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Summary of Key Health Care Provisions in the Second COVID Stimulus Bill

The Big Picture

Late Wednesday afternoon, the U.S. Senate passed—by a 90-8 vote—the Families First Coronavirus Response Act, a COVID stimulus package. In addition to the healthcare provisions described below, which focus largely on ensuring access to free testing as well as Medicaid fiscal relief, [H.R. 6201](#) includes emergency supplemental appropriations to agencies on the front lines of the response to the pandemic, \$1 billion in food aid, the establishment of an emergency paid leave benefits program, and the extension of sick leave benefits.

The House initially passed H.R. 6201 by an overwhelming majority on Saturday. On Monday evening, the House unanimously passed technical corrections that included a handful of changes to the bill's health care provisions. These included changes to clarify that private insurance must cover, without cost sharing, COVID-19 testing and screening provided during a telehealth office visit; provide that zero cost sharing is available under Medicare for online digital evaluation and management services related to COVID-19 testing or evaluation; and amend the maintenance of effort requirements for states to receive a temporary increased federal match under Medicaid.

While H.R. 6201 eliminates cost sharing for coronavirus/COVID-19 testing and testing-related services across all payers, these protections may not be sufficient to protect patients from cost-sharing obligations. Today, healthcare providers are following strict protocols and algorithms to determine when to test patients for coronavirus. Typically, a test is available only after a patient has tested negative for the flu because coinfections with influenza and COVID are rare. Patients who test positive for the flu would never get the COVID test and presumably would be billed for all of their care and treatment as a regular visit, not based on the special coverage provisions in the legislation. The gap in protection that this scenario exposes may become less important in the coming weeks as the current shortage of supplies eases.

As H.R. 6201 heads to the President's desk for signature, members in the House and Senate are continuing to discuss provisions for a third COVID stimulus package, but there is—at least for now—a partisan divide over the contents of the legislation.

Medicare Provisions

Sections 6002 and 6003. Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19; Coverage of Testing for COVID-19 at No Cost Sharing Under the Medicare Advantage Program. Medicare has been covering SARS-CoV-2 and COVID-19

testing at zero cost sharing for dates of service on or after February 4, 2020, thanks to an interpretation that the tests fall under Part B's coverage of clinical diagnostic laboratory services. This bill confirms that coverage in the original Medicare and Medicare Advantage programs. It also inserts provisions that provide for zero cost sharing for certain evaluation and management services (including online and digital services) that result in or relate to COVID-19 testing or evaluation. Prior authorization and utilization management requirements for these services are prohibited in the Medicare Advantage program. These provisions are effective upon enactment and are applicable for the duration of the public health and national emergency period.

Section 6010. Clarification Relating to Secretarial Authority Regarding Medicare Telehealth Services Furnished During COVID-19 Emergency Period. The bill includes a technical correction to the Medicare telehealth waiver provisions of the recently passed Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (P.L. 116-123; Manatt Insights' summary is available [here](#)) that inadvertently excluded coverage of telehealth services for some new Medicare beneficiaries. That bill allowed additional Medicare coverage of telehealth, but limited coverage to services from any provider who had treated the enrollee within the past three years, or from members of that provider's practice. The bill accomplished this by requiring the provider to have a prior Medicare claim on file for those services. This inadvertently excluded new Medicare beneficiaries whose prior relationship with physicians may have been paid for under commercial coverage. The new language permits coverage of telehealth services for a beneficiary who had been seen by a provider (or a member of the provider's practice) within the past three years and had received a service that could have been paid for by Medicare if the person had been enrolled in Medicare; the new bill does not require an actual Medicare claim for the service. This provision is effective upon enactment, but practically speaking will have little impact. The Centers for Medicare & Medicaid Services (CMS) implemented the unamended waiver provisions in P.L. 116-123 on March 17, 2020 (retroactive to March 6, 2020), and [announced](#) that it will not enforce the requirement that patients have a prior established relationship.

