permanent to ensure that children receive adequate nutrition during holidays, school vacations, and any other school closures. Currently, the federal government provides prepared meals for free to eligible students through the Summer Food Services program, but as few as one in seven eligible students accesses the program because it requires eating at physical meal sites (Thomhave 2021). Pandemic EBT offers a way of increasing access to benefits and ensuring that children have enough to eat when their schools are closed.

3.D Food Insecurity during the Pandemic

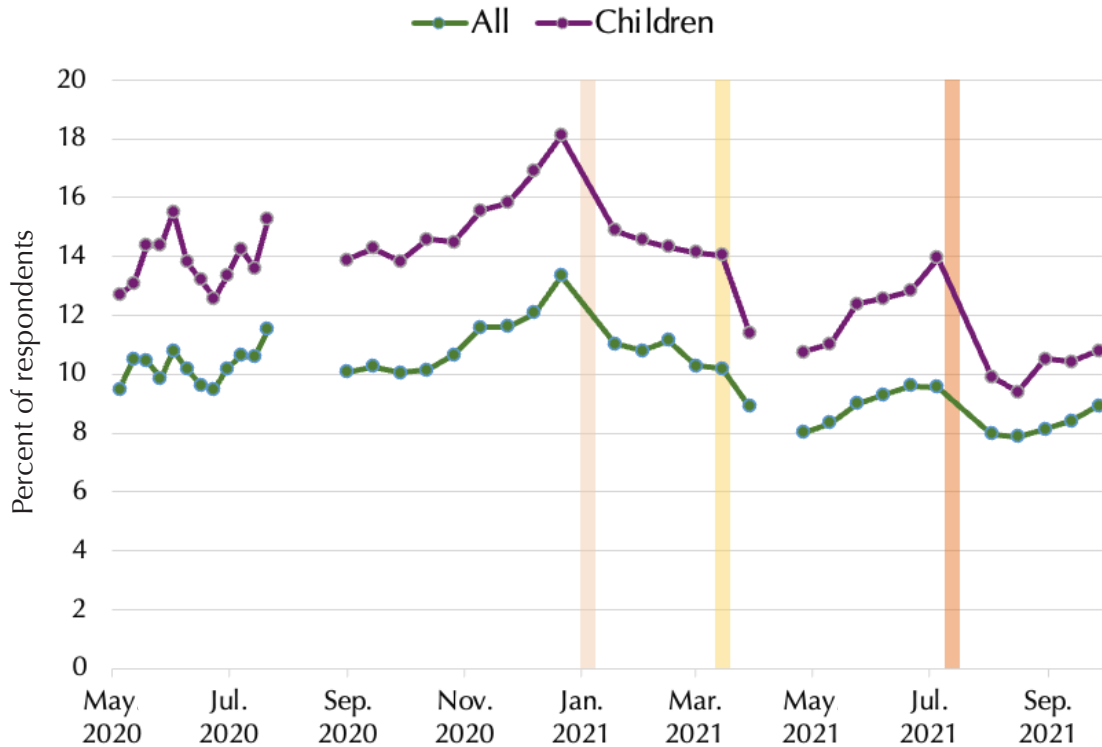
Despite the many changes in laws and administrative rules to increase access to income supports and the amounts of aid, some evidence suggests that the prevalence and intensity of hunger and food insecurity increased during the pandemic. Food banks reported sharp increases in requests for help. Feeding America reported distributing almost 60 percent more food to families in the third quarter of 2020 than in pre-pandemic times (Cohen 2020). Similarly, the Urban

Food insecurity among Black and Hispanic families increased, while food insecurity among White families declined. The pandemic seemed to exacerbate already large disparities in food insecurity by race and ethnicity.

Institute’s Well-Being and Basic Needs Survey (WBNS) showed that the share of adults reporting charitable food use increased during the pandemic (Figure 3-8) (Gupta, Salas, and Waxman 2022). In contrast, the December Current Population Survey Food Security Supplement (CPS-FSS) reported that overall food insecurity was unchanged between 2019 and 2020.⁴² Beneath this national average, the survey indicated that food insecurity among Black and Hispanic families increased, while food insecurity among White families declined (Figure 3-9) (Bitler, Hoynes, and Schanzenbach 2022). The pandemic seemed to exacerbate already large disparities in food insecurity by race and ethnicity.

42 Food insecurity is defined as answering “yes” to three or more food security questions, which include statements like “We worried whether our food would run out before we got money to buy more” and “In the last 12 months did any of the children ever not eat for a whole day because there wasn’t enough money for food?” See https://cps.ipums.org/cps/resources/food_security/err141.pdf for more detail (Coleman-Jensen et al. 2011).

Figure 3-10: Rate of food insufficiency in the last seven days, May 2020 to August 2021



Source: Bauer, Ruffini, Whitmore Schanzenbach (2021).

A second survey—the Household Pulse Survey, which was established by the Census Bureau to monitor household conditions during the pandemic—can show the time patterns of food insecurity at a granular level, since the survey was done frequently throughout the pandemic. Unfortunately, comparisons to pre-pandemic times are difficult because the survey only began during the pandemic and asks a different question than is typically asked.

The survey showed that food insufficiency—defined as the share of survey respondents reporting that they sometimes or often did not have enough to eat in the prior week—increased from the spring of 2020 through

the end of 2020, perhaps reflecting the waning impact of the EIPs and the expiration of the additional \$600 per week in UI benefits. Food insufficiency began falling in January 2021, likely reflecting the continued reopening of the economy, the second and third rounds of EIPs, the 15 percent increase in SNAP maximum benefits, and, in July 2021, the first monthly CTC payment.

Given the mixed evidence, it is unclear whether more families and children suffered from food insecurity during the pandemic. That those numbers would have increased, but for the large expansions in SNAP, the rollout of Pandemic EBT, and increases in other sources of fiscal support, is indisputable.

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CHAPTER 4

Health, Health Insurance, and Health Care during the Pandemic

How well did government programs aimed at ensuring the health care access and health of individuals and families function during the pandemic? How did the pandemic alter the financial status of these programs?

This chapter first describes the health effects of the pandemic on individuals and families. It then describes the interactions between the pandemic, social insurance, and related programs devoted to health care—Medicare, Medicaid and Children’s Health Insurance Program (CHIP), and the Affordable Care Act’s (ACA’s) marketplaces. It also explains how the Provider Relief Fund first enacted as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act affected providers and their patients, how nursing homes performed, the use of telemedicine, and how the public health infrastructure acted to mediate the effects of the pandemic on the health system and outcomes. Workers Compensation, which provides first-dollar coverage to workers who contract a compensable disease at work, is discussed in chapter 2, Income Security. This chapter ends with a brief examination of the legislative changes during the pandemic aimed at providing temporary universal sick leave and universal access to COVID-19 vaccines and treatments.

4.A The Health Effects of the Pandemic

As of September 1, 2022, over 94 million cases of COVID-19 had been reported to the Centers for Disease Control and Prevention (CDC n.d.). How many additional cases were unreported because people self-tested at home or suffered no symptoms is not known with precision. The CDC estimated that roughly 200 million individuals in the U.S. had been infected with COVID-19 as of February 2022.⁴³ The number of COVID-19 deaths is over 1 million; here too, reporting is imperfect because the cause of death may not be listed, and people who die may suffer from multiple conditions. Accordingly, many studies have focused on “excess deaths,” that is, the difference between actual deaths and what would be expected under “normal conditions.” This measure aims to capture deaths from the pandemic, whether or not recorded as being from COVID-19.⁴⁴ The CDC estimated that between the start of the pandemic and September 2022, there were 1.3 million excess deaths.⁴⁵

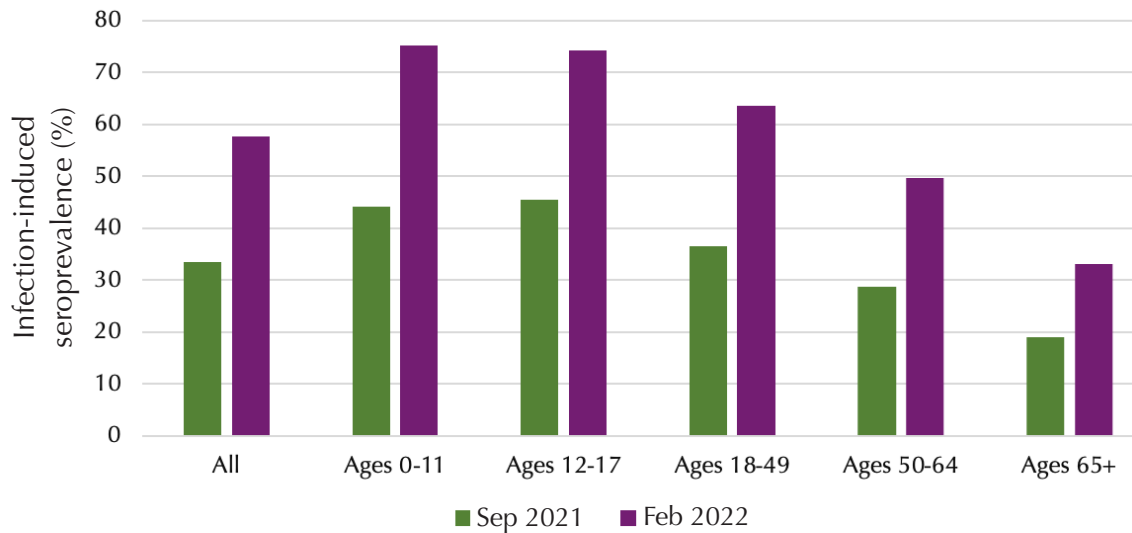
Because of the large gaps between the numbers of recorded cases and of actual infections, and the probability that these gaps vary by age group, examining the age distribution of reported cases may not be a reliable measure of infection rates. To better understand the population-level incidence of COVID-19, the CDC

43 Calculated from data in Clarke et al. (2022).

44 These deaths may be from unrecorded COVID-19 infections or from other causes of death that were elevated during the pandemic.

45 As of May 2023 (National Center for Health Statistics n.d.-b).

Figure 4-1: Seroprevalence of infection-induced SARS-CoV-2 antibodies by age group—United States, September 2021 and February 2022

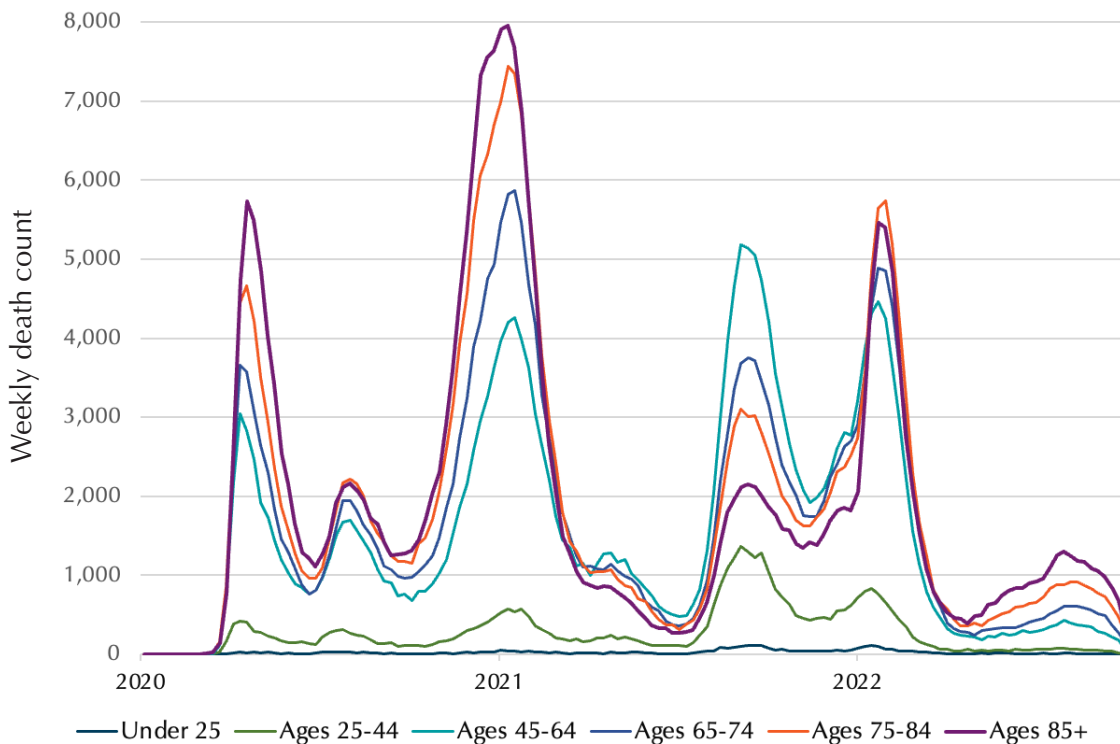


Note: SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2).
 Source: <https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7117e3-H.pdf>.

examined the proportion of the living population with SARS-CoV-2 antibodies—or seroprevalence—from September 2021 through February 2022 (Clarke et al. 2022). Figure 4-1 displays these results. According to

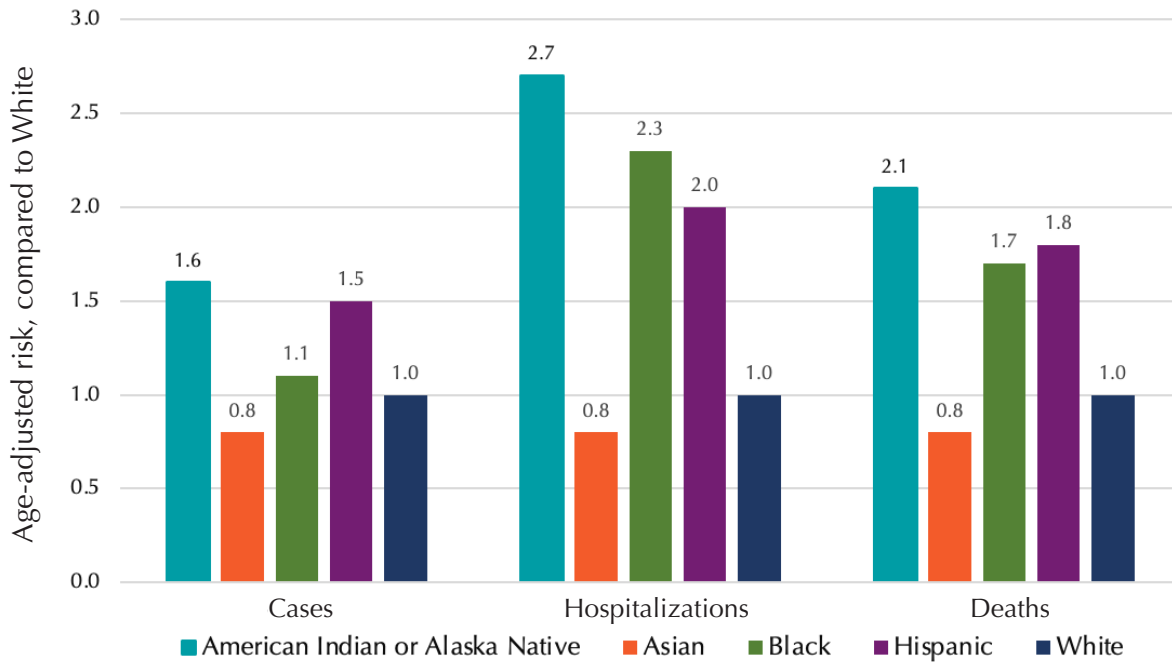
this CDC study, infection rates varied by age, with children the most likely to show evidence of a previous infection by SARS-CoV-2, followed by 18- to 49-year-olds, 55- to 64-year-olds, and finally those 65

Figure 4-2: Weekly COVID-19 deaths by age group



Source: CDC.

Figure 4-3: Relative age-adjusted risk of COVID-19 infection, hospitalization, and death by race and ethnicity, through September 2022



and over.⁴⁶ Older persons may have been less likely to be infected by COVID-19 because they were more cautious, more likely to be retired and therefore less exposed to COVID-19, or more likely to be vaccinated.

The data on mortality tell a strikingly different story.⁴⁷ Although older people had lower infection rates, COVID-19 mortality rates were much higher among older people than younger people. Mortality has been highest for those 75 and over (Figure 4-2). About 1.25 percent of the population 65 and older had died by June 2022 because of COVID-19.⁴⁸

Figure 4-4, based on the 66 percent of COVID-19 cases for which race or ethnicity were reported to the CDC, shows the risk of COVID-19 infection, hospitalization,

and mortality for population groups of color as compared to non-Hispanic whites.⁴⁹ Age-adjusted death rates for Blacks and Hispanics were almost double that for non-Hispanic Whites, while mortality among American Indian/Alaska Natives was more than double that of non-Hispanic Whites.⁵⁰ These differences in mortality reflect higher reported case rates for Hispanics and American Indian/Alaska Natives and much worse outcomes for those who contracted COVID-19 for each population group of color except those of Asian descent.⁵¹ Even though the case rates may not fully reflect incidence rates at the population level—most cases are not reported to the CDC—the hospitalization and mortality rates show the hugely disparate effects of the pandemic by race and ethnicity (CDC 2022).

