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DEBATE-COMMENTARY

HSR Health Services Research

Expanded unemployment benefits and their implications for health during the COVID-19 pandemic

1 | INTRODUCTION

The COVID-19 pandemic caused by the SARS-CoV-2 virus has roiled the world since early 2020, which has resulted in over 220 million infections and over 4.5 million deaths as of early September 2021.[1] The United States has recently struggled to contain a resurgence of cases associated with the more transmissible Delta variant,[2] leading to hospitals again reaching capacity and many states, municipalities, and institutions to re-institute precautions, such as mask mandates and testing requirements, as well as many employers beginning to require that their employees be vaccinated.[3–5]

2 | EXPANDED UNEMPLOYMENT BENEFITS DURING THE COVID-19 PANDEMIC

Early on, as the United States and the world were still coming to grips with the challenge that we were collectively facing, public health measures to stem the spread of COVID-19 led to a need to support workers who had become unemployed during this pandemic-induced economic crisis. In the United States, unemployment peaked at 14.8% and labor force participation fell to 60.2% in April 2020—their worst in decades.[6] Black and Latinx populations experienced the double jeopardy of having disproportionately higher unemployment rates while those still working faced relatively greater COVID exposure risks as essential and frontline workers.[6–10] The Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law on March 27, 2020 by President Donald J. Trump,[11] including a Federal Pandemic Unemployment Compensation (FPUC) program that added a $600 weekly supplement to state unemployment insurance (UI) benefits designed to help Americans manage the evolving pandemic financially.[12] FPUC ended in July 2020 before being partially reinstated in January 2021 at half the original amount ($300 weekly supplement). Other measures to support workers included the following: (1) Pandemic Emergency Unemployment Compensation (PEUC), also part of the CARES Act and extended in the American Rescue Plan Act, which extended benefits for up to 53 weeks once state benefits are exhausted; (2) Pandemic Unemployment Assistance (PUA), which extends UI benefits to those not traditionally eligible (e.g., self-employed, independent contractors); and (3) Mixed Earners Unemployment Compensation (MEUC), which supports those with eligibility for regular UI benefits who also have income from traditionally ineligible sources. The PUA and MEUC programs are particularly important for equity. Our UI system was designed to disadvantage Black and Latinx workers from the beginning by excluding certain occupations and work arrangements as well as a federalist approach to implementation, which resulted in wide variation in generosity and investment on the part of states, similar to Medicaid.[13–15]

3 | IMPACT OF EXPANDED UNEMPLOYMENT BENEFITS ON HEALTH CARE SPENDING

In this issue, Evangelist, Wu, and Shaefer focus on a key question—how did expanded UI benefits affect health care spending?[16] The authors describe how health care use early in the pandemic plummeted for both routine and emergent non-COVID-related care, with concerns about health care costs in the face of large increases in unemployment thought to play a key role alongside reductions in availability of in-person care and avoidance of exposure risk. But disentangling these various motives, as well as state-level differences in UI eligibility on top of the effect of FPUC, was no small feat. The authors used aggregated debit and credit card transaction data at the state-week level obtained from Opportunity Insights for January to August 2020, which captured approximately 10% of US transactions. This approach provided a seasonally adjusted index of health care spending relative to pre-pandemic levels. Their triple differences framework exploits variation in the UI claims rate and availability of FPUC, separating state-level UI benefit eligibility and generosity from the enhanced payment to those receiving UI benefits while also controlling for Economic Impact Payments made in April 2020.

They find that health care spending fell by 1.0% from pre-pandemic levels for every percentage point increase in UI claims rate across all states, with a similarly sized effect in Medicaid expansion states (−1.0%) but double in non-expansion states (−2.0%). Without that pathway to coverage and potentially facing the full price for any health care used, it seems plausible that many individuals and families would choose to simply defer care. FPUC offset approximately half of the decline in health care spending associated with increasing unemployment, though it was only significant at the 10% level. However, when stratified by Medicaid expansion status, FPUC offset 80% of the unemployment-related decline in health care spending in expansion states compared with 65% in non-expansion states. This protective effect of FPUC against reductions in health care spending also carried over to all consumer spending, which has implications for spending on food, housing, transportation, and other needs.