Medicaid, CHIP, and Uninsured Provisions

Section 6004. Coverage at No Cost Sharing of COVID-19 Testing Under Medicaid and CHIP. The bill amends Titles XIX and XXI to specify that during the public health and national emergency period, tests to detect or diagnose, respectively, SARS-CoV-2 and COVID-19 are Medicaid and the Children's Health Insurance Program (CHIP) covered benefits, and that Medicaid and CHIP cannot charge cost sharing for the administration of such tests or any testing-related services. (The CHIP changes apply to children as well as targeted low-income pregnant women in states that opt to cover them.) Without this change, states were faced with eliminating cost sharing for other services in order to provide COVID-19 testing without a copay. The bill also prohibits states (and territories) from charging "alternative cost sharing" under Section 1916A for testing services and related visits.

Section 6004 also gives states the option to extend Medicaid eligibility to uninsured individuals for purposes of SARS-CoV-2/COVID-19 diagnostic testing and testing-related services during the duration of the public health emergency. States that elect this option would see their medical and administrative costs fully matched by the federal government. The bill also provides for payment of out-stationed eligibility workers and the use of streamlined applications for uninsured individuals covered by this new provision. “Uninsured individuals” in this context are defined in the bill as those individuals who are not eligible for Medicaid under a mandatory group (e.g., children, pregnant women) and not enrolled in other public or commercial coverage. Additional guidance will be needed from CMS to understand how this provision will be implemented.

These provisions are effective upon enactment and are applicable for the duration of the public health and national emergency period.

Division A, Title V. Second Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Department of Health and Human Services. The bill also separately includes \$1 billion to the Public Health and Social Services Emergency Fund, specifically for the National Disaster Medical System (NDMS). Under this Department of Health and Human Services (HHS) authority, the funding is directed to be used to pay claims for providers for reimbursement of SARS-CoV-2/COVID-19 testing and testing-related visits for uninsured individuals. This appears to cover uninsured individuals in states that do not elect the Medicaid option to cover uninsured populations, authorized in Section 6004 of the bill. Additional guidance from HHS will be needed to understand how this provision will be implemented, but it appears that reimbursement could occur through the NDMS Definitive Care Reimbursement Program. The program is activated during a public health emergency, and participating institutions and practitioners are reimbursed for care to patients referred by a Federal Coordinating Center. The funding is available until September 30, 2020.

Section 6008. Temporary Increase of Medicaid FMAP. The bill includes a temporary 6.2 percentage point increase in the regular (e.g., non-expansion) Medicaid matching rate for both states and territories, retroactive to March 13, 2020, and lasting through the last day of the calendar quarter in which the emergency ends. To qualify for the increased matching rate, states would have to satisfy a maintenance of effort (MOE) requirement. There are several notable aspects to the MOE. States would need to provide Medicaid coverage without cost sharing for testing *and treatment* of COVID-19, including vaccines, equipment, and therapies for its Medicaid beneficiaries. With respect to Medicaid program eligibility, states would not be able to impose more restrictive eligibility standards, methodologies, or procedures, or to charge higher premiums than those in effect on January 1, 2020. States may not disenroll individuals from Medicaid through the end of the emergency period unless an individual voluntarily terminates their eligibility or ceases to be a resident of the state. This applies to individuals who are enrolled on the date of enactment and those who enroll during the emergency period, in effect creating a form of continuous eligibility and waiver of eligibility re-determinations in states that seek the increased FMAP. Notably, the technical amendment to the original House-passed bill removed

two conditions on enhanced funding that were included in the original House bill: (1) a prohibition on conducting automated income checks or eligibility redeterminations more frequently than once every 12 months and (2) a restriction on states from terminating or denying enrollment for reasons other than a failure to satisfy financial, categorical, and residency requirements. The changes will thus help people who are enrolled in Medicaid remain covered for the duration of the emergency period but no longer specifically bar certain policies that Democratic House drafters seemed to be targeting in their original language.