46 These patterns are somewhat different from those using the age distribution of cases reported to the CDC, which show children having lower incidence than non-elderly adults. This discrepancy likely reflects the fact that children are much more likely to be asymptomatic.

47 Virtually all deaths from COVID-19 are reported to the CDC, so these data do not suffer from the same problems as data on cases.

48 Compares total deaths from COVID-19 from the CDC through June 2, 2022, to the population age 65 and over in 2021 from most recent Social Security Trustees Report.

49 No seroprevalence studies are available by race or ethnicity.

50 These race-based disparities declined over time—even reversing themselves in some cases—as people of color became more likely than White people to get vaccinated (Johnson and Keating 2022).

51 It is very important to analyze these data holding the age distribution constant because COVID-19 has such different effects by age and because the age distribution of the population by race and ethnicity differs quite a bit.

4.B Medicare and the Pandemic

Medicare is a health insurance program for individuals ages 65 years and over and people with disabilities. It is comprised of four parts. Part A helps pay for inpatient hospital services, hospice care, and skilled nursing facility and home health services following a hospital stay. All Part A expenditures are paid out of the Hospital Insurance (HI) Trust Fund, which is financed by a dedicated stream of revenues consisting largely of employee and employer contributions (89 percent of revenues in 2020), income taxes on high-income taxpayers (8 percent of revenues in 2020), and interest earnings on Trust Fund assets (2 percent of revenues in 2020).⁵² Before the pandemic, the Centers for Medicare and Medicaid Services (CMS) actuaries projected that the HI Trust Fund would be depleted in 2026.⁵³ CMS reported that, after 2026 and in the absence of legislative changes, funds would be available to finance only 80 percent to 90 percent of projected Part A expenditures.⁵⁴

Medicare Part B helps pay for physician, outpatient hospital, and home health services, among others, while Medicare Part D helps pay for prescription drugs. These two programs are financed out of the Supplementary Medical Insurance (SMI) Trust Fund. SMI revenue comes from premiums and enough general revenues to fill the gap between expenditures and the sum of premiums and other dedicated income. For that reason, under current law, the SMI Trust Fund will never be depleted.

Medicare also has a Part C (also known as Medicare Advantage), which allows beneficiaries to enroll in private insurance plans that cover all Medicare Part A and Part B services, instead of enrolling in traditional

It is useful to take a broader perspective and ask how Medicare influences the federal budget overall, rather than focus on the status of Medicare's trust funds.

Projections find that rising Medicare expenditures are one of the drivers of the long-term fiscal challenges facing the U.S.

Medicare. The vast majority of Part C plans also include Part D (Freed, Damico, and Neuman 2021). Part C costs are financed partly out of the HI Trust Fund and partly out of the SMI Trust Fund.

It is also useful to take a broader perspective and ask how Medicare influences the federal budget overall, rather than focus on the status of Medicare's trust funds.

Projections find that rising Medicare expenditures are one of the drivers of the long-term fiscal challenges facing the U.S.

4.B.1 The Effect of the Pandemic on Medicare's Financial Outlook

Many analysts expected the pandemic to hasten the depletion of the HI Trust Fund because they expected payroll taxes to decline as a result of the recession.⁵⁵ Instead, the Medicare Trustees now expect the HI Trust Fund to be depleted in 2028, two years later than pre-pandemic projections. This improvement reflects in part the premature deaths from COVID-19 of potential beneficiaries, which reduced Part A spending more than they reduced employment and cut revenues.⁵⁶

52 From the 2022 Medicare Trustees Report data supplement entitled "Historical Operations of the Hospital Insurance (HI) Trust Fund for Calendar Years."

53 The 2020 Trustees Report was issued in April 2020, after the pandemic had commenced, but it did not account for any effects of the pandemic in its projections.

54 From the 2020 Trustees Report Figure II E.2. It is unclear what would happen were the trust fund to be depleted because the Medicare program would be faced with two competing but inconsistent laws: those governing Medicare benefits and provider payments, which would ensure no cuts in spending, and those governing the trust fund, which would preclude spending beyond available resources.

55 Even by September 2020, six months into the pandemic, the Congressional Budget Office estimated that the HI Trust Fund would be depleted in 2024—two years sooner than expected pre-pandemic, largely on account of an expectation of lower contributions (<https://www.cbo.gov/publication/56541>). Other analysts also expected much faster depletion on account of the pandemic.

56 Adjusted for consumer price index inflation, total Part A revenues were 1 percent higher in 2020 but 6.8 percent lower in 2021 than the Medicare Trustees' April 2020 projection, a projection that did not account for any possible effects of

Despite COVID-19, use of Medicare services fell sharply as fears of becoming infected kept people home and as health care providers canceled or deferred elective services. As shown in Figure 4-4, Medicare claims were 33 percent lower in April 2020, when pandemic-related restrictions were at their peak, than in April 2019. Spending on physicians and outpatient facility services was depressed even more. Spending increased through the spring of 2020, but was still slightly below 2019 levels until the last few months of 2020.⁵⁷

The Medicare Trustees expect only part of the health spending to be made up in coming years. Furthermore, the higher mortality associated with COVID-19 lowered projected expenditures, especially because COVID-19 mortality was concentrated among Medicare beneficiaries with other medical problems. In addition, payment rates for Part A services were not fully adjusted for inflation, meaning that the high inflation over the past year boosted tax revenues (by boosting wages) more than it increased expenditures (Fiedler 2021).

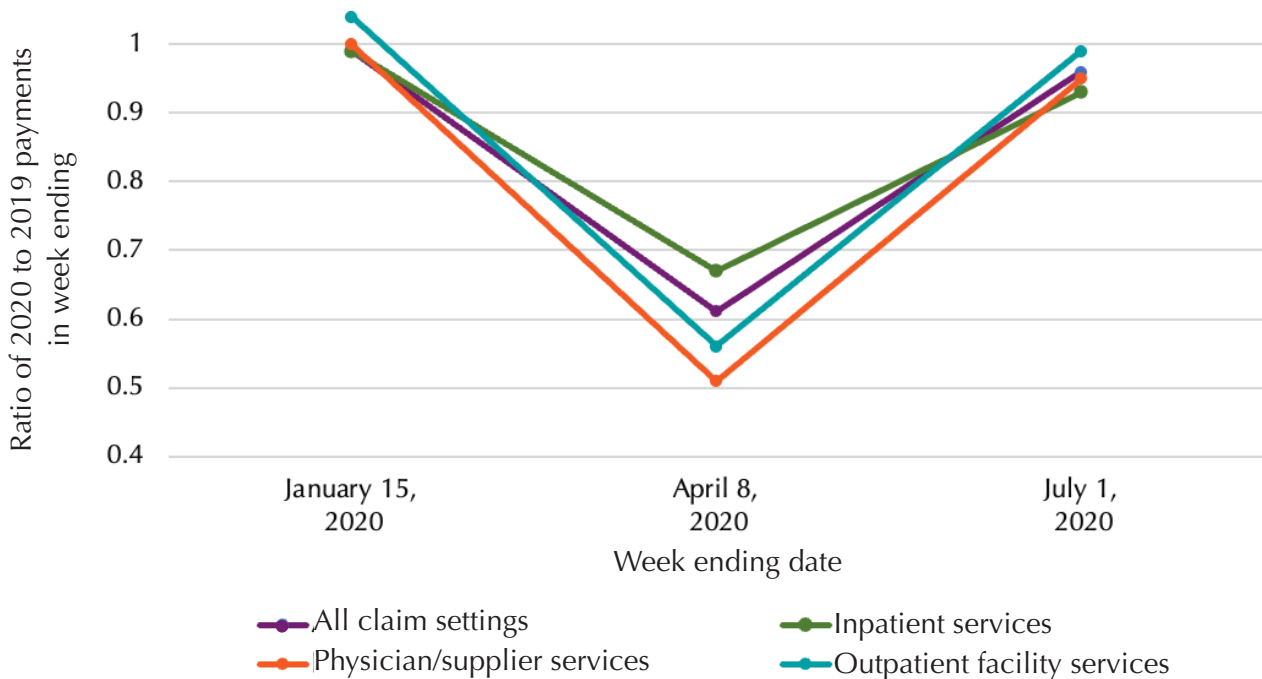
These same factors are also projected to lower Medicare Part B spending over roughly the next decade. Longer-term projections for Medicare spending have largely been unaffected by the pandemic thus far.

4.B.2 Lessons Learned and Policy Options for Medicare

Vulnerability of the Medicare System to Economic Conditions

It has been understood for a long time that currently projected revenues plus accumulated reserves will at some point become insufficient to pay for all HI benefits, forcing benefit cuts if spending growth does not slow or Congress does not increase revenues. Multiple policy proposals have been advanced over the years to deal with this problem.⁵⁸ In Box 4-1, we summarize some possible reforms to Part A financing to help address the looming shortfalls in the HI Trust Fund.

Figure 4-4: Medicare utilization relative to 2019, by service type



the pandemic on revenues. In April 2022, the Trustees projected that inflation-adjusted revenues in 2022 would be just 0.3 percent below what had been projected in April 2020.

57 While reductions in spending are helpful for the finances of the Medicare system, they may have adverse effects on the health of the elderly. As discussed in section 4.F, below, the use of telehealth prevented even larger declines in utilization, but uneven access to telehealth likely meant that some populations experienced even larger reductions in the use of health services and potentially more adverse long-term consequences.

58 See, for example, *Policy Options to Sustain Medicare for the Future (2013)* from the Kaiser Family Foundation.

BOX 4-1: Options to Improve the Solvency of the Hospital Insurance Trust Fund

Part A of the Medicare program, which provides coverage for inpatient services and most post-acute services, is funded by the Hospital Insurance (HI) Trust Fund. The looming exhaustion of the HI Trust Fund means that changes will have to be made in the next few years to prevent disruption of the Medicare program.⁵⁹ Current law does not specify how the Medicare program should adjust payments if the HI Trust Fund is exhausted. Instead, the Medicare program would face two competing legal requirements: (1) to make the payments to Part A providers as specified under law or (2) to make payments only out of HI Trust Fund balances and incoming revenues. Congress will have to act to resolve this tension.

The options for addressing shortfalls in the HI Fund fall into three general categories: (1) dedicating new revenues to HI; (2) reducing spending; and (3) financing through general revenues. Because the spending reduction or tax increases required to prevent Trust Fund exhaustion in isolation would be so large, many believe that some combination of these three options will be needed.

Increased contributions or other revenues: The primary source of HI income is a mandatory contribution of 2.9 percent on all covered wages and self-employment income (divided equally between employers and employees) and an additional 0.9 percent on earnings above certain thresholds. According to the Medicare Trustees, a 0.76 percentage point tax increase, if implemented immediately, is projected to extend the solvency of the HI Fund for 75 years.

As part of its 2022 budget, the Biden Administration proposed closing a loophole that allows some pass-through income of high-income taxpayers to avoid both the Medicare tax on self-employment income and the net investment income tax (described below) on unearned income. The proposal would dedicate this additional revenue to the HI Trust Fund. The reconciliation bill that the House passed would also have closed this tax loophole, but without providing any additional income for HI. Others have proposed raising the estate tax and dedicating the additional revenues to HI.

Reductions in Medicare Part A spending: The Trustees estimate that an immediate and permanent 16 percent reduction in Medicare Part A spending would extend the solvency of the HI Trust Fund for 75 years.

Analysts have suggested several proposals to reduce Part A spending. Some claim to increase the efficiency of the Medicare system. Some would curb payments to insurers or providers. Some claim to do both. These include:

Changes to Medicare Advantage: The Medicare program pays private insurance plans to cover beneficiaries who choose to enroll in Medicare Advantage (Part C). Medicare Advantage payment is based on fee-for-service payments in Part A and Part B. Whether a beneficiary chooses to receive coverage through fee-for-service Medicare or Medicare Advantage, all beneficiaries have access to the same standard Part A and Part B Medicare benefits (although some MA plans offer extra benefits).

The part of the payment that reflects Part A services is paid out of the HI Trust Fund, so lowering payments to private plans would help increase Trust Fund solvency. Several reforms have been suggested in recent years, including:

59 Although the SMI Trust Fund finances Part B and Part D of Medicare, it is partly funded by general revenues, and it will never be exhausted.

BOX 4-1: Options to Improve the Solvency of the Hospital Insurance Trust Fund continued

- Improving risk adjustment in Medicare Advantage: Risk adjustment seeks to ensure that private plans receive compensation commensurate with each enrollee's expected medical spending. Some analysts, including the Medicare Payment Advisory Commission (MedPAC), have argued that the current system results in payments that are higher than justified by enrollees' health care needs. Improving the accuracy of risk adjustment might be considered as a way to reduce Medicare Part C spending (MedPAC 2022).
- Reforming the quality incentives in Medicare Advantage: The Medicare program provides bonuses to private plans if they meet certain quality standards. Some observers, including MedPAC, have argued that these payments are substantially increasing federal spending without generating commensurate improvements in plan quality, and the Commission has proposed changes to the quality bonus program that would reduce federal spending.

Value incentive programs and payment reductions for post-acute care: Post-acute care is treatment administered outside of a medical center that provides recovering patients the opportunity to regain autonomy and reduce disability (Yu-Chun Wang et al. 2019). Geographic variation in Medicare spending on post-acute care exceeds that of any other Medicare service due to a lack of guidelines on which patients need services, to what extent those services are provided, and a wide distribution of facilities that accommodate these patients. Efforts have been underway to design a value incentive program that would tie compensation to the administration of high-quality, low-cost care. In addition, MedPAC has argued that Medicare overpays, on average, for post-acute care, with payments substantially higher than costs and exceeding payments from other payers. In MedPAC's March 2022 report, it recommended a 5 percent reduction in provider reimbursement for skilled nursing facilities and home health services (MedPAC 2023).

Increased use of utilization management: Utilization management is a method of influencing patient care through case-by-case evaluation of the appropriateness of services. Patients are encouraged to pursue less resource-intensive care before seeking more costly and less effective treatment.⁶⁰ An expansion of utilization management in Medicare is one strategy that might be considered to reduce Medicare costs.

Premium support system: The House Republican Study Committee (RSC) and others have proposed shifting Medicare to a premium support system. Premium support would replace Medicare's guarantee of a defined health benefit package with a flat payment, or voucher, that beneficiaries would use either to purchase a private health insurance plan (like Medicare Advantage) or a version of traditional Medicare. How much premium support would cut spending, how it would affect traditional Medicare, and how it would affect beneficiaries would depend on how the value of the voucher is set initially and how it is increased over time.

Increasing the eligibility age for Medicare: The RSC also proposes raising the age of eligibility for Medicare from 65 to 67 and indexing it for increases in longevity.⁶¹

The options described above would all directly reduce Part A spending. However, there may also be opportunities to reduce Medicare spending in Part B (which covers outpatient care and physician-administered drugs) and Part D of the program (which covers prescription drugs). Changes in one part of Medicare, such

60 Curto et al. (2017) found evidence that utilization is lower for people enrolled in Medicare Advantage plans and suggest that utilization management might be a contributing factor.

61 Blueprint to Save America. Republican Study Committee (2023).

BOX 4-1: Options to Improve the Solvency of the Hospital Insurance Trust Fund continued

as Part D coverage of drugs, might also affect the costs of other parts of Medicare, such as Part A, to the extent that drugs help keep people healthy enough to stay out of hospitals. Policymakers might consider implementing changes affecting these parts of the program and dedicating the savings to the HI Trust Fund. One such proposal is:

Site-neutral payments: The Medicare payment rates for some services depend on where care is delivered. For example, a given service provided in hospital outpatient departments is often reimbursed at a higher rate than the same service provided in physician offices. Site-neutral payments would limit Medicare reimbursement to the payment rate at the most efficient setting. When applied to certain treatments, this policy may maintain high standards of care while reducing costs (MedPAC 2022).

