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Healthcare Provisions in the American Rescue Plan

Introduction

On March 11, 2021, President Joe Biden signed into law the *American Rescue Plan Act of 2021* (ARPA).[1] Biden first announced this $1.9 trillion relief package on January 20, 2021, as part one of a two-step COVID-19 rescue and recovery plan.[2] In addition to another round of stimulus checks and extended unemployment benefits, ARPA includes several provisions related to insurance subsidies and coverage as well as healthcare providers.[3] The law looks to alleviate the burden felt by the millions of people who lost their employer-sponsored health insurance over the first six months of the pandemic and assist the hardest-hit communities through the extension of the *Patient Protection & Affordable Care Act* (ACA) and *Consolidated Omnibus Budget Reconciliation Act* (COBRA) subsidies, expanding Medicaid coverage, increasing funding for behavioral health, ramping up COVID-19 vaccines and testing, providing financial relief for rural providers, and enacting other individual and healthcare system protections.[4]

Coverage and Subsidy Expansions for Public Insurance

ARPA provisions related to state Medicaid programs span several areas: encouraging states that have yet to expand their Medicaid programs to expand; increasing coverage for COVID-19 patients and pregnant women; and, providing additional funding and support for home and community services as well as nursing facilities, among other temporary or emergency provisions.[5] In order to encourage Medicaid expansion in the 12 states that have not yet expanded, the ARPA increases the *Federal Medical Assistance Percentage* (FMAP), the share of Medicaid expenses paid by the federal government, by 5% for two years after the state's expansion.[6] This increase is in addition to the current 6.2% FMAP increase in place for the duration of the COVID-19 *public health emergency* (PHE); notably, the extra funds received from the increased FMAP will not apply to *disproportionate share hospital* (DSH) payments or the *Children's Health Insurance Program* (CHIP).[7]

Any state that expands Medicaid will be required to cover COVID-19 vaccines and treatments without cost sharing, in order to receive the increased FMAP.[8] The costs associated with COVID-19 vaccines will be matched at a rate of 100% FMAP until one year after the end of the PHE.[9] The new law also provides states with the option to provide COVID-19 vaccines and treatments to the uninsured without cost sharing and receive reimbursement for those otherwise uncompensated services at Medicaid rates.[10]

The law also provides for one-year increases in FMAP for home-based and community-based services and those services provided through the Urban Indian Organizations and Native Hawaiian Health Care Systems.[11] To account for the increased FMAP during COVID-19, the law calls for a recalculation of DSH payment allotments for each year in which the temporary FMAP increases apply in order to reconcile what the state would have made without those FMAP increases.[12]

Increased Access to Individual Insurance Coverage

ARPA seeks to further expand insurance coverage through reducing the costs of Marketplace coverage and expanding COBRA coverage. Through tax year 2022, individuals who make between 100 and 150% of the *federal poverty level* (FPL) will not pay Marketplace premiums.[13] Households above the previous eligibility threshold of 400% FPL may also now be eligible for Marketplace tax credit subsidies.[14] Additionally, individuals who receive unemployment benefits during 2021 are eligible for Marketplace coverage.[15]

COBRA gives workers (and their families) the ability to maintain their group health coverage for limited periods of time after a life event such as job loss, job transition, divorce, or death.[16] However, those individuals are typically obliged to pay the entire premium for coverage during that time (in contrast to sharing that premium with the employer).[17] In an attempt to provide coverage to out-of-work individuals as a result of the pandemic, ARPA requires the federal government to fully subsidize COBRA premiums for eligible individuals and families through September 30, 2021.[18]

Mental and Behavioral Health Funding

Studies have shown that anxiety, depression, and substance use have all skyrocketed during the COVID-19 pandemic.[19] Research indicates a fourfold increase in anxiety and depression symptoms between January to June 2019 and December 2020 to January 2021, from 11% to over 40%.[20] Isolation, stress, and worry, stemming (for many) from isolation, job loss, and other pandemic-related changes, have had far-reaching effects.[21]

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ARPA seeks to address these pandemic consequences through the allocation of $3.5 billion for behavioral health and substance abuse programs, $3 billion of which will go toward mental health and substance use disorder block grants.[22] The new law also provides $15 million for states to develop mobile service programs for individuals experiencing mental health or substance abuse crises for five years, as well as $80 million for pediatric mental health services.[23] The remaining funds will be given out as grants to:

(1) Clinics participating in the Certified Community Behavioral Health Clinic program;

(2) Behavioral health workforce education and training programs;

(3) Certain institutions for training in decreasing mental health disorders among healthcare personnel and for encouraging good health behaviors among staff;

(4) Overdose prevention and harm prevention programs;

(5) Education for healthcare staff and first responders in identifying and preventing behavioral health disorders; and,

(6) Community-based programs addressing child and adolescent mental health.[24]

Relief for Rural Providers

The law allocated a further $8.5 billion to rural healthcare providers.[25] These funds will be distributed once the *Department of Health and Human Services* (HHS) creates a process for eligible providers to apply.[26] This provision is meant to reimburse these rural providers for both additional expenses and lost revenues related to COVID-19.[27] Rural providers have been previously targeted by executive orders and legislation[28] because of their vulnerability, which was exacerbated by the COVID-19 PHE, as well as their importance in providing healthcare access to rural populations. Approximately 20% of rural Americans depend on local hospitals for their care, but even in early 2020 (prior to the pandemic), 25% of rural hospitals were at risk of closing; a total of 20 rural hospitals closed in 2020.[29] For an industry that comprises approximately 1,800 rural hospitals, a double-digit number of closures in a one-year span, and a 7% closure rate over the past 10 years, is not insignificant.[30] Whether more hospitals will close before the end of the pandemic period remains to be seen, but ARPA has attempted to thwart these vulnerable providers by targeting them with greater funding and relief.

Other Emergency Protections

ARPA also allows for $250 million to create strike teams that will specifically focus on the health and safety of nursing facility residents and employees and be responsible for tasks such as aiding in clinical care, infection control, and staffing, both during, and for one year after, the current PHE.[31] In total, there have been over 1.3 million COVID-19 cases and nearly 175,000 COVID-19 deaths across the more than 33,000 long-term care facilities in the U.S.[32] As of March 2021, despite only representing 1% of the nation's population, 34% of COVID-19 deaths had occurred in these facilities.[33] Because of the disproportionate burden of cases and deaths on nursing facilities, much of the COVID-19 response and infection prevention focus has been, and continues to be, focused on these entities. Some experts have even called for infection prevention staff to be hired permanently at nursing and other residential facilities,[34] and the creation of these strike forces may serve to answer these calls.

Conclusion

The long-term effects of ARPA remain to be seen. It is, however, giving relief to myriad areas in the healthcare industry, on both the patient and provider side, identified as having the most urgent needs: rising uninsured rates, individual financial struggles, behavioral health and substance use disorders, vulnerable rural providers, and residents of long-term care facilities. As mentioned briefly above, this law was only step one of President Biden's two-step plan for rescue and recovery. The next step is currently being deliberated by the president's advisors and is expected to be presented to government leaders in April 2021.[35] This $3 trillion plan will address economic inequality, infrastructure, reducing carbon emissions, and other measures to boost the economy in order to "*[build] back better than before [the pandemic]*."[36] The legislation is also expected to include measures specifically targeting pharmaceutical industry and drug pricing reform, which draws from the *Elijah E. Cummings Lower Drug Costs Now Act* that was passed by the U.S. House of Representatives at the end of 2019.[37] However, with no official announcements from the president, how this new legislation will build upon healthcare reform and relief included in the recently-passed ARPA remains to be seen.

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