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Commentary

COVID-19 pandemic relief funding—a lifeline for equity

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COVID-19 relief programs have been instrumental in supporting large-scale testing, vaccination, and treatment efforts over the past year; however, the recent dwindling of federal funding risks a backslide in pandemic protection, with disproportionate effects on the most vulnerable Americans. Despite urging from the White House, Congress has stalled on passing a multi-billion-dollar COVID-19 relief funding bill, with funding for existing programs having run out since March 2022. The impact of these funding cuts has since begun to manifest, with the suspension of the Provider Relief Fund and the Uninsured Program: enacted in March 2020 and August 2020 respectively, these programs ameliorated financial barriers to accessing COVID-19 medical care. The Provider Relief Fund allowed targeted distribution of funds to providers serving high-need or vulnerable populations, including safety-net hospitals. On the other hand, the Health Resources and Services Administration's COVID-19 Uninsured Program provided free COVID-19 testing, vaccines, and treatment for individual Americans without health insurance coverage. Funding cuts to these programs have thus exacerbated existing health inequities, leading to greater COVID-19 infections, hospitalizations, and deaths among racial and ethnic minorities.[1] In turn, this defunding has created a 2-track pandemic in the United States whereby preventable death and suffering are perpetuated among already disadvantaged populations while the privileged enjoy plentiful access to testing, vaccination, and treatment.

Vulnerable populations already face a disproportionate burden from COVID-19 due to social inequities that have been amplified during the pandemic. Indeed, Black, Hispanic, and American Indian and Alaska Native (AIAN) populations experience significantly higher COVID-19 hospitalizations and death rates than non-Hispanic white populations. This disparity was caused by an array of reasons, such as diminished healthcare access, lack of insurance coverage, and increased occupational and social susceptibility to viral exposure. For example, a 2014 National Institutes of Health study found that hospitals in predominantly Black neighborhoods are more likely to face closure than those in primarily white neighborhoods, leading marginalized populations to face more significant difficulties accessing health care.[2] Without access to regular care, patients receive fewer preventative services, are less equipped to manage chronic health conditions, and are more likely to be diagnosed at later stages of disease. It is a vicious cycle where social vulnerability exacerbates COVID-19 susceptibility and health outcomes, which in turn further exacerbates social vulnerability.

Terminating the Provider Relief Fund threatens to further exacerbate this inequity in health access. Safety-net hospitals, which have a mission to provide health care regardless of ability to pay, have played essential roles during the pandemic, serving as the primary point of care for many marginalized communities. However, the high levels of uncompensated and charity care they provide lead safety-net hospitals to run on average profit margins of less than one-fifth of other hospitals.[3] The stresses of the pandemic have worsened these financial strains and highlighted the importance of the Provider Relief Fund, which distributed $10 billion to safety net hospitals and $3 billion to acute care hospitals or hospitals operating on thin margins that also serve vulnerable populations. Without this federal support to offset costs, safety-net hospitals are once again at precipitous risk of closure, which would further impede healthcare access from already disadvantaged populations.

Given that Black, Hispanic, and AIAN communities are more likely to be uninsured than white Americans, the rollback of the Uninsured Program has similarly exacerbated pandemic vulnerability among those most at risk and limited the lifesaving COVID-19 care they receive. Since its implementation with the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Uninsured Program has provided federal funding for free testing and vaccines for individuals without insurance. Still, the Program stopped accepting such claims on March 22 and April 5, respectively. With the continued emergence of immune evasive variants, widespread testing and vaccination will always be critical for the country to adapt to rapidly changing pandemic trends and limit COVID-19 hospitalizations and mortality.

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On March 22, the Uninsured Program also stopped accepting new claims for COVID-19 treatment, given insufficient funding. With no federal reimbursement for treating individuals without insurance, providers have been forced to either absorb the costs themselves, at risk of financial insolvency or turn away patients without insurance coverage. Such patients already avoid medical services out of fear of high costs of care: for instance, a Gallup poll from 2018 showed that, over the past 12 months, more than half of adults without insurance had delayed medical care because of costs. Given that COVID-19 treatment ranges from $14,000 to $40,000 per patient depending on the severity of hospitalization, the end of funding for the Uninsured Program will likely price patients without insurance out of COVID-19 care, aggravating this deadly paradigm of financial toxicity. A study by Galvani et al has already attributed up to 338,594 COVID deaths in the United States to incomplete insurance coverage.[4] As recent COVID-19 treatments have been shown to be highly effective (for example, monoclonal antibodies can reduce the risk of hospitalization or death by 85%) denying or delaying this essential care to patients based on financial need would be a tragic outcome. One analysis has already found that the end of the Uninsured Program may have contributed to lower oral COVID-19 antiviral dispensing rates in high-vulnerability populations.[5]

Insufficient funds for the Uninsured Program are also especially worrisome given the risk of derailing long-standing efforts to build trust and health care access among marginalized communities—after centuries of erosion by the medical establishment. Early in the pandemic, Darius Settles, a 30-year-old Black patient from Nashville, was diagnosed with COVID-19 but refused to go to the hospital because he lacked health insurance; he was unaware that the Uninsured Program would have covered his treatment. Pleading with his father and pastor to "pray for me," Settles died that day at home, the city's youngest fatality.[6] Throughout the pandemic, grassroots efforts by public health officials and community leaders have sought to build awareness about relief programs and prevent needless tragedies like Settles'.[7] Suspension of funding for COVID-19 relief programs undermine these trust-building efforts and may even threaten the credibility of grassroots organizers as previous promises of coverage are retracted. Instead of allowing funding to lapse for the Provider Relief Fund and Uninsured Programs, Congress should prioritize COVID-19 prevention and care for marginalized communities so that trust can continue to be restored instead of further eroded.

The world has faced immeasurable pain and grief over the past 2 years. The nation is fatigued, and many are eager to declare COVID-19 over, even among US public health agencies. Yet we must remain diligent lest we suffer an Icarian fate, our over-reach for normalcy eliciting the downfall of our most vulnerable. The pandemic has already exacerbated American health inequities in grueling ways, and we should revitalize relief programs, irrespective of daily COVID-19 trends because they are more broadly critical to stopping disparities from widening. This virus, and all future public health threats, will not be sympathetic to our leniency.

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