Revenue or Spending Reallocation: Alternatively, existing tax revenues might be allocated to the HI Trust Fund or spending might be shifted out of it, which would have the same effect on the HI Trust Fund. For example, the 3.8 percent Net Investment Income Tax enacted in 2010 might be allocated to the HI Trust Fund. This tax, also known as the Unearned Income Medicare Contribution, is a tax on the investment income of high earners equal to the 2.9 percent Medicare contribution, plus the 0.9 percent Medicare tax on high earners. Because of procedural rules related to the congressional reconciliation process used to enact this tax, the proceeds of the tax were never dedicated to the HI Trust Fund and are instead part of general revenues (Van de Water 2021).⁶² More broadly, Congress might allocate general revenue funding to the Part A Trust Fund to the extent necessary to cover expenses. Alternatively, expenses covered by Part A might be reclassified as Part B expenses and thus financed by premiums and general revenues (Jacobson and Gustafsson 2021). Such an approach was taken in the Balanced Budget Act of 1997, which transferred some home health expenditures from Part A to Part B.⁶³

The looming exhaustion of the HI Trust Fund means that changes will have to be made in the next few years to prevent disruption of the Medicare program.

62 General Revenues Should Be Part of the Medicare Financing Solution. Van de Water (2021).

63 Medicare Home Health Benefit Primer: Benefit Basics and Issues. Congressional Research Service (2014).

This report concentrates on the lessons learned from the pandemic experience. One such lesson is the vulnerability of the Medicare system to changes in economic conditions. Although, as explained above, COVID-19 has not damaged Medicare’s financial outlook, the pandemic did demonstrate the vulnerability to unexpected economic forces of a system with only a small contingency reserve. There is no assurance that a future pandemic or economic crisis would not affect Medicare’s finances more adversely.

One lesson is the vulnerability of the Medicare system to changes in economic conditions. Although COVID-19 has not damaged Medicare’s financial outlook, the pandemic did demonstrate the vulnerability to unexpected economic forces of a system with only a small contingency reserve.

The pandemic also revealed the sensitivity of Medicare to changes in inflation (Fiedler 2021). While most elements of the nation’s fiscal system—tax brackets, Social Security benefits, and Supplemental Nutrition Assistance Program (SNAP) benefits, for example—are indexed to inflation, Medicare payments to physicians and certain other qualified providers are not. Under current law, payments increase at predetermined rates over time. When overall prices rise, real payments to physicians and other qualified providers grow less rapidly or fall; when overall prices fall, real payments grow more rapidly. Payments to hospitals are indexed based on *projected* provider input cost growth. When those projections are wrong, the error is never made up. The projected change in the hospital market basket, the Centers for Medicare and Medicaid Services’ (CMS’s) measure of hospital

input costs, for fiscal year 2022 was 2.7 percent. When this projection was made, inflation was low. Actual growth in hospital costs will likely exceed the projection.⁶⁴ The desirability of pandemic-era declines in real Medicare payment rates depends on whether Medicare’s payment rates were too low or too high to start with, a question that is beyond the scope of this report. Arguably, real payments to providers should not depend on inflation or on the accuracy of inflation projections.

POLICY OPTION 4.B.1: Consider measures to maintain HI Trust Fund solvency during economic downturns

Policies that specifically address these risks include providing general revenues to finance HI spending when unexpected shortfalls arise; a one-time transfer of assets to the HI Trust Fund to ensure a larger cushion; or a transfer of revenues to the HI Trust Fund or a transfer of spending to the SMI Trust Fund to lower the imbalances between revenues and expenditures.

POLICY OPTION 4.B.2: Insulate provider payments from unanticipated errors in inflation projections.

Payments to hospitals and other providers might incorporate a correction method like the one used for skilled nursing facilities, that adjusts for projection errors in the following year. Notably, this correction goes both ways: If payments are higher than expected, payment rates may be reduced to correct the error, so this provision should be financially neutral on average over time. To address the vulnerability of physician payments to inflation, payments might be legislated in real terms—for instance, a measure of inflation minus some specified percentage.

64 Compensation for workers in private hospitals was almost 5 percent higher in the first three quarters of fiscal 2022 than over the same period in 2021 according to the Bureau of Labor Statistics’ Employment Cost Index. This discrepancy means that payments to providers will be lower in real terms—forever—because next year’s update will be based only on projected changes in inflation rates from 2022 and 2023. One exception is payments to skilled nursing facilities (SNFs). If the difference between the projected and actual change in the cost of inputs to SNF care is 0.5 percentage point or higher, then an adjustment to the payment rate is made in the following year to correct for that error.

Table 4-1: Sources of health insurance coverage by age, 2019

	All	Under 65	Under 19	19-64	65+
Any	90.8%	89.2%	94.3%	87.1%	99.2%
Any private	67.4	69.2	60.3	72.8	58
Employment-based	55.4	60	52.7	62.9	31.6
Any public	35.4	23.6	38.1	17.7	95.9
Medicare	18.1	2.9	0.6	3.8	95.8
Medicaid	19.8	21	37.6	14.4	13.7
Uninsured	9.2	10.8	5.7	12.9	0.8

Note: People may have multiple sources of insurance coverage.
Source: American Community Survey.

4.C Medicaid and the ACA Marketplaces during the Pandemic

4.C.1. Insurance for the Non-elderly during the Pandemic

Public health insurance programs like Medicaid, CHIP, and Medicare are important sources of health insurance for non-elderly, as well as elderly, persons, covering 23 percent of the non-elderly (ages 0–64) in 2019 (Table 4-1). Medicaid provides health coverage for the low-income population with a focus on children and their

parents, pregnant women, people with disabilities, and people ages 65 and older. Under the ACA, other low-income adults may be eligible for Medicaid expansion if states have adopted it. CHIP provides coverage to eligible children in households with somewhat higher incomes through Medicaid and separate CHIP programs. Medicare provides health insurance to the 65 and older population and to the non-elderly who have long-term disabilities. About 6 percent of the non-elderly population obtains coverage through the individual market, and most of these receive premium subsidies through the ACA marketplaces.⁶⁵

Before the enactment of the ACA, recessions typically led to increases in the number of persons without health insurance, as employees lost coverage through employ-

er-sponsored health insurance, a loss that was only partially offset by increased coverage through Medicaid and other public plans. For example, during the Great Recession, the number of uninsured rose by over 5 million, according to the National Health Interview Survey (National Center for Health Statistics n.d.-b). In contrast, the share of those without health insurance *decreased* during the pandemic (Figure 4-5).

Figure 4-6 breaks down the changes in insurance by income. Rates of uninsurance for non-elderly families fell sharply across the income spectrum, with the sharpest declines experienced by those with income between 100 percent and 199 percent of poverty (in 2021, between \$17,240 and \$34,480 for a family of two).

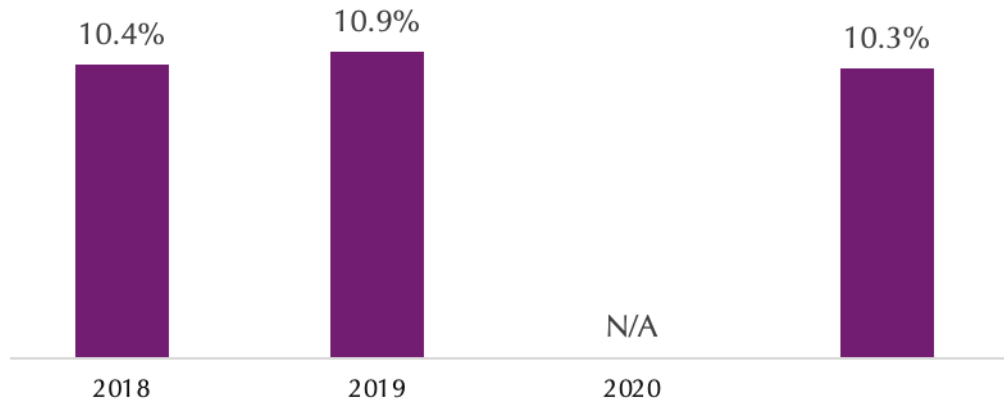
Figure 4-7 breaks out changes in uninsurance rates by race and ethnicity, again using the American Community Survey. Rates of uninsurance fell for all groups except American Indian/Alaskan Natives, the group with the highest rate of uninsurance.⁶⁶ Understanding why the program expansions did not benefit this group might be a high priority for research and policymakers.

Several factors likely contributed to the overall reduction in the share of those who are uninsured. First, the pandemic recession reduced employer-sponsored insurance by less than historical patterns had suggested it would. One reason is that unemployment during the

65 The shares of insurance by source are from the National Health Interview Survey for 2019.

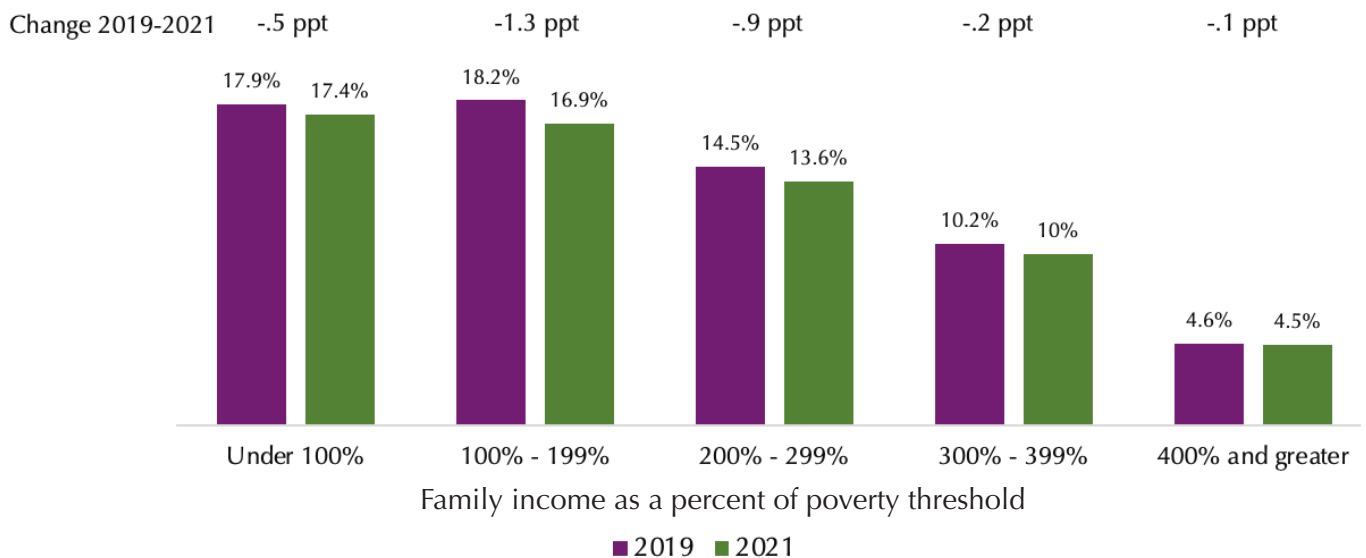
66 The decline in insurance among American Indian/Alaskan Natives was not statistically significant.

Figure 4-5: Non-elderly uninsured rates, 2018-2021



Estimates not available for 2020 due to pandemic-related disruptions to the American Community Survey.
Source: American Community Survey.

Figure 4-6: Share of non-elderly without insurance, by income

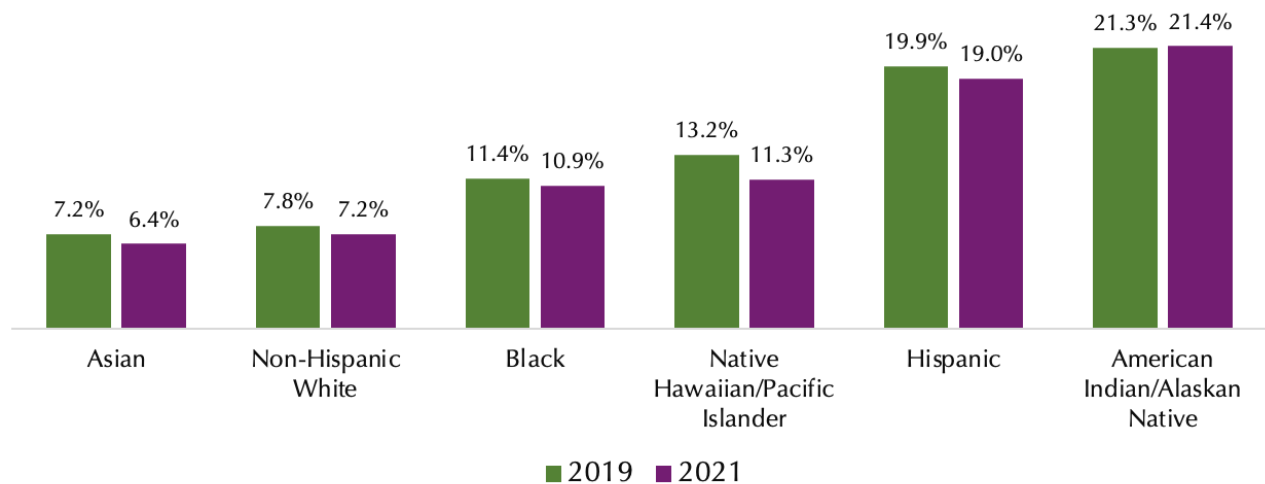


Note: ppt (percentage point).
Source: American Community Survey.

COVID-19 recession was unusually concentrated among low-wage workers, who have comparatively low rates of health insurance coverage through their jobs (Johnston et al. 2020). Another reason is that many employers who laid workers off in April 2020 during the economy-wide lockdowns anticipated bringing them back and continued paying for health insurance. According to the BLS, approximately 42 percent of establishments paid health insurance premiums for some employees who were told not to work (U.S. Bureau of Labor Statistics 2020).

Second, several legislative changes helped boost enrollment in publicly financed health insurance programs. Congress increased the share of Medicaid spending financed by the federal government (the Federal Medical Assistance Percentage, or FMAP) for most spending by 6.2 percentage points and indirectly increased the CHIP matching rate by 4.34 percentage points. As a condition of accepting the enhanced FMAP, states could not tighten Medicaid eligibility rules or make their enrollment procedures more restrictive. In addition, under a continuous coverage requirement, states could not discontinue Medicaid coverage during

Figure 4-7: Non-elderly uninsurance rates by race and ethnicity



Note: The figure reports average insurance rates for people who choose only one race/ethnicity; for example, “Black” means Black only.

Source: American Community Survey.

the public health emergency: Anyone who was on Medicaid before the pandemic or newly enrolled during the pandemic could not have their benefits terminated. Several states also adopted the ACA’s Medicaid expansion during or right before the pandemic.⁶⁷

In addition, other legislation—from the CARES Act to the American Rescue Plan—provided substantial aid to state and local government budgets. Together with the increased FMAP, this fiscal assistance far exceeded any revenue losses states might have suffered as a result of the pandemic (Sheiner 2022). States did not have the same need or incentive to cut Medicaid spending, such as by cutting benefits or provider payments, that they may have had in previous recessions.

Finally, the COVID-19 recession was the first economic downturn since the enactment of the ACA. The ACA expansion of Medicaid meant that a larger share of those losing their jobs could qualify for Medicaid coverage than in previous downturns. (Previously, only some low-income parents were eligible and most nondisabled adults without children were not eligible at all.) In

addition, some who lost employer-sponsored insurance during the pandemic qualified for subsidized health insurance through the ACA marketplaces. (The next section describes the performance of Medicaid, and the marketplaces are described in the following section.)

4.C.2. Medicaid during the Pandemic

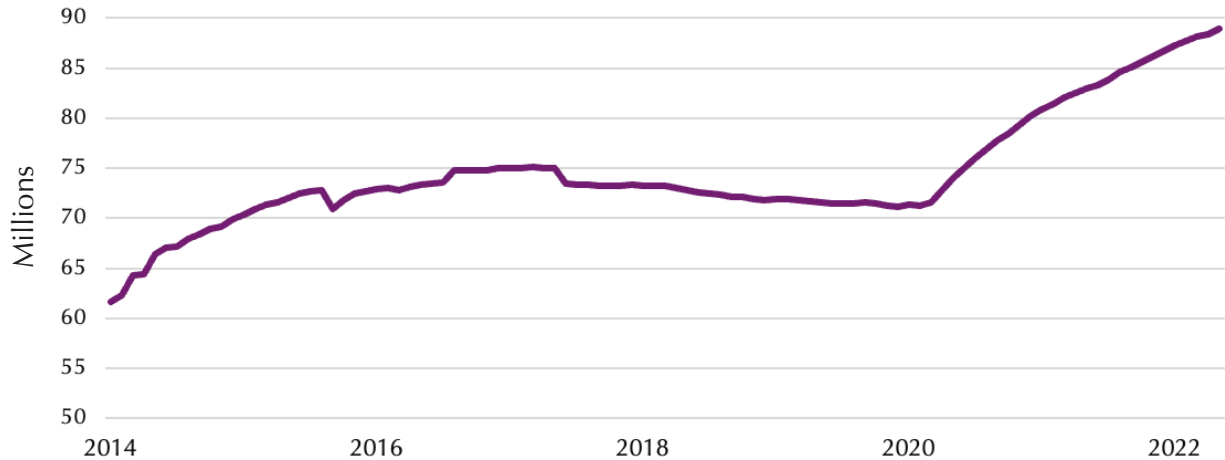
As shown in Figure 4-8, Medicaid/CHIP enrollment rose throughout the pandemic. In August 2020, enrollment was up by about 8 percent—about 6.5 million people—relative to before the pandemic. By February 2022, enrollment was up about 23 percent (16 million people).⁶⁸ Many analysts ascribe the bulk of this increase in enrollment to the continuous coverage requirement for states (Figure 4-8) (Kaiser Family Foundation 2022).