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A considerable limitation of this study is the authors' inability to separate current spending (i.e., copayments at time of visit) from paying for past health care (i.e., cost-sharing from past visits) in their data, which led the authors to make clear that their focus is on spending rather than utilization. Patients could have deferred or chose not to pay bills for past care to increase savings or cover other expenses without necessarily sacrificing current health care use, or they could have done the opposite to avoid going to collections. Also, the inability to capture spending on prescriptions is unfortunate as medication adherence is key for chronic disease management. Observing how reductions in or loss of UI benefits affect medication adherence could potentially bolster the case for continuing UI expansions as a means of protecting against greater non-COVID-related health consequences of the pandemic. Another important consideration is that low-income individuals and Black and Latinx populations are considerably more likely to be unbanked or underbanked, which means that they lack access to a checking, savings, or money market account or use them in combination with alternative financial instruments like payday or title loans.[17] This presents a generalizability problem for their study; however, it seems plausible that this bias toward the banked population could understate the size of their observed effects. That said, the unbanked may also face larger barriers to consistent receipt of UI benefits (e.g., checks by mail rather than direct deposit) and likely have worse access to care (e.g., greater chance of being uninsured) so the effect of their inclusion on the findings may be ambiguous.

4 | IMPACT OF EXPANDED UNEMPLOYMENT BENEFITS ON SOCIAL NEEDS AND HEALTH

There have been documented improvements in food insecurity, mental health, health-related social needs, and access to health care associated with receiving UI during the COVID-19 pandemic,[18–20] which provide important context for this study and our continued policy responses to this crisis. Raifman, Bor, and Venkataramani used data from an online nationally representative longitudinal cohort between April and November 2020, and they found that receipt of UI with FPUC was associated with nearly double the reduction in food insecurity compared to UI without FPUC (−5.9 percentage points vs. −3.0).[18] Berkowitz and Basu used data from the cross-sectional Household Pulse Survey conducted by the US Census Bureau to investigate a range of outcomes, and they found relative risk reductions for food insufficiency, missing housing payments, delays in health care, and symptoms of depression (PHQ-2) and anxiety (GAD-2) associated with receipt of UI benefits during June and July 2020.[19]

5 | SUNSETTING EXPANDED UNEMPLOYMENT BENEFITS

All the previously highlighted federal UI expansions lapsed in early September 2021, which kicked an estimated 7.5 million Americans off of UI benefits.[21] However, about half of the states chose to opt out of some or all of these supplemental UI expansions earlier, with many states doing so as early as June, claiming that overly generous benefits were the reason that employers were having difficulty filling job openings.[22] Early evidence suggests that this has not borne itself out in a rapid decrease in unemployment that governors may have expected. A recent working paper using financial services data found that ending expanded UI benefits in states that did so early only increased employment by 4 percentage points while reducing UI receipt by 35 percentage points through early August 2021 among those who had been unemployed and on UI at the end of April 2021.[23] The authors found that new earnings from employment only offset 5% of the lost UI benefits on average, with total weekly spending falling by 20%.[23] Another analysis that is pre-registered but yet to be peer-reviewed found that net employment did not seem to be responsive to ending expanded UI benefits.[24] These results suggest that the termination of pandemic UI benefits will create only pain for American households, which will reverse their protective effects on health and health-related social needs, without the promised or imagined labor market effects.

6 | CONCLUSION

The COVID-19 pandemic is not yet over despite our collective desire for things to return to normal. Expanded unemployment benefits and other expansions of the patchwork social safety net in the United States, such as increased Supplemental Nutrition Assistance Program benefits, are key to supporting individuals and families through this crisis. The long-run effects on health equity and income inequality of withdrawing public health measures and financial supports too soon will be disastrous if low-income and minoritized populations are forced to disproportionately bear the costs of this pandemic in ways that will reverberate for years and generations to come.

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