The Financial Effects and Consequences of COVID-19
A Gathering Storm

As the COVID-19 pandemic swept across the globe in 2020, the US faced a unique challenge in mobilizing and aligning its fragmented health insurance system to address the public health emergency. With 29 million people uninsured, 39% of households reporting insufficient savings to cover a $1000 emergency, and 1 in 46 individuals having a medical bill in collections in early 2020, the US faced the dual threat of overwhelmed medical facilities and an acute affordability crisis for patients who required testing and treatment for COVID-19.

In response, the US mounted a multifaceted effort to shield patients from the financial sequelae of COVID-19. These efforts included a federal requirement that private insurers and employers cover the full cost of testing, and funds for the Health Resources and Services Administration (HRSA) to compensate (at Medicare rates) the costs of COVID-19 testing and treatment for those who are uninsured. The health insurance industry also contributed and waived patient cost-sharing requirements for COVID-19 treatment for most privately insured people. In March 2020, Congress established a $178 billion Provider Relief Fund to offset unreimbursed expenses for COVID-19 treatment (eg, personal protective equipment, additional staff time) and other revenue losses that occurred during the pandemic. As a condition of receiving these funds, recipients were prohibited from billing patients on an out-of-network basis for COVID-19 care, effectively shielding patients from out-of-network responsibilities and “surprise” medical bills. In addition, the US undertook an unprecedented effort to pre-purchase vaccine doses and provided the HRSA with funds to ensure that vaccines would be administered at no out-of-pocket cost to uninsured patients.

Combined, these efforts constituted a temporary universal coverage system—within-a-system for COVID-19. That is, unlike every other disease treated in the US, for most patients the entire spectrum of testing and treatment for COVID-19 was covered at no out-of-pocket cost. But as the US contends with the fourth major wave driven by the Delta variant, major financial components of this temporary system have already been reduced or will expire.

In early 2021, as vaccines became widely available and as the winter surge receded, insurers changed their approach toward patient responsibility for COVID-19 treatment costs. For example, Aetna and United removed cost-sharing waivers for commercially insured individuals in January 2021. Cigna followed in February, and Anthem in May with similar policies. By early summer 2021, nearly all major insurers required patient cost sharing for COVID-19 treatment. With COVID-19 hospitalizations estimated to cost between $38,000 and $73,000, even a 10% coinsurance requirement could result in individual patients and their families incurring responsibility for thousands of dollars in medical bills. Given that medical bills constitute the largest source of debt in collections, and that COVID-19 has disproportionately affected low-income and other disadvantaged groups, these costs could exacerbate an already troubling dynamic in the US health care system.

As for uninsured individuals, HRSA continues to pay out claims for COVID-19 care. By late August 2021, HRSA had reimbursed $5.9 billion for testing, $3.6 billion for treatment, and $573 million in vaccine administration claims. However, these HRSA funds have required periodic reinforements by Congress, creating considerable uncertainty about when these funds will no longer be available to compensate hospitals and shield the most financially vulnerable people from the costs of COVID-19 testing and treatment. By May 2021 only $25 billion remained in unallocated funds (down from $178 billion in March 2020) in the federal Provider Relief Fund. Hospitals also have reported challenges in receiving relief payments tied to the winter 2020-2021 COVID-19 wave. In response, in September 2021 the Department of Health and Human Services allocated an additional $25.5 billion allotment of relief funds, although these funds only cover revenue losses and operating expenses incurred through March 31, 2021. At present, no relief funds are allocated toward care provided during the recent Delta variant surge, which has pushed facilities in heavily affected states well beyond previous peak patient volume and hospitalization levels set in January and February 2021. Critically, recipients of relief funds are only prohibited from billing patients on an out-of-network basis until those funds are exhausted. Thus, once relief payments are exhausted, out-of-network bills may become a frequent responsibility for patients with COVID-19 in surge regions.

It is a great testament to the fragmented US health care system that insurers, policy makers, and caregivers were able to mount a rapid response to help protect patients from financial toxicity from COVID-19. But these efforts were a stopgap measure, and despite threats of further surges in cases, Congress has a waning appetite for allocating additional emergency funds. Moreover, the long-term fiscal effects of COVID-19 are now emerging: 23% of patients hospitalized with COVID-19 in a national cohort reported having exhausted their savings after the hospitalization. Any new efforts to mitigate financial harm to patients should also consider what has been learned about disparate losses across the health care system. Insurers have reported record profits due to reductions in

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health care utilization; some large health systems did not experience anticipated losses and returned Provider Relief Funds back to the federal government. At the same time, primary care practices and smaller safety net clinicians and health care centers have struggled to take advantage of relief funds and to compete with larger institutions that pivoted quickly to alternative service models, such as telemedicine.

As the SARS-CoV-2 Delta variant (and perhaps other variants) surge and emergency benefits run out in the coming months, the financial threat to individuals and families from COVID-19 looms large. Current rates of new cases make it clear that the US will remain in the acute phases of the COVID-19 pandemic for the foreseeable future and the number of patients receiving bills for the costs of treatment for COVID-19–related hospitalizations will likely increase. Additionally, individuals experiencing the long-term health effects of COVID-19, such as kidney dysfunction and “long COVID,” may have chronic medical needs that expose them to decades of financial risk. Further efforts will be needed to mitigate the effects of the gathering COVID-19 financial storm on patients, their families, and community hospitals struggling to care for them. These could include extensions of the insurance provisions enacted during the public health emergency, ongoing government purchase and provision of vaccines and treatments, targeted financial relief to hospitals, or other means that address the evolving costs of fighting the COVID-19 pandemic. Before the next pandemic hits, however, policy makers would be wise to codify these practices so that the US health care system is more responsive and resilient and US residents know they will be financially protected.

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REFERENCES