The changes in Medicaid enrollment by eligibility group, shown in Figure 4-9, demonstrate the importance of both the continuous coverage requirement and the Medicaid expansion. The group with the largest *percentage* increase was pregnant women, who have long been eligible for Medicaid but, without the continuous

67 According to Corallo and Moreno (2023), Utah and Idaho implemented the expansion in January 2020, Nebraska in October 2020, Missouri in October 2021 (with coverage retroactive to July 2021), and Oklahoma in July 2021.

68 This increase in enrollment, from administrative data, far exceeds the reported increases in Medicaid enrollment in survey data such as the Current Population Survey or American Community Survey, reflecting the well-known undercount problem in survey data (<https://www.shadac.org/news/understanding-undercount-medicaid-enrollees-2020-current-population-survey-health-insurance>).

Figure 4-8: Enrollment in Medicaid or CHIP



Note: CHIP (Children’s Health Insurance Program).
Source: Kaiser Family Foundation.

coverage mandate, often lose access to Medicaid coverage just two months after giving birth (Clark and Osorio 2022). This group is relatively small (roughly 1 million people) and accounted for just 5 percent of the total increase in Medicaid enrollment during the pandemic.

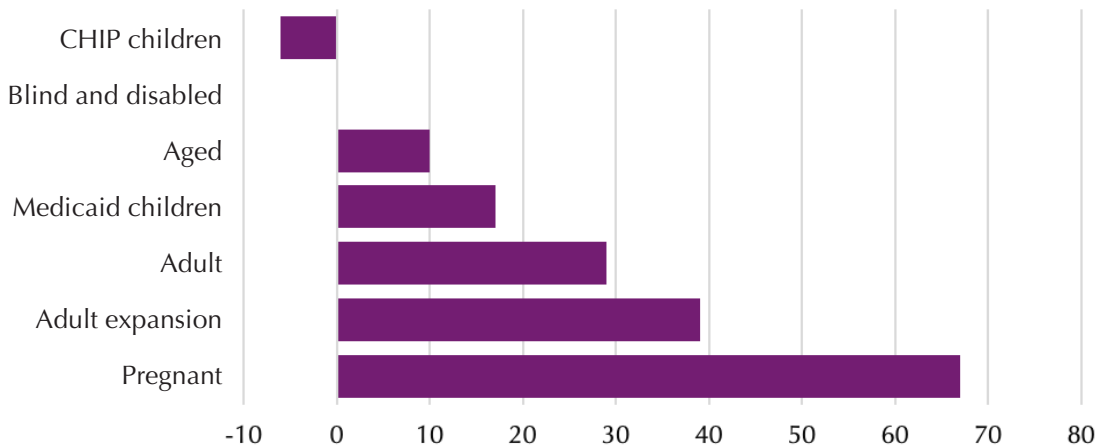
The group with the second largest percentage increase is the expansion group—adults who are eligible for Medicaid only because of the ACA’s Medicaid expansion that was adopted by 38 states plus the District of Columbia. In previous recessions, this group would

not have been able to turn to Medicaid as a source of insurance. This group accounts for about one-half of the total increase in Medicaid enrollment during the pandemic.⁶⁹

Children and nonexpansion, nonpregnant adults under age 65 account for most of the rest of the increase.

The uninsured population is larger in the 10 states that have not adopted the ACA’s Medicaid expansion. The Kaiser Family Foundation estimated that more than 2

Figure 4-9: Percent change in Medicaid and CHIP enrollment for each eligibility group, February 2020 to April 2021



Note: CHIP (Children’s Health Insurance Program).

69 <https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-08-31-2021.pdf>

million uninsured adults would have been eligible for Medicaid had these states adopted the expansion. Of that estimate, the vast majority of uninsured individuals reside in four states (Florida, Georgia, North Carolina, and Texas). In 2019, an estimated 18.4 percent of adults 19–64 were uninsured in Medicaid nonexpansion states as compared with 9.8 percent of their counterparts in Medicaid expansion states.⁷⁰

4.C.3 Utilization of Health Services by Medicaid Beneficiaries during the Pandemic

The pandemic kept many people home and led to a sharp reduction in the use of medical services. From March 2020 through January 2022, there were 5 percent fewer well-child screenings, 18 percent fewer dental services, and 23 percent fewer mental health services per child enrolled in Medicaid and CHIP than in the pre-pandemic period.⁷¹ For adults on Medicaid, the number of mental health services was about 19 percent lower⁷² during this period than before the pandemic, despite substantial evidence of a significant rise in mental health problems (Panchal et al., 2023). Overall hospital admissions (not only Medicaid) fell about 30 percent in the spring of 2020 and, despite some bounce-back, remained about 10 percent below the predicted level through mid-2021 (Gallagher et al., 2021).

The reduced utilization was beneficial for insurers but strained providers. About 70 percent of Medicaid beneficiaries are enrolled in private managed care plans—plans with which state Medicaid agencies contract to manage care (Medicaid and CHIP Payment and Access Commission [MACPAC] 2022). Medicaid pays these plans a fixed rate, negotiated in advance. Profits increase when utilization falls. Most Medicaid managed care plans, unlike private insurance plans,

are not required to pay rebates when use falls below certain thresholds, although many states do have such requirements.⁷³

Medicaid providers have lower margins on average than do other providers because Medicaid payment rates tend to be lower than private payment rates and because they tend to be safety-net providers that provide significant uncompensated care. Recent surveys suggest that Medicaid payments to both hospitals and physicians are roughly 50 percent of private payments, although the amount varies significantly across health conditions and geographic areas.⁷⁴

The decline in service use during the pandemic put providers serving Medicaid patients under financial strain. Smaller independent providers—particularly those specializing in behavioral health and substance abuse treatment, which suffered huge declines in service use—were most at risk.

Recognizing the financial strain on providers during the pandemic, federal policymakers enacted a Provider Relief Fund. As explained below, providers that disproportionately served Medicaid patients tended to receive smaller grants on a per-patient basis in initial funding disbursements, depriving them of a vital lifeline during times of financial strain.

Lessons Learned and Policy Options for Medicaid

The large increase in Medicaid enrollment during the pandemic in part reflected the continuous coverage mandate in place during the public health emergency. Now that the continuous enrollment provision has ended, states are going through a process of redetermining eligibility for beneficiaries. An estimated

70 Changes in coverage and access. MACPAC.

71 Medicaid and CHIP and the COVID-19 Public Health Emergency. CMS Preliminary Medicaid and CHIP Data Snapshot.

72 Medicaid and CHIP and the COVID-19 Public Health Emergency. CMS Preliminary Medicaid and CHIP Data Snapshot.

73 Self-funded group health insurance plans, like those run by most large employers, are also not subject to medical loss ratio requirements.

74 We calculate the difference as follows: For hospitals, MACPAC (2017) calculated that Medicaid payments to hospitals were about 6 percent higher than Medicare payments across the 18 conditions they studied. Lopez et al. (2020) reported that Medicare hospital rates are about half of private insurance rates.

For physicians, Zuckerman, Skopec, and Aarons (2021) found that Medicaid physician and other qualified health providers' fees are about 70 percent of Medicare rates and Fielder (2021) reported that commercial prices for physician services are between 120 percent and 163 percent of Medicare's, resulting in an estimate of Medicaid physician prices of 43 percent to 58 percent of commercial prices.

15 million low-income people might lose coverage as a result; exactly how many will depend on how states implement redeterminations and how many people are found ineligible.⁷⁵

One important concern is that many people will lose coverage for procedural reasons despite continuing to be eligible. Research has established that even small barriers to health insurance significantly reduce access, while reducing barriers even a small bit may increase take-up.

One important concern is that many people will lose coverage for procedural reasons despite continuing to be eligible. Research has established that even small barriers to health insurance significantly reduce access, while reducing barriers even a small bit may increase take-up (Baicker and Wright 2017).⁷⁶ Historical patterns suggest that 6.8 million people might lose coverage for procedural reasons despite continuing to be eligible.⁷⁷ How large the loss of coverage will actually be among people who remain eligible will depend in part on (1) how well current enrollees cope with confusing forms to renew coverage, (2) how many eligible people miss deadlines (including due to changes in address and returned mail) or do not realize they need to file new applications, and (3) what types of outreach are made to try to mitigate the loss of coverage.

This problem of ending continuous coverage occurs in ordinary times, not just during a pandemic. Normally, most enrollees must renew eligibility every 12 months. They must also report any changes in income or

family status that may affect their eligibility during this 12-month period. Income increases, even for brief periods, may cause Medicaid enrollees to lose eligibility. In these cases, people must reapply to reestablish eligibility. Many states routinely check quarterly wage data and other information to identify people who have experienced increases in income. If such information indicates loss of eligibility, states may require enrollees to provide paperwork to prove they are still eligible. It is likely that many people who actually are eligible lose coverage because they do not respond in time (Wagner and Solomon 2022).

POLICY OPTION 4.C.1: Guarantee the ability to remain enrolled in Medicaid and CHIP for 12 months, regardless of changes in income. Several options might help address the Medicaid churn—temporary lapses in coverage that often occur as enrollees go on and off Medicaid over short periods of time. One option to consider might be to require states to maintain continuous enrollment on a permanent basis—specifying that all individuals enrolled in Medicaid and/or CHIP are guaranteed 12 months of coverage—regardless of what happens to income during those 12 months.⁷⁸ (This might also include a requirement for 12 months of postpartum coverage.) Under this policy, some people would get Medicaid for a part of the year when they no longer meet eligibility criteria, but many who are eligible for public health insurance but are not enrolled because of administrative hurdles would be covered. Given that Blacks, Latinos, and American Indians/Alaskan Natives are more likely to be uninsured and eligible for Medicaid than Whites, such a policy might also help address health disparities (Brooks and Gardner 2021). In addition, such a rule might lower administrative

75 <https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf>.

76 For example, see Shepard and Wagner (2021), who showed that a modest hassle leads to major reductions in coverage for low-income people in Massachusetts. McIntyre, Shepard, and Wagner (2021) also showed the importance of inattention in reducing health insurance coverage.

77 <https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf>.

78 States already have the option to provide 12-month continuous eligibility for children in Medicaid and CHIP. New York and Montana have such a continuous eligibility policy for adults, allowed through a “waiver” under the Medicaid law. In an evaluation of New York state’s 12-month continuous eligibility policy for adults, Liu et al. (2021) found that the policy increased the duration of Medicaid coverage by 8.2 percent in the population enrolled through the ACA marketplaces and 4.2 percent among those enrolled through local social service departments. Medicaid costs increased 2.6 percent and 3.1 percent, respectively, as some of the increased duration was offset by lower per-member monthly costs.

costs associated with constantly checking eligibility and processing people as they churn on and off the rolls.⁷⁹

POLICY OPTION 4.C.2: Make it easier for states to adopt continuous enrollment provisions. Another option might be to allow states to adopt continuous eligibility for adults and multiyear continuous eligibility for children without requiring waivers.⁸⁰ Removing the need to apply for a waiver might lower the administrative hurdles faced by states wanting to adopt these policies.

POLICY OPTION 4.C.3: Reduce administrative barriers to help people enroll in and maintain Medicaid coverage. Even small premiums discourage Medicaid participation. Barring states from requiring premiums or copayments for Medicaid might increase coverage and access, as might improvements in outreach to beneficiaries and improving customer service by investing in navigators dedicated to helping people sign up for and maintain Medicaid coverage.

POLICY OPTION 4.C.4: Require MACPAC to develop policy options to ensure greater equity in Medicaid coverage of adults across states. As noted above, there are wide disparities in access to insurance across racial and ethnic groups, driven in part by differences across states in Medicaid rules and procedures. Developing and implementing policies to reduce uninsurance rates among non-elderly poor and near-poor will allow Medicaid to be more responsive to the health needs of some of the most disadvantaged individuals and families during the next health crisis. It also will help achieve greater racial equity in health coverage.

The experience during the pandemic also pointed to some changes in Medicaid financing that might help bolster state finances and prevent cutting Medicaid during public health emergencies and recessions.

POLICY OPTION 4.C.5: Require medical loss ratio rebates for Medicaid managed care. When claims fall below a certain percentage of insurance premiums (the medical loss ratio, or MLR), many private insurance

plans are required to pay rebates to customers. States have the option of imposing similar requirements on Medicaid managed care plans, but only 24 states (plus the District of Columbia) require all plans to pay rebates to the state when plans fail to meet their MLRs.⁸¹

States might be required to establish MLRs and require plans to pay rebates when they do not meet the requirement. During the pandemic, such a requirement would have ensured that states recouped excess Medicaid payments when there was a decline in use. States could have repurposed some of the rebated funds to help health care providers that were suffering from the loss of revenue.

Not only does the [Federal Medical Assistance Percentage] provide general aid to states by temporarily lowering their share of Medicaid costs, but it also discourages states from trying to balance their budgets by making cuts to their Medicaid programs.

POLICY OPTION 4.C.6: Make an increase in the FMAP automatic during downturns. The increase in the FMAP—the share of Medicaid expenditures financed by the federal government—is a particularly important tool during a recession. Not only does it provide general aid to states by temporarily lowering their share of Medicaid costs, but it also discourages states from trying to balance their budgets by making cuts to their Medicaid programs. While Congress temporarily increased the FMAP during previous recessions (in 2003, 2009, and 2020) (Mitchell 2020), states cannot presume such increases until and unless Congress acts. As a result, prospective budget shortfalls may cause states to cut back on Medicaid or other services at the very time they are most needed. An automated FMAP increase might also tailor the duration of assistance to match economic conditions. This likely would have lengthened the duration of the higher FMAP

79 <https://www.congress.gov/bill/117th-congress/house-bill/5376>.

80 Oregon received a waiver from CMS to provide multiyear continuous eligibility for children in October 2022, and Washington, California, and New Mexico are in the process of seeking such a waiver. States are already able to provide 12 months of continuous coverage for children without a waiver.

81 <https://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes>.

during the Great Recession but shortened it during the pandemic recession. The Government Accountability Office (2011) developed a prototype formula for a national automatic FMAP increase triggered by overall economic conditions.⁸² Fiedler, Furman, and Powell (2019) proposed a state-specific FMAP increase tied to the change in a state's unemployment rate.⁸³ As with past FMAP increases, this increase might be tied to a prohibition against states cutting their programs, making it harder for individuals to enroll or renew their coverage, and/or disenrolling beneficiaries.

Improved data collection and data systems . . . may not seem essential to dealing with widespread illness. Yet the lack of such data and the sluggishness of reporting impeded the response to COVID-19, particularly for Medicaid beneficiaries.

POLICY OPTION 4.C.7: Invest in improved data collection. Improved data collection and data systems—including improved reporting requirements by states, detailing Medicaid and other health insurance enrollment by race, ethnicity, age, and eligibility category—may not seem essential to dealing with widespread illness. Yet the lack of such data and the sluggishness of reporting impeded the response to COVID-19, particularly for Medicaid beneficiaries. Standardized, timely data will greatly improve understanding what happened during the pandemic and why.

4.D The ACA Health Insurance Marketplaces during the Pandemic

Several changes were made to the ACA marketplaces during the pandemic. Congress, as part of the American Rescue Plan, substantially increased the subsidies available for insurance purchased through the ACA marketplaces for many who were already eligible and made people with incomes exceeding 400 percent of the federal poverty thresholds newly eligible for subsidies.⁸⁴ This subsidy expansion began in 2021; the Inflation Reduction Act in 2022 extended the expansion through 2025.

The federal government also created an expansive COVID-19 Special Enrollment Period for the federal health exchange from February 2021 to August 2021 to allow those who had missed the standard open enrollment period to sign up for coverage. Some state marketplaces extended special enrollment periods even further.