As was the case with the American Recovery and Reinvestment Act's 2009 increase in the Federal Medical Assistance Percentage (FMAP), states may not require a political subdivision to pay a greater percentage of the nonfederal share of expenditures than the political subdivision would have been required to pay under regular FMAP rules as of March 11, 2020. In other words, to qualify for the increased FMAP, states must ensure that the required nonfederal share contributions by localities decline in recognition of the increased federal contribution. While this provision is targeted to ensure states do not cost-shift to localities in response to the increased federal match, it would also restrict potential changes in states like New York, which had been considering increasing local contributions for Medicaid due to budgetary challenges.

Section 6009. Increase in Medicaid Allotments for the Territories. In addition to the 6.2 percentage point increase in the FMAP, the bill also includes increased funding for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the remainder of Fiscal Year (FY) 2020 and FY 2021.

Marketplace and Private Insurance Provisions

Section 6001. Coverage of Testing for COVID-19. Group health plans (including self-insured ERISA plans) and health insurance issuers in the individual and group markets (including grandfathered plans) must cover, without cost sharing, SARS-CoV-2 and COVID-19 testing and items and services related to testing and screening furnished during provider office visits (whether conducted in-person or by telehealth), urgent care center visits, and emergency room visits that result in testing for COVID-19. The provision is effective on or after the date of enactment of the act and is applicable for the duration of the public health and national emergency period.

Other Healthcare Provisions

Section 6005. Treatment of Personal Respiratory Protective Devices as Covered Countermeasures. Some personal respiratory protective devices are declared in the bill to be "covered countermeasures" for purposes of the Public Readiness and Emergency Preparedness (PREP) Act. The bill specifically includes the N95 respirators for which the Food and Drug Administration (FDA) issued an emergency use authorization on March 4, 2020, and leaves room

for HHS to include others. The designation of these respirators as covered countermeasures will add them to the drugs and devices enjoying PREP Act protection from liability arising from their manufacture and use under some circumstances, in accordance with the Secretary of HHS's PREP Act [declaration](#) on March 10, 2020. The provision applies to covered devices that are used from January 27, 2020, through October 1, 2024, and in response to the coronavirus public health emergency.

Section 6006. Application with Respect to TRICARE, Coverage for Veterans, and Coverage for Federal Civilians. In keeping with the provisions described above, the bill prohibits TRICARE and the Department of Veterans Affairs from charging cost sharing for SARS-CoV-2 or COVID-19 testing. Similarly, such cost sharing may not be imposed on federal civil servants, including but not limited to those enrolled in the Federal Employees Health Benefits Program. The provision is effective on or after the date of enactment of the act and is applicable for the duration of the public health and national emergency period.

Section 6007. Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care. The bill prevents cost sharing for testing and testing-related visits for American Indians and Alaskan Natives who receive services through the Indian Health Service (IHS), including through contracted health services providers. The provision is effective on or after the date of enactment of the act and is applicable for the duration of the public health and national emergency period.

General Healthcare Appropriations

In addition to the funding appropriated in the March 6 Coronavirus Preparedness and Response Supplemental Appropriations Act, H.R. 6201 appropriates a second round of funding to several agencies and offices within HHS, including:

- \$64 million for the IHS for health services related to SARS-CoV-2 or COVID-19 (available until September 30, 2022)
- \$250 million for Aging and Disability Services Programs provided by the HHS Administration for Community Living, including Home-Delivered Nutrition Services, Congregate Nutrition Services, and Nutrition Services for Native Americans (available until September 30, 2021)

The bill provides that state and local governments receiving funds or assistance under the bill shall ensure that the respective State Emergency Operations Center receives regular and real-time reporting of aggregated data on testing and results from state and local public health departments, as determined by the Centers for Disease Control and Prevention (CDC), and that such data is transmitted to the CDC.

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