4.D.1 Enrollment

Enrollment in ACA marketplaces increased during the pandemic, rising by 800,000, or about 9 percent (Figure 4-10), by the end of 2020 relative to the same month in 2019. Largely as a result of the change described above, enrollment increased further in 2021 and 2022 and now appears on track to be around 3 million (28 percent) above its 2019 level for 2022.⁸⁵

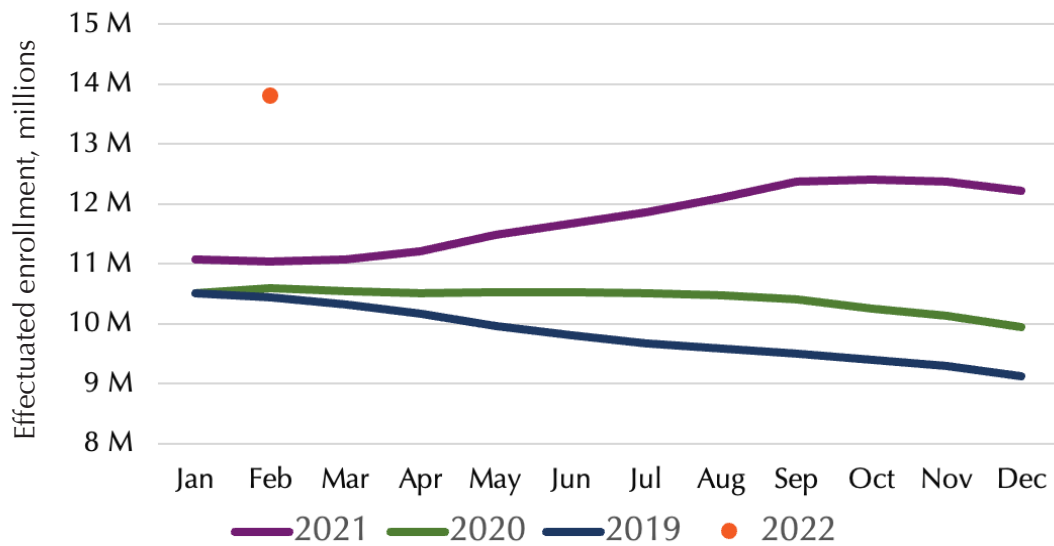
82 <https://www.gao.gov/products/gao-12-38>.

83 In particular, they set a state-specific unemployment rate threshold tied to historical unemployment rates in the state and would increase the given state's Medicaid matching rate by 3.8 percentage points for each percentage point by which the state's unemployment rate exceeds the threshold.

84 Under the American Rescue Plan, people with income above 400 percent of the federal poverty level will receive subsidies equal to the difference between the premium for the benchmark plan (the second lowest cost silver plan in their area) and 8.5 percent of household income. <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/>.

85 <https://aspe.hhs.gov/sites/default/files/documents/77ba3e9c99264d4f76dd662d3b2498c0/aspe-ib-uninsured-aca.pdf>.

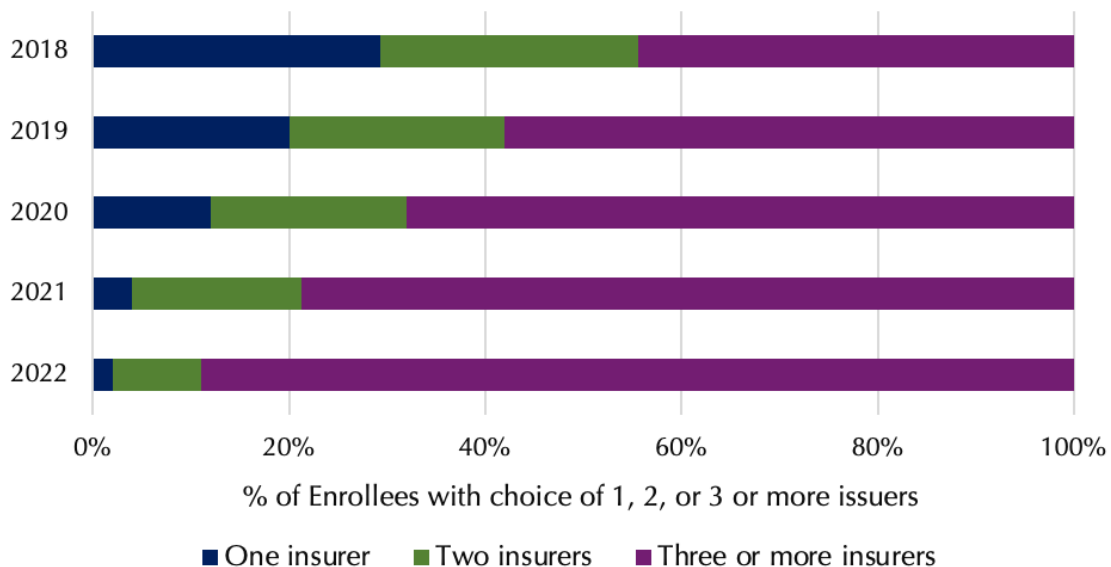
4-10: Monthly enrollment in ACA marketplace plans



Note: ACA (Affordable Care Act). February 2022 values are from the CMS (Centers for Medicare and Medicaid Services) Early Snapshot. Effectuated enrollment is defined as the number of individuals enrolled in marketplace plans who have paid their premium or have a grace period for that month. The number for 2022 is the Department of Health and Human Services' estimate based on enrollment during the 2022 open enrollment period.

Source: CMS, Monthly Effectuated Enrollment.⁸⁶

Figure 4-11: Insurer participation in ACA marketplaces



Note: ACA (Affordable Care Act). This figure reports insurer participation for states using the healthcare.gov platform.

Source: <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiumsChoiceReport.pdf>.

86 For 2019 and 2020: <https://www.cms.gov/files/document/2016-2021-Feb-Effectuated-Enrollment-Tables.xls>. For 2021 and early 2022: <https://www.cms.gov/files/document/early-2022-and-full-year-2021-effectuated-enrollment-report.pdf>.

4.D.2 Insurer participation

Insurer participation in ACA marketplaces increased during the pandemic, continuing a pre-pandemic trend toward greater insurer participation. In states using healthcare.gov, 89 percent of enrollees had a choice of at least three insurers in 2022, compared to 58 percent in 2019 (Figure 4-11).⁸⁷

Lessons Learned and Policy Options for the Marketplaces

Strength of the ACA marketplaces: The ACA marketplaces generally operated well during the pandemic. Marketplaces handled 30 percent more customers in 2022 than in 2019 and the number of issuers offering plans in the marketplace increased, continuing a pre-pandemic trend.

POLICY OPTION 4.D.1 Expand the premium tax credit. Similarly, Congress might also consider making permanent part or all of the increase in the premium tax credits enacted as part of the American Rescue Plan (which were recently extended through 2025 in the Inflation Reduction Act). The Congressional Budget

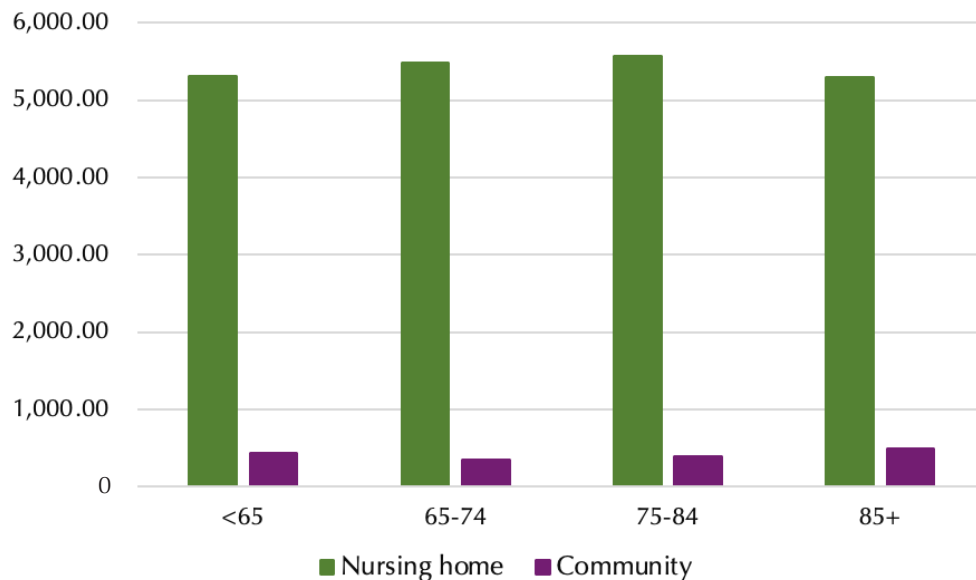
Office estimates that doing so would increase the number of insured by about 2 million people, at a cost of about \$25 billion to \$30 billion per year (Swagel 2022). Doing so would remove a large notch—the abrupt loss of substantial benefits for people whose income rises above 400 percent of the federal poverty threshold.

4.E COVID-19 and Nursing Facilities

Medicare and Medicaid both have roles in regulating and paying for nursing home care. Medicare beneficiaries may receive care for a limited duration in skilled nursing facilities following a qualifying inpatient hospital stay of at least three days. Medicaid pays for short- and long-term nursing home care for beneficiaries; some qualify for Medicaid only after they have spent nearly all of their assets.⁸⁸ Approximately 60 percent of residents in long-term care facilities are covered by Medicaid. States are responsible for inspecting nursing homes to ensure quality of care and compliance with nursing home standards.

COVID-19 was particularly devastating to nursing home residents. In 2020, Medicare beneficiaries living

Figure 4-12: COVID-19 cases per 100,000 people, 2020

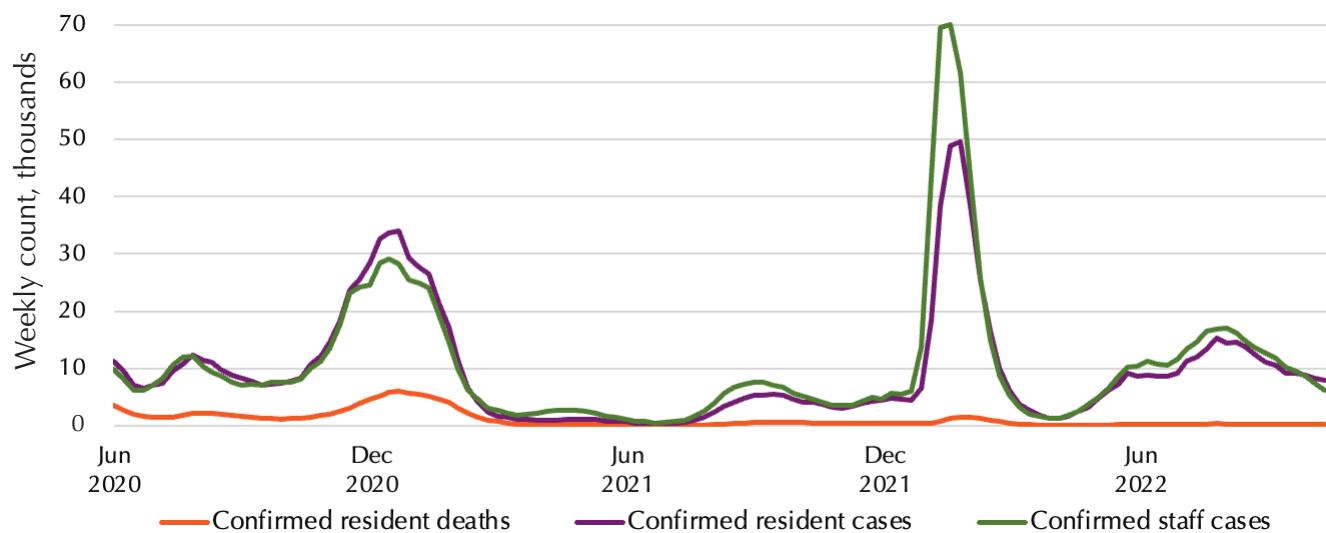


Source: Centers for Medicare and Medicaid Services (n.d.).

87 <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiumsChoiceReport.pdf>.

88 There is a great deal of variation across the states in the Medicaid eligibility criteria for residents of long-term care facilities.

Figure 4-13: Nursing home COVID-19 cases and deaths



in nursing homes were 14 times more likely to be diagnosed with COVID-19 than beneficiaries living in the community. This difference is not because nursing homes residents are older, as case rates for COVID-19 did not vary much by age for the population over 65 (Figure 4-12) (Centers for Medicare and Medicaid Services 2022).

Nursing home residents who were hospitalized for COVID-19 were found to be less likely to survive after a hospitalization than community residents, even after controlling for age (Centers for Medicare and Medicaid Services n.d.). COVID-19 deaths among nursing home residents fell sharply with the rollout of vaccines in early 2021, as shown in Figure 4-13. However, lower-than-optimal rates of vaccination remained a problem. As of July 2021, only 82 percent of nursing home residents and 57 percent of nursing home staff were fully vaccinated. As of December 2021, only 58 percent of vaccinated residents and 25 percent of vaccinated staff had received a booster (Reber and Kosar 2022).

Nursing home staff faced sharply increased risks of becoming sick and experienced unprecedented stress. The pandemic exacerbated problems that had long

been apparent—low pay, high staff turnover, and low quality at nursing facilities—problems that lead to poor outcomes for patients (Ochieng, Chidambaram, and Musumeci 2022). According to the Kaiser Family Foundation, in March 2022, 24 percent of nursing facilities reported shortages of nursing staff, up from 15 percent in May of 2020. Employment in private nursing homes has declined 16 percent since the start of the pandemic—compared with a roughly 10 percent drop in nursing home residents.⁸⁹

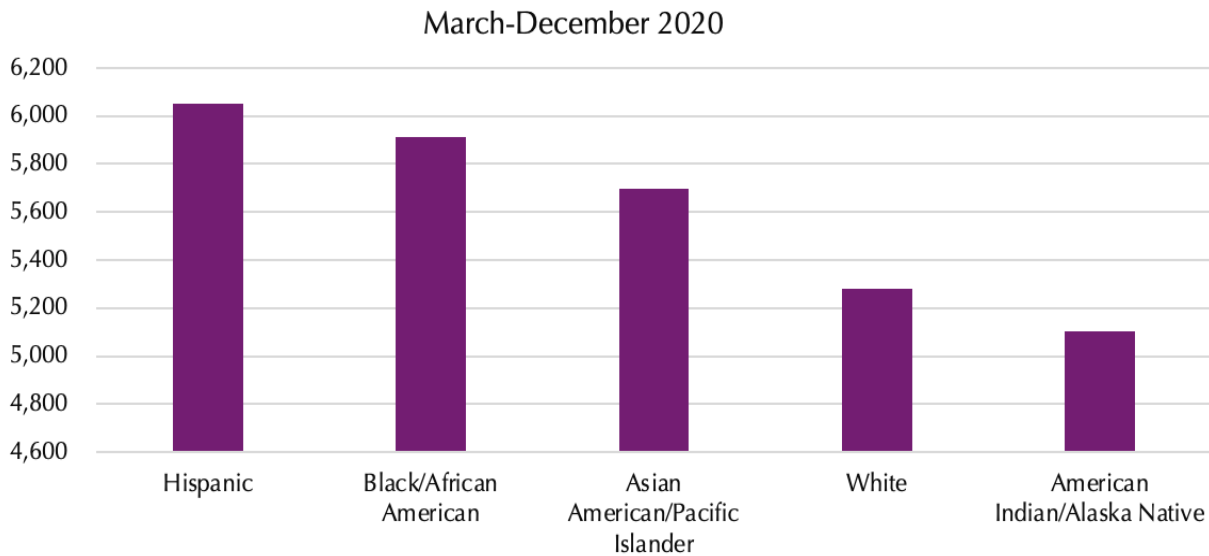
The variation in COVID-19 vaccination rates of nursing home residents mirrors pre-COVID-19 variation in flu vaccinations.⁹⁰ Black nursing home residents are more likely to be in facilities with low vaccination rates of both residents and staff. Facilities with low resident and staff vaccination rates are more likely to be for profit, dependent on Medicaid financing, and rated low quality by CMS’s nursing home rating system (Reber and Kosar 2021).

Black, Hispanic, and American Indian/Alaska Native Medicare beneficiaries in nursing homes had notably higher case rates than White and Asian/Pacific Islander beneficiaries (Figure 4-14).

⁸⁹ According to the National Investment Center for Seniors Housing & Care (2022), skilled nursing occupancy was 86.6 percent before the pandemic, but 77.6 percent in the first quarter of 2022.

⁹⁰ In contrast, the variation in vaccinations of nursing home staff is quite correlated with the Trump share of the 2020 presidential election vote.

Figure 4-14: COVID-19 cases per 100,000 Medicare beneficiaries residing in nursing homes



Source: Centers for Medicare and Medicaid Services (n.d.).

Lessons Learned and Policy Options for Nursing Home Residents

The high mortality toll and the much higher case rates among Hispanic, Black, and American Indian/Alaska Native residents of nursing homes underscored the urgency of closer monitoring of quality and enforcement of accountability at these facilities, particularly during major public health emergencies like a pandemic.

The Biden Administration proposed nursing home reforms to address some of these problems, including (1) establishing a minimum nursing home staffing requirement to ensure an adequate ratio of nurses and other staff to residents; (2) reducing multi-bed nursing home rooms to increase privacy and to reduce the spread of infectious diseases; and (3) basing payments on measures of nursing home quality, including staffing adequacy, the resident experience, and staff retention.

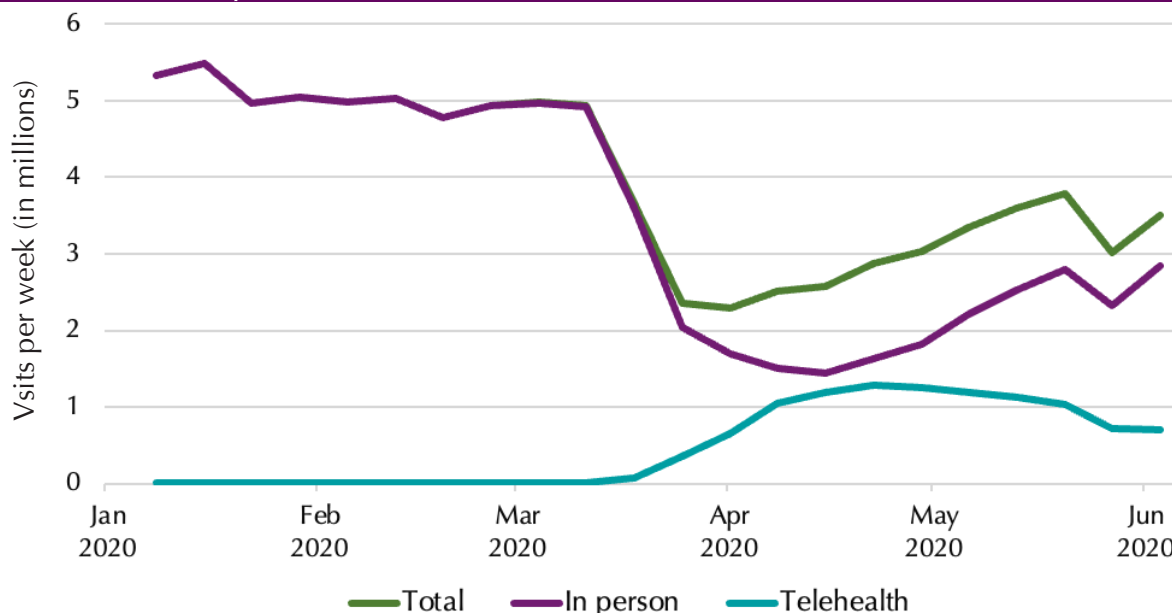
A recent report by the National Academies of Sciences, Engineering, and Medicine (2022), “The National Imperative to Improve Nursing Home Quality,” also included an expansive list of options for improving nursing home care.

POLICY OPTION 4.E.1: Congress could consider adopting reforms that would increase nursing home staffing, improve pay and working conditions for nursing home staff, and increase the number of full-time jobs. These reforms would likely lead to improved outcomes for nursing home residents (Stevens et al. 2012). Reducing the number of staff working part-time at multiple facilities is particularly helpful during a pandemic since staff movement between facilities was associated with a large share of COVID-19 cases among nursing homes residents early in the pandemic (Chen et al. 2020).

POLICY OPTION 4.E.2: Congress might consider requiring nursing home workers to be vaccinated for COVID-19 and other infectious diseases like the flu. Raising vaccination rates would improve resident health (Sinha and Konetzka 2022) and, given that Black residents are more likely to reside in nursing homes with low vaccination rates, would help address racial disparities.

POLICY OPTION 4.E.3: Congress might consider expanding the Medicare graduate medical education programs to include nurse training. This could subsidize the cost of nurse training to help address the nursing shortage in nursing homes.

Figure 4-15: Primary care visits for fee-for-service Medicare beneficiaries



Source: Assistant Secretary for Planning and Evaluation (2020).

4.F Telemedicine

Total use of medical services declined despite a significant increase in telemedicine. As shown in Figure 4-15, telehealth primary care visits offset almost 40 percent of the drop in in-person primary care visits in April 2020. The use of care declined much less for clinical services—such as mental health services—that could be more easily delivered via telemedicine (Patel et al. 2021), as shown in Figure 4-16.⁹¹

As the economy reopened and in-person visits increased, the use of telehealth has diminished. Still, even by the end of 2020, telehealth made up roughly 10 percent of Medicare primary care visits (Samson et al. 2021).

Telemedicine also became much more common in Medicaid. Examining data from five states, the Government Accountability Office (2022) reported that 32.5 million services were delivered via telehealth from March 2020 to February 2021, compared to just 2.1 million the prior year.⁹²

Relaxation of CMS rules during the pandemic helped increase the use of telemedicine in Medicare. Before the pandemic, Medicare covered telemedicine only for rural patients, and it required these patients to travel to specific health care sites outside the home to receive the care (O'Reilly 2022). During the pandemic, Medicare paid providers the same rates for telehealth visits from any location that it did for in-person visits. Under current law, most of the new rules covering telemedicine will expire in December 2023 (payment parity) or December 2024 (most other rules).⁹³

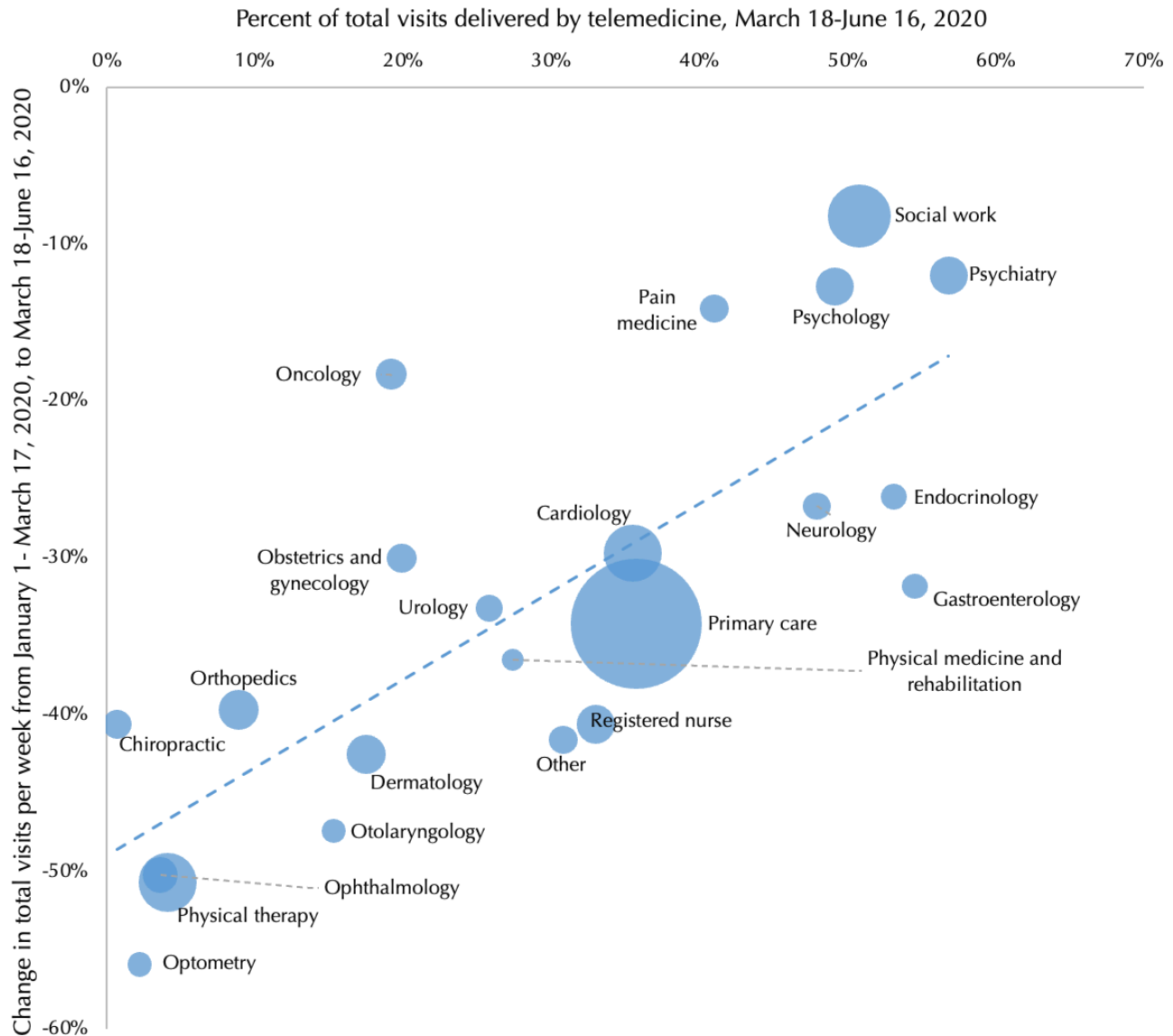
States helped the expansion of telemedicine in other ways as well. Most states relaxed licensing rules to allow out-of-state physicians to provide telemedicine (American Medical Association 2021). They relaxed or waived scope of practice regulations to allow nurse practitioners and physician assistants to provide a greater range of services, including remote visits without a physician present (Weiner 2021). State Medicaid agencies also made telehealth services more broadly available during the pandemic (Guth and Hinton 2020).

91 The figure shows the relationship between telehealth and total health visits for the whole population, not just Medicare and Medicaid.

92 The states examined were Arizona, California, Maine, Mississippi, and Missouri.

93 Franco, Miranda. The Secretary of the Department of Health and Human Services has the authority to declare a public health emergency (PHE). The PHE for COVID-19 began on January 27, 2020, and ended on May 11, 2023.

Figure 4-16: Change in weekly total outpatient visits compared to percent of weekly visits delivered by telemedicine, by clinician specialty



Circle size indicates the proportion of total visits during pandemic period by clinical specialty. Source: Patel et al. (2021).

The move to online services during the pandemic poignantly dramatized the “digital divide.” Low-income, elderly, and non-White people have less access to, or comfort with, digital services and computers. Black adults and elderly adults were less likely to use video telehealth services during the pandemic than were other groups (Shah, Alkureishi, and Lee 2021). Among Medicare beneficiaries, there were disparities in access to telehealth by sex, income level, and location (Ng and Park 2021). Audio-only telemedicine services by telephone—instead of by video—partly offset this digital gap.

How the reduction in health care services during the pandemic and unequal access to telemedicine will affect health disparities is as yet unknown, but merits more research.

Lessons Learned and Policy Options for Telemedicine

Telemedicine holds great promise in increasing the efficiency of health care and reducing disparities in health care. Whether the modifications made to the

rules during the pandemic will be made permanent and whether further changes will be needed remain unclear. The Consolidated Appropriations Act of 2022 extended Medicare’s pandemic telehealth rules for five months after the end of the public health emergency. It also requires MedPAC to report on how Medicare telehealth affects payments, access, and quality and for the Department of Health and Human Services (HHS) to report on “program integrity” risks (e.g., the potential for fraud) associated with Medicare telehealth services.⁹⁴

POLICY OPTION 4.F.1: Encourage CMS to work with states to determine whether some or all of the waivers of scope of practice regulations during the pandemic should be made permanent or whether they should be automatic during public health emergencies.

POLICY OPTION 4.F.2: Enact policies to help narrow the digital divide. These options include ensuring high-speed internet in every community, subsidizing internet for low-income households, and providing other tools—perhaps in-person aides—to help beneficiaries who are uncomfortable with computers and the internet take advantage of telehealth. Without such efforts, telehealth might widen rather than narrow health disparities. According to the 2018 American Community Survey, 26 percent of Medicare beneficiaries did not have access to either a computer with high-speed internet or a smartphone with a wireless data plan (Eyrich, Andino, and Fessel 2021). Older, Black, and Hispanic beneficiaries were particularly likely to have limited access to these technologies.

4.G. The Provider Relief Fund

With the increased costs associated with COVID-19 and declining use of other medical services, the pandemic threatened the solvency of many health care providers. These threats were particularly acute for “safety net” providers that serve a larger-than-average proportion of uninsured and Medicaid patients because these providers

Telemedicine holds great promise in increasing the efficiency of health care and reducing disparities in health care.

typically have tight financial constraints even in ordinary times. “Essential hospitals” had an operating margin of 2.9 percent in 2019, compared to 8.8 percent for hospitals overall (America’s Essential Hospitals 2021). In 2018, the poorest 25 percent of all U.S. hospitals had enough cash on hand to pay operating expenses for 7.6 days, compared to 53 days for the median hospital (Khullar et al. 2020).

To support health care providers whose revenues fell and whose costs rose because of COVID-19, Congress allocated \$178 billion to the Provider Relief Fund (PRF).⁹⁵ The legislation allowed HHS broad discretion on how to allocate the funds (Congressional Research Service 2022). HHS allocated much of the PRF based on total patient revenues—that is, the larger a provider’s pre-COVID-19 revenues, the greater the aid they received. This mechanism helped deliver funds quickly, but it was not well targeted to providers who experienced the most hardship. Providers largely dependent on commercial insurance companies, which pay higher rates than Medicare and Medicaid, received larger grants than did providers paid mostly by Medicare and Medicaid.

As a result, PRF allocations went disproportionately to the least financially stressed providers. Citing cash on hand in 2018 as a metric of financial well-being, Grogan, Lin, and Cusmano (2021) showed that hospitals with the least cash on hand received about \$55,000 per hospital bed, while those with the most cash on hand received about \$110,000 per bed. Payments to many financially vulnerable hospitals were delayed. As a result, the PRF widened rather than narrowed inequalities among hospitals.

HHS might instead have helped public and nonprofit safety-net hospitals first and allocated more funds per

94 This discussion draws from Marks and Augenstein (2022).

95 The Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted on March 27, 2020, included \$100 billion for provider relief funding, and the Paycheck Protection Program and Health Care Enhancement Act (enacted on April 24, 2020) included an additional \$75 billion. The Consolidated Appropriations Act, 2021, signed on December 27, 2020, appropriated \$3 billion.

bed to them rather than less, given that these hospitals served patients who had been harmed disproportionately by the pandemic (Grogan, Lin, and Gusmano 2021).

For the final phase of the allocation of the PRF, the federal government announced that funding would be “distributed with an eye towards equity, to ensure providers who serve our most vulnerable communities will receive the support they need.” In particular, smaller providers—who tend to operate on thin margins—would be reimbursed for lost revenues and COVID-19 expenses at a higher rate than larger providers and would include bonus payments for providers who serve Medicaid, CHIP, and/or Medicare patients (HHS 2021).

Lessons Learned and Policy Options for Provider Relief during Public Health Emergencies

That the U.S. health system is replete with inequities is beyond dispute. The shortcomings of policies adopted in response to COVID-19 and ways to do better in future crises are at the core of this report. Much of the assistance to health care providers over the past two years aggravated, rather than alleviated, inequities, at least initially. Given the vastly different exposure to COVID-19 among Blacks, Hispanics, and American Indians/Alaska Natives—people most likely to be served by safety-net providers—this response constituted a significant failure.

POLICY OPTION 4.G.1: Establish a process to ensure that funds provided to health care providers during public health emergencies are targeted to financially vulnerable safety-net providers, including safety-net hospitals, community health centers, and Medicaid behavioral health providers. This targeting might include both the amount of aid provided and the speed at which it is distributed.

4.H Public Health Infrastructure

While public health infrastructure is not typically viewed as part of the social insurance system, the pandemic made clear its central importance in protecting the health of individuals and families and the dire effects of this infrastructure’s demonstrable shortcomings.

Because of this report’s focus on social insurance, it does not give public health the attention that it deserves. Interested readers may wish to review the recent work of the National Academy of Medicine, “Public Health: COVID-19 Impact Assessment: Lessons Learned and Compelling Needs” (DeSalvo et al. 2021).

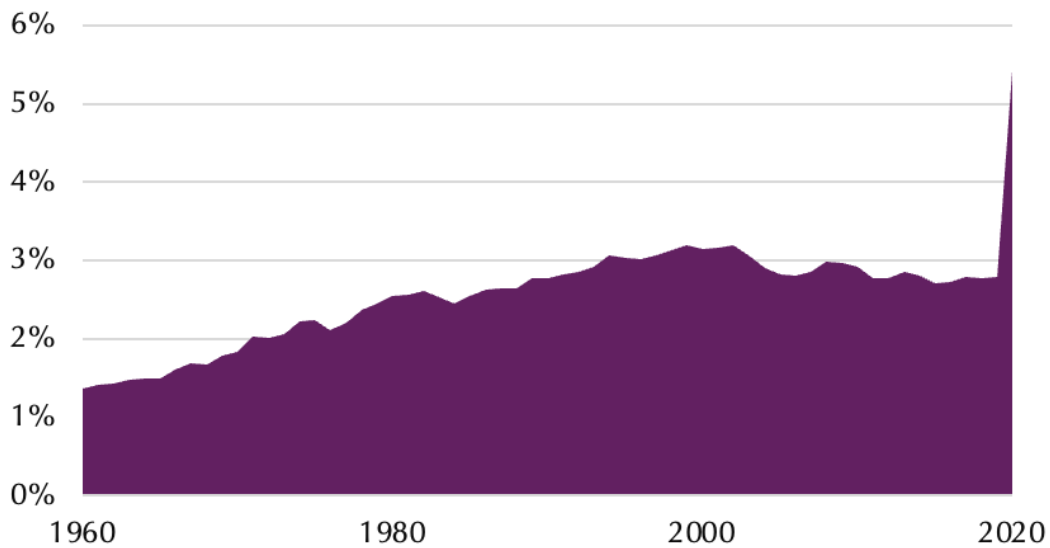
The Institute of Medicine (now National Academy of Medicine) asserted in 1988: “The Nation has lost sight of its public health goals and has allowed the system of public health to fall into disarray.” Little progress has been made since then. Tragic losses during the pandemic resulted from the nation’s neglect of its public health system. Vaccination rates in the U.S. are lower than in many other countries, including France, Canada, and Japan. Months elapsed before supplies of personal protective equipment were available. Politicization of testing, masks, and vaccinations have resulted in tens, if not hundreds, of thousands of premature deaths—a toll borne disproportionately by the poor and other disadvantaged communities (Ritchie et al. 2020). This is not a case in which more for some means less for others: All would have benefited from better preparation of public health interventions.

Tragic losses during the pandemic resulted from the nation’s neglect of its public health system.

Needed investment in public health: While total investment in public health spending has increased over time, from about 0.3 percent of gross domestic product (GDP) in 1990 to about 0.5 percent in 2019 (Figure 4-17), other indicators suggest that the investment has been far from sufficient—over a period in which overall U.S. health care spending expanded from 12.2 percent to 17.6 percent of GDP.

The Association of State and Territorial Health Officials (2020) reported that, between 2012 and 2019, the number of full-time equivalents working in state health agencies declined by almost 10 percent. The association noted that funding from federal and state sources also declined about 10 percent over this period. The U.S. public health sector visibly lacks surge capacity (physical and human) to address national emergencies such as

Figure 4-17: Public health share of national health expenditures



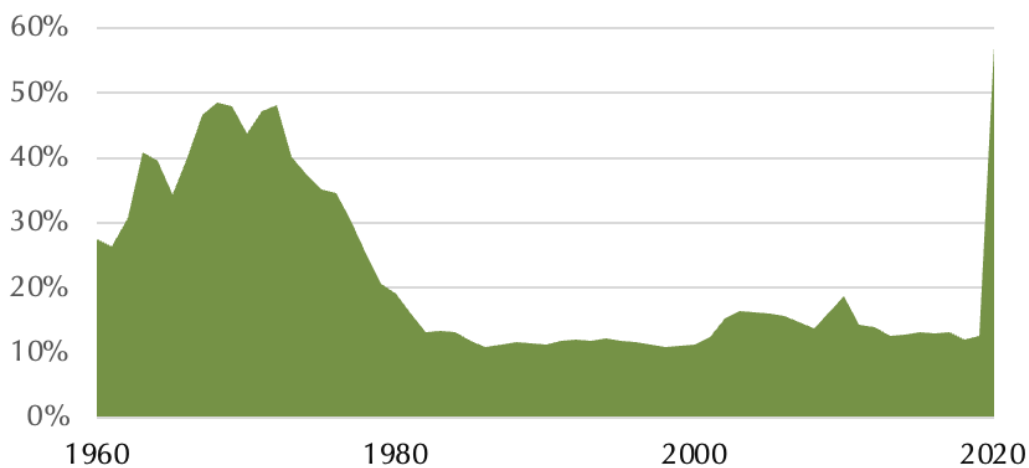
Source: Centers for Medicare and Medicaid Services, National Health Accounts (2020).

COVID-19. The sector also lags technologically. As noted by Pollack (2020), the sector had to rely on fax-based paper reporting systems during the pandemic to identify infected people and to locate others at risk. Poor technology infrastructure hinders the sector’s immediate performance. Less tangibly, the sector’s shortcomings hinder efforts to recruit highly skilled personnel and undermine public confidence in the nation’s public

health system during a crisis, precisely when it is most needed.

The federal government financed a large share of public health expenditures in the late 1960s, but its role shrank—at least until COVID-19 (Figure 4-18). As a result, much of the onus of public health has been placed on state and local governments.⁹⁶

Figure 4-18: Federal share of public health spending



Source: Centers for Medicare and Medicaid Services, National Health Accounts (2020).

⁹⁶ Public health includes “epidemiological surveillance, inoculations, immunization/vaccination services, disease prevention programs, the operation of public health laboratories, and other such functions,” but excludes government

There was much that the public health system might have done—not only during the pandemic but also before—that it did not do because of poor infrastructure, insufficient advance funding, and a lack of planning. The public health system is key to preparation and prevention, to ensure that supplies of personal protective equipment are adequate in an emergency and that contact tracing can be geared up expeditiously, to recognize that rural and safety-net providers will need funds quickly, and to have a means of providing those funds to them. This system has to address the risks facing populations that are most exposed to a pandemic—because of patterns in employment, housing, and structural inequities in our health system—and to ensure that the public has confidence in this health system, providing public communication that is trusted across partisan and ideological lines.

The combination of such shortcomings was lethal. The direct activities of public health agencies were desperately needed during the pandemic for testing and contact tracing, vaccinations, public communication, and surveillance (e.g., the rates and locations of COVID-19 cases, the morbidity and mortality of those contracting COVID-19, and how these varied by patient race and ethnicity).

Lessons Learned for Public Health

Because of this report's focus on social insurance, this Task Force Working Group has not given the formulation of public health policy options the attention that it deserves.⁹⁷ In thinking about public health in the context of our social insurance system, this report notes the very different financing mechanisms and incentives used by state agencies. In short, the public health system is not viewed as part of our social insurance system. What has become clear is that failure to invest more in public health, and carry out advance planning for future health shocks, will leave the nation needlessly vulnerable to the spread of disease, to hospitalizations, and to deaths.

The public health system is not viewed as part of our social insurance system. What has become clear is that failure to invest more in public health, and carry out advance planning for future health shocks, will leave the nation needlessly vulnerable to the spread of disease, to hospitalizations, and deaths.

Everyone—including those who rely on social insurance programs—experience diverse social disadvantages. These increase their risk for poor outcomes in a public health crisis. The nation requires a strong public health infrastructure to support resilience and recovery. Current fiscal structures and policy designs systematically underfund the public health sector.

State–federal funding formulas specifically incentivize states, particularly low-income states that receive substantial Medicaid matches, to privilege personal medical services over public health. To note one clear example, the federal government matches each dollar that a state spends on Medicaid with a \$1–\$4 automatic match that is not available when states spend the same funds on traditional public health services. As a result, spending on public health is more costly for states, even when such spending is a more efficient way to improve health than is direct spending on Medicaid-financed clinical services. At the margin, states understandably respond to such incentives through expenditures in services that receive a federal match. These incentives are particularly acute in low-income states that receive the highest Medicaid match and that often face the most acute challenges within both medical care and population health.

This report is focused on social insurance systems. It is beyond its scope to provide a granular analysis of public health infrastructure finance. The most recent annual report from Trust for America's Health (2022)

spending for public works, environmental functions, emergency planning, and other such functions. <https://www.cms.gov/files/document/definitions-sources-and-methods.pdf> per CMS National Health Expenditure Accounts: Methodology Paper (2021)

97 We direct interested readers to the recent work of the National Academy of Medicine, “Public Health: COVID-19 Impact Assessment: Lessons Learned and Compelling Needs” (DeSalvo 2021).

provides specific recommendations to achieve a sustained level of adequate funding. The Commonwealth Fund Commission on a National Public Health System (2022) also offers multiple recommendations to strengthen these structures, noting that “Congress should provide an adequate and reliable source of federal public health funding to states, localities, tribes, and territories to support a modern public health infrastructure.”

POLICY OPTION 4.H.1: Consider the multiple recommendations from Trust for America’s Health and the Commonwealth Fund Commission on a National Public Health System to improve our public health infrastructure.

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CHAPTER 5

Conclusions and Policy Options

This report describes and evaluates the performance of the U.S. social insurance system during the pandemic. Based on this analysis, the Task Force Working Group developed a list of potential reforms to our social insurance system for policymakers to consider. These options are reproduced below. A full discussion of the options and the rationales for them may be found in chapters 2 through 4.

Lessons Learned and Policy Options in Regard to Income Security

POLICY OPTION 2.A.1: Modify formulas used to calculate the national average wage index (AWI).

Several changes might protect retiring workers from a permanent reduction in benefits because the wage index is depressed by high unemployment. The simplest solution would be to bar reductions in the AWI when unemployment is high or rising.⁹⁸ Such a change might be limited to retirees with low lifetime earnings.

POLICY OPTION 2.A.2: Modify formulas used to calculate benefits when inflation is high.

Several changes might protect retiring workers from a permanent reduction in benefits when inflation is high in the years before they are eligible for benefit indexation. For example, benefits could be increased over those years when inflation exceeds some threshold. Such a change also might be limited to retirees with low lifetime earnings.

POLICY OPTION 2.A.3: Make adjustments for early or delayed claiming of Social Security benefits actuarially fair. Workers who claim Social Security early face a lifetime of lower benefits. One option to prevent workers from having to claim early during periods of unemployment is to ensure that UI replaces a sufficiently large share of earnings (a policy option described below), as it did during much of the pandemic, to lessen the need for early claiming. Another is to modify the formula used to calculate benefits so that workers do not receive lower lifetime benefits when they claim early. Given that early claimants are disproportionately low earners, this change would be progressive.

POLICY OPTION 2.A.4: Ensure that administrative challenges do not impair access to Social Security Disability Insurance. Closure of Social Security field offices hampered applications for benefits, particularly by those without access to the internet or who have difficulty using it. While a shift to online services might reduce administrative costs and improve customer service for many or most applicants, ensuring high-speed internet access, improving phone services, and providing virtual visits for people who need more help filling out forms might guarantee that no one is left behind.

Now that field offices have reopened, the Social Security Administration (SSA) might consider taking steps to meet the pent-up demand by extending hours and increasing the number of appointment slots, particularly in areas where applications declined most during the pandemic (Stein and Weaver 2021). Because the

98 The “Protecting Benefits for Retirees Act,” introduced in July 2020 by Senators Tim Kaine (D-VA) and Bill Cassidy (R-TX), stipulates that if, in a given year, the standard formula leads to a reduction in the AWI, the AWI should be left unchanged. This would provide only partial protection against variations due to business cycle conditions because it would still mean that a reduction in aggregate earnings because of higher unemployment might still lead to a smaller increase in the AWI.

SSA's administrative budgets have been falling, after adjustment for inflation and rising caseloads, service expansion will be possible only if Congress boosts those budgets (Romig 2022a).

POLICY OPTION 2.A.5: Investigate the relationship between higher Unemployment Insurance benefits and SSDI.

To what extent government financial assistance reduced Social Security Disability Insurance (SSDI) applications remains unclear. Because most people who are awarded SSDI benefits never return to the workplace, the provision of substantial but temporary Unemployment Insurance (UI) benefits during any future epidemics might cause fewer people to leave the labor force, which would have better long-term consequences for workers than reliance on SSDI as a means of weathering economic downturns. The relationship between household support and SSDI merits extensive future research.

POLICY OPTION 2.A.6: Ensure that people who cannot work because of long COVID-19 are covered by SSDI.

Looking forward, it will be important for the SSA to be able to provide SSDI benefits to those who are suffering from long COVID-19 and unable to work. Some have suggested that SSA include long COVID-19 as one of the medical conditions listed in the Disability Evaluation Under Social Security guidance document (also known as the Blue Book), arguing that such a listing might ensure that long-COVID sufferers with conditions that prevent them from working actually receive the support they need (Petrie-Flom Center Staff 2022). While it is too soon to know whether such a listing is necessary or whether the current guidelines about what constitutes a qualifying disability will be sufficient to address long COVID-19, this is an important area for Social Security policymakers to address.

POLICY OPTION 2.B.1: Ensure that administrative changes do not impair access to SSI. SSI participation declined during the pandemic, and it seems clear

that changes in the SSA's operating procedures were a significant factor. To the extent that the SSA will maintain remote work going forward, it needs to ensure adequate support for those who need help navigating the application process.⁹⁹ As SSI beneficiaries have few assets and little or no income, delays processing SSI applications will contribute to protracted hardship.

POLICY OPTION 2.B.2: Simplify the eligibility and reporting requirements for SSI.

One of the factors that makes it so difficult for applicants to navigate the system is the complexity of SSI and the burdensomeness of eligibility requirements (Altman 2020). Congress might consider revamping and simplifying eligibility and benefit rules, so that they do not needlessly impede access to benefits. For example, SSI's "in-kind support and maintenance" rules require beneficiaries to disclose any non-financial help they receive from family and friends. These rules are complicated and, according to some analysts, impose administrative costs on the SSA that far exceed any savings they may generate (Altman 2020; Romig 2021).¹⁰⁰

POLICY OPTION 2.B.3: Improve clarity in communication when fiscal policy changes have the potential to affect SSI eligibility.

In normal times, UI counts as unearned income for the purposes of calculating Survivors Insurance benefits and eligibility, and checks like the Economic Impact Payments (EIPs) are only excluded from countable resources for one year. The SSA changed the treatment of both programs during the pandemic—specifying a permanent exclusion of pandemic-related UI benefits and EIPs for the purposes of determining SSI eligibility or benefit levels ("Special Processing Instructions" 2022).

POLICY OPTION 2.C.1: Clarify the treatment of pandemic-related illnesses under state Workers' Compensation programs.

States might make clear which illnesses and which workers will be covered for pandemic-related illnesses, as was done by the State of California, which created a rebuttable presumption

99 While SSA field offices are now open, employees have more opportunity to telework than they did before the pandemic (Friedman 2022).

100 For determining whether EIPs or UI has been saved or not (and hence excludable from resources), the SSA assumes that any spending out of savings comes from countable funds first (Altman 2020; Romig 2021).

of compensability for all workers who contracted COVID-19, and by the State of Alaska, which created an irrebuttable presumption of compensability for first responders. The expansion of these efforts to provide guidance for all pandemic-related illnesses would improve transparency in the system for workers, employers, and insurance carriers.

POLICY OPTION 2.C.2: Increase Workers' Compensation wage replacement rates to achieve benefit adequacy, generally thought to be a replacement rate equal to two-thirds of pre-injury earnings.

POLICY OPTION 2.C.3: Increase eligibility for Workers' Compensation benefits for infectious occupational diseases. States might consider developing more inclusive rules, including presumptions for diseases, that enhance the availability of benefits to workers who contract an occupational disease.

POLICY OPTION 2.C.4: Improve data collected regarding Workers' Compensation benefits paid for COVID-19-related conditions. Requirements for reporting of COVID-19 as an occupational disease were relaxed by the federal government during the pandemic. Sound data, including by race and ethnicity, are essential for the development of Workers Compensation policies that are fair and equitable.

POLICY OPTION 2.C.5: Consider federal guidelines for Workers' Compensation to increase consistency and fairness across the states.

POLICY OPTION 2.D.1: Increase replacement rates for UI. UI replaces at most 50 percent of previous earnings and often much less, much below replacement rates in other countries (Gruber 2005). Replacement rates could be raised for all UI recipients (Ganong et al. 2022) or for those with low earnings histories (Dube 2021). Alternatively, both replacement rates and duration of benefits could be automatically increased when a state's unemployment rate rises, if not permanently.

POLICY OPTION 2.D.2: Increase eligibility for UI. In normal times, many unemployed workers are ineligible for UI, including low-wage and part-time workers without sufficient earnings histories, the self-employed, new labor force entrants, and workers who

leave their jobs voluntarily. The expansions during the pandemic showed that broadening eligibility is feasible. One analyst proposed lowering earnings thresholds and allowing workers who quit for good cause to be eligible for UI, where good cause might include changes in work circumstances, such as wage cuts or shortened hours, and extenuating family circumstances, such as poor health or the relocation of a spouse (Dube 2021). Another analyst proposed a federal Jobseeker's Allowance—a small, short-term allowance to support workers who are ineligible for UI because they lack a recent work history, including the self-employed and new entrants to the labor force (West et al. 2016).

POLICY OPTION 2.D.3: Increase federal financing of UI. These reforms would raise UI costs and necessitate additional funding. One option is that the federal government could pay a share of UI costs for states that meet some minimum replacement rates and eligibility standards—just as it did for states that expanded Medicaid under the Affordable Care Act. Alternatively, UI could become a fully federal program, like Social Security (Dube 2021). Federalization and uniform national rules might reduce current inequities, including the fact that UI is currently less adequate for Black than for White workers. A third option could be federal legislation that might encourage states to raise the UI payroll tax base, which currently is as low as \$7,000.

POLICY OPTION 2.D.4: Address UI technology now, before the next downturn. The experience during the pandemic demonstrated the importance not only of getting the policies right, but also of having adequate administrative capacity. Some states have worked on modernizing their systems over the past 10-20 years, and the American Rescue Plan provided grants to states that should lead to further improvements. State policymakers might move quickly to modernize their UI systems to ensure that unemployed workers can access UI benefits easily, without undue administrative burdens, while also ensuring that the system has checks in it to prevent fraud and has the flexibility to adjust replacement rates or other rules if desired.

POLICY OPTION 2.E.1: Make the American Rescue Plan Act (ARPA) Child Tax Credit (CTC) permanent. This option would reinstate the CTC as formulated under ARPA and make it permanent.

POLICY OPTION 2.E.2: Amend the ARPA to maintain some of the connection of the CTC to earnings, while still increasing the value of the CTC to poor families by increasing the CTC faster as income rises or faster for large families.

POLICY OPTION 2.E.3: The IRS and state agencies might take measures to increase tax filing. When filing increases, so does participation in the Earned Income Tax Credit and CTC (Goldin et al. 2021). The IRS might do more to inform people of the value of filing. It might send potential filers prepopulated tax returns using data from administrative records and continue the “simplified filing” process that allows families with very low incomes to provide a limited set of data to establish tax benefits without having to file full tax returns (Code for America 2022). In addition, states might be provided with funding to identify non-filers by comparing their Supplemental Nutrition Assistance Program (SNAP) and Medicaid rolls to the tax rolls. They might then reach out to non-filers and provide them with help filling out their tax forms.

POLICY OPTION 2.F.1: Consider a national eviction moratorium—combined with rental assistance—during a future public health emergency or economic downturn. Eviction moratoriums during public health emergencies may save lives, and so they are particularly valuable. To protect small landlords, however, such moratoriums might be combined with rental assistance programs.

POLICY OPTION 2.F.2: Expand current housing assistance programs. The decline in evictions during the pandemic demonstrated that substantial financial support may improve the lives of the most disadvantaged families. Under our current social insurance system, fewer than one in four eligible households actually receives support because of lack of program funds. Increasing the amount of aid available might help bolster our social insurance system.

POLICY OPTION 2.F.3: Improve data collection about renters. There is a great need for more comprehensive data on the rental market and renters. Because of a paucity of pre-pandemic data, it was hard to determine whether renters were facing unusual financial

distress during the pandemic and hard to gauge exactly how much rental assistance was necessary.

Lessons Learned and Policy Options in Regard to Food Security

POLICY OPTION 3.A.1: Lower administrative barriers to SNAP take-up. The increase in SNAP participation during the pandemic appears related to changes in administrative procedures that made it easier to enroll in and stay on SNAP. These included the extension of certification periods, reduced paperwork and interview burdens, telephonic signatures, and electronic filing of paperwork. Administrative burdens reduce SNAP participation among eligible individuals, and reforms that simplify recertification may increase retention (Gray 2019; Homonoff and Somerville 2021). To boost SNAP take-up, some or all of the pandemic changes might be made permanent (or at a minimum, be designed to take effect automatically, if unemployment rises sufficiently) to ensure that administrative burdens are not preventing some families from accessing vital nutrition assistance.

POLICY OPTION 3.A.2: Enact triggers that would loosen SNAP requirements and raise benefits during recessions. The changes to the SNAP program enacted during the pandemic helped address rising food insecurity, but benefit increases during downturns are not automatic. Even when Congress acts, it may take time. Rather than rely on future Congresses to enact increases in SNAP, legislation might be passed to temporarily amend the SNAP program as a function of economic circumstances—e.g., the national unemployment rate or even state specific-unemployment rates. The changes might include increases in the maximum SNAP benefit (which would be more progressive than simply providing every household with the maximum benefit), a suspension of the three-month time limit (which is particularly problematic during times of high unemployment), the easing of rules related to recertification and verification, and an increase in the federal share of administrative costs. This policy might help both from a macroeconomic perspective, because SNAP benefits are an effective fiscal stimulus, and to prevent families from going hungry during downturns.

POLICY OPTION 3.A.3: Allow the USDA Secretary the authority to make such modifications in the event of a recession or public health emergency. Congress might provide broad authority to the Secretary to modify SNAP requirements. A more limited option would be to modify the Stafford Act, which allows the Secretary to modify various SNAP rules in the case of a natural disaster, to include federally declared national health emergencies.

POLICY OPTION 3.A.4: Change appropriations language for SNAP funding. Although SNAP is typically viewed as an “entitlement,” its funding comes through the regular annual appropriations process, where it receives a fixed dollar appropriation instead of an appropriation for “such sums as may be necessary.” SNAP does have an appropriated contingency reserve, but the reserve equals only a fraction of one month’s benefits.

Under SNAP’s authorizing law, across-the-board benefit cuts are triggered if funding is insufficient to pay full benefits. This has never occurred, and, during the pandemic, SNAP benefits were successfully raised a number of times.

The possibility of insufficient funding triggering benefit cuts might be addressed by replacing the fixed dollar amounts provided for SNAP in appropriations bills with “such sums as may be necessary” or by combining a fixed dollar amount in appropriations bills with language in those bills that provides “such sums as may be necessary” for the fourth quarter of the fiscal year.

POLICY OPTION 3.B.1: Establish performance metrics for cross-enrollment in the Women, Infants, and Children program (WIC) of eligible SNAP and Medicaid participants. WIC is an extremely important program that provides health and food support at a crucial time in children’s lives. Increasing WIC take-up might help improve outcomes for children and reduce racial disparities in maternal and child health and food insecurity. While not fully understood, the much larger increase in SNAP and Medicaid participation and the higher take-up rates for children in those programs suggest that many people who might have been eligible for WIC did not receive benefits. Measuring and establishing performance metrics for cross-enrollment

of eligible SNAP and Medicaid participants into WIC, similar to the performance metrics for the National School Lunch Program, might in turn provide needed attention for serving this important group. It might provide an additional incentive for states to conduct the crucial outreach and institute the appropriate reforms in application and related processes needed to get people signed up for the program

POLICY OPTION 3.C.1: Make Pandemic Electronic Benefits Transfer (EBT) permanent to address food insecurity during summer and holiday school closures. The pandemic demonstrated the importance of school meals to families and the dire consequences of school closures. Pandemic EBT was a successful program that efficiently and effectively addressed food insecurity stemming from school closures (but did not address the deep learning losses associated with those closures). The program might be made permanent to ensure that children receive adequate nutrition during holidays, school vacations, and any other school closures. Currently, the federal government provides prepared meals for free to eligible students through the Summer Food Services program, but as few as one in seven eligible students access the program because it requires eating at physical meal sites (Thomhave 2021). Pandemic EBT offers a way of increasing access to benefits and ensuring that children have enough to eat when schools are closed.

Lessons Learned and Policy Options in Regard to Health Security

POLICY OPTION 4.B.1: Consider measures to maintain Hospital Insurance (HI) Trust Fund solvency during economic downturns. Policies that specifically address these risks include providing general revenues to finance HI spending when unexpected shortfalls arise; a one-time transfer of assets to the HI Trust Fund to ensure a larger cushion; or a transfer of revenues to the HI Trust Fund or a transfer of spending to the SMI Trust Fund to correct the imbalances between revenues and expenditures.

POLICY OPTION 4.B.2: Insulate provider payments from unanticipated errors in inflation projections.

Payments to hospitals and other providers might incorporate a correction method, such as that used for skilled nursing facilities, that adjusts for projection errors in the following year. Notably, this correction goes both ways: If payments are higher than expected, payment rates may be reduced to correct the error, so this provision should be financially neutral on average. To address the vulnerability of physician payments to inflation, payments might be legislated in real terms—e.g., a measure of inflation minus some specified percentage.

POLICY OPTION 4.C.1: Guarantee the ability to remain enrolled in Medicaid and CHIP for 12 months, regardless of changes in income. Several options might help address the Medicaid churn—temporary lapses in coverage that often occur as enrollees go on and off Medicaid over short periods of time. One option to consider might be to require states to maintain continuous enrollment on a permanent basis—specifying that all individuals enrolled in Medicaid and/or CHIP are guaranteed 12 months of coverage—regardless of what happens to income during those 12 months.¹⁰¹ (This might also include a requirement for 12 months of postpartum coverage.) Under this policy, some people would get Medicaid for a part of the year when they no longer meet eligibility criteria, but many who are eligible for public health insurance but not enrolled because of administrative hurdles would be covered. Given that Blacks, Latinos, and American Indians/Alaskan Natives are more likely to be uninsured and eligible for Medicaid than Whites, such a policy might also help address health disparities (Brooks and Gardner 2021). In addition, such a rule would lower administrative costs associated with constantly checking eligibility and processing people as they churn on and off the rolls.¹⁰²

POLICY OPTION 4.C.2: Make it easier for states to adopt continuous enrollment provisions. Another option is to allow states to adopt continuous eligibility for adults and multiyear continuous eligibility for children without requiring waivers.¹⁰³ Removing the need to apply for a waiver might lower the administrative hurdles faced by states wanting to adopt these policies.

POLICY OPTION 4.C.3: Reduce administrative barriers to help people enroll in and maintain Medicaid coverage. Even small premiums discourage Medicaid participation. Barring states from requiring premiums or copayments for Medicaid might increase coverage and access, as might improvements in outreach to beneficiaries and improving customer service by investing in navigators dedicated to helping people sign up for and maintain Medicaid coverage.

POLICY OPTION 4.C.4: Require MACPAC to develop policy options to ensure greater equity in Medicaid coverage of adults across states. As noted above, there are wide disparities in access to insurance across racial and ethnic groups, driven in part by differences across states in Medicaid rules and procedures. Developing and implementing policies to reduce uninsurance rates among non-elderly poor and near-poor will allow Medicaid to be more responsive to the health needs of some of the most disadvantaged individuals and families during the next health crisis. It will also help achieve greater racial equity in health coverage.

The experience during the pandemic also pointed to some changes in Medicaid financing that might help bolster state finances and prevent states from cutting Medicaid during public health emergencies and recessions.

101 States already have the option to provide 12-month continuous eligibility for children in Medicaid and CHIP. New York and Montana have such a continuous eligibility policy for adults, allowed via a “waiver” under the Medicaid law. In an evaluation of New York state’s 12-month continuous eligibility policy for adults, Liu et al. (2021) found that the policy increased the duration of Medicaid coverage by 8.2 percent in the population enrolled through the ACA marketplaces and 4.2 percent among those enrolled through local social service departments. Medicaid costs increased just 2.6 percent and 3.1 percent, respectively, as some of the increased duration was offset by lower per-member monthly costs.

102 <https://www.congress.gov/bill/117th-congress/house-bill/5376>.

103 Oregon received a waiver from CMS to provide multiyear continuous eligibility for children in October 2022, and Washington, California and New Mexico are in the process of seeking such a waiver. States are already able to provide 12-months of continuous coverage for children without a waiver.

POLICY OPTION 4.C.5: Require MLR rebates for Medicaid managed care: When claims fall below a certain percentage of insurance premiums (the medical loss ratio, or MLR), many private insurance plans are required to pay rebates to customers. States have the option of imposing similar requirements on Medicaid managed care plans, but only 24 states (plus the District of Columbia) require all plans to pay rebates to the state when plans fail to meet their MLRs (Gifford et al. 2019).

States might be required to establish MLRs and require plans to pay rebates when they do not meet the requirement. During the pandemic, such a requirement might have ensured that states recouped excess Medicaid payments when there was a decline in use. States might have repurposed some of the rebated funds to help health care providers that were suffering from the loss of revenue.

POLICY OPTION 4.C.6: Make an increase in the FMAP automatic during downturns. The increase in the FMAP—the share of Medicaid expenditures financed by the federal government—is a particularly important tool during a recession. Not only does it provide general aid to states by temporarily lowering their share of Medicaid costs, but it also discourages states from trying to balance their budgets by making cuts to their Medicaid programs. While Congress temporarily increased the FMAP during previous recessions (in 2003, 2009, and 2020) (Mitchell 2020), states cannot presume such increases, until and unless Congress acts. As a result, prospective budget shortfalls may cause states to cut back Medicaid or other services at the very time they are most needed. An automated FMAP increase might also tailor the duration of assistance to match economic conditions. This likely would have lengthened the duration of the higher FMAP during the Great Recession but shortened it during the pandemic recession. The Government Accountability Office (2011) developed a prototype formula for a national automatic FMAP increase triggered by overall economic conditions. Fiedler, Furman, and Powell (2019) proposed a state-specific FMAP increase tied to

the change in a state's unemployment rate.¹⁰⁴ As with past FMAP increases, this increase might be tied to a prohibition on states cutting their programs, making it harder for individuals to enroll or renew their coverage, and/or disenrolling beneficiaries.

POLICY OPTION 4.C.7: Invest in improved data collection. Improved data collection and data systems—including improved reporting requirements by states, detailing Medicaid and other health insurance enrollment by race, ethnicity, age, and eligibility category—may not seem essential to dealing with widespread illness. Yet the lack of such data and the sluggishness of reporting impeded the response to COVID-19, particularly for Medicaid beneficiaries. Standardized, timely data would greatly improve understanding what happened during the pandemic and why.

POLICY OPTION 4.D.1: Expand the premium tax credit. Similarly, Congress might also consider making permanent part or all of the increase in the premium tax credits enacted as part of the American Rescue Plan (which were recently extended through 2025 in the Inflation Reduction Act). The Congressional Budget Office estimates that doing so would increase the number of insured by about 2 million people, at a cost of about \$25 billion to \$30 billion per year (Swagel 2022). Doing so would remove a large notch—the abrupt loss of substantial benefits for people whose income rises above 400 percent of the federal poverty threshold.

POLICY OPTION 4.E.1: Expand the Medicare graduate medical education programs to include nurse training. This would help subsidize the cost of nurse training to help address the nursing shortage in nursing homes.

POLICY OPTION 4.E.2: Consider requiring nursing home workers to be vaccinated for COVID-19 and other infectious diseases like the flu. Raising vaccination rates would improve resident health (Sinha and Konetzka 2022) and, given that Black residents are more likely to reside in nursing homes with low vaccination rates, would help address racial disparities.

104 In particular, they set a state-specific unemployment rate threshold tied to historical unemployment rates in the state and increase the states' Medicaid matching rate by 3.8 percentage points for each percentage point by which the states' unemployment rate exceeds the threshold.

POLICY OPTION 4.E.3: Congress might consider expanding the Medicare graduate medical education programs to include nurse training. This could subsidize the cost of nurse training to help address the nursing shortage in nursing homes.

POLICY OPTION 4.F.1: Encourage the Centers for Medicare and Medicaid Services to work with states to determine whether some or all of the waivers of scope of practice regulations during the pandemic should be made permanent or whether they ought to be automatic during public health emergencies.

POLICY OPTION 4.F.2: Enact policies to help narrow the digital divide. These options include ensuring high-speed internet in every community, subsidizing internet for low-income households, and providing other tools—perhaps in-person aides—to help beneficiaries uncomfortable with computers and the internet to take advantage of telehealth. Without such efforts, telehealth could widen rather than narrow health disparities. According to the 2018 American

Community Survey, 26 percent of Medicare beneficiaries did not have access to either a computer with high-speed internet or a smartphone with a wireless data plan (Eyrich, Andino, and Fessell 2021). Older, Black, and Hispanic beneficiaries were particularly likely to have limited access to these technologies.

POLICY OPTION 4.G.1: Establish a process to ensure that funds provided to health care providers during public health emergencies are targeted to financially vulnerable safety-net providers, including safety-net hospitals, community health centers, and Medicaid behavioral health providers. This targeting might include both the amount of aid provided and the speed at which it is distributed.

POLICY OPTION 4.H.1: Consider the multiple recommendations from Trust for America’s Health and the Commonwealth Fund Commission on a National Public Health System to improve our public health infrastructure.

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