

Medicare, Medicaid, and the Uninsured

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In response to the COVID-19 global pandemic, three bills were signed into law in the U.S in March 2020, to improve access to testing and care for vulnerable patients, address medical supply shortages, and support the health care workforce and system as a whole. This fact sheet focuses on provisions of the COVID-19 legislative packages that directly impact Medicare, Medicaid, and the uninsured population.

Overview of Legislation

[The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020](#) was signed into law on March 6, 2020, and provides \$8.3 billion in emergency funding to various federal agencies to address the outbreak of COVID-19. \$6.2 billion of the appropriated funding was allocated to the Department of Health and Human Services (HHS).

The second bill, [The Families First Coronavirus Response Act](#), was signed into law on March 18, 2020. This bill includes many provisions to address the outbreak of COVID-19, such as additional funding for nutritional programs, additional coverage of COVID-19 testing related visits, expansion of emergency paid sick days and paid leave, additional funding for unemployment insurance programs, and increasing the federal matching rate for state Medicaid programs.

The third bill, [The Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#), was signed into law on March 27, 2020. This \$2.2 trillion dollar stimulus package aims to mitigate the current economic decline due to the COVID-19 pandemic and includes provisions to expand the unemployment insurance programs, to provide ‘recovery rebates’ to low- and middle-income families, and to develop a \$150

billion Coronavirus Relief Fund to address emerging budget holes in states and localities. The CARES Act builds upon the coverage and insurance provisions of the Families First Coronavirus Response Act for Medicare and Medicaid patients and includes additional health provisions to address medical supply shortages and over-the-counter drug review.

Provisions related to Medicare

The COVID-19 response legislation includes various provisions to increase the availability of telehealth and home health services for Medicare beneficiaries, increase provider payments, and ensure coverage of U.S. Food and Drug Administration (FDA) approved COVID-19 testing services with no cost-sharing or utilization management.

The Coronavirus Preparedness and Response Supplemental Appropriations Act

The Coronavirus Preparedness and Response Supplemental Appropriations Act provides \$8.3 billion in emergency funding to various federal agencies to address the outbreak of COVID-19 with a majority of the funding, \$6.2 billion, allocated to HHS. At an estimated cost of \$500 million, this bill also includes a specific Medicare provision that allows providers to offer telehealth services to all beneficiaries instead of only beneficiaries in rural communities.

The Families First Coronavirus Response Act:

Under the traditional Medicare program, beneficiaries are exempt from out-of-pocket costs related to clinical diagnostic laboratory tests, including for coronavirus. This bill includes additional protection for traditional Medicare beneficiaries by eliminating the cost-sharing for a medical visit that leads to testing/diagnostic services for coronavirus. This visit could occur in a range of settings, including a physician's office, outpatient center, nursing facility, emergency room, hospital observation, or home health visit. This coverage is also extended to online digital evaluation and management services.

Prior to this bill, Medicare Advantage (MA) plans might or might not require cost-sharing for clinical diagnostic laboratory tests. Under this bill, MA plans are required to cover the testing/diagnostics for coronavirus and the associated visit with no patient out-of-pocket costs or prior authorization/utilization management as defined under the traditional Medicare program.

These requirements begin after the bill was enacted and will continue to apply while a public health emergency is declared. These provisions will be enforced by HHS. The bill also instructs HHS to develop a claims modifier for coronavirus-related claims.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act:

Telehealth Services Access: The CARES Act increases Medicare beneficiaries' access to telehealth services during the public health emergency period, including:

- The Medicare telehealth provision of The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 is enhanced by allowing beneficiaries to access telehealth services without having a pre-existing relationship with the provider during the COVID-19 emergency period.
- Federally Qualified Health Centers and Rural Health Clinics can furnish telehealth services to Medicare beneficiaries in their homes.
- Telehealth visits are allowed to fulfill the face-to-face requirements between home dialysis patients and physicians, and between hospice physicians or nurse practitioners and patients, for recertification requirements.

Home Health Services: The CARES Act lifts the requirement that only physicians can order home health services for beneficiaries by allowing physician assistants, nurse practitioners, and other professionals to order home health services.

Provider Payment Updates:

- Temporarily lifts the Medicare sequester that would have reduced payments to providers by 2% from May 1 through December 31, 2020.
- Creates a new COVID-19 Medicare Hospital Inpatient Prospective Payment System code that increases the payment for treating COVID-19 patients by 20% during the emergency period.
- Prevents scheduled reductions in Medicare payments for durable medical equipment during the emergency period.
- Prevents scheduled reductions in Medicare payments for clinical laboratory tests until 2021.
- For the duration of the COVID-19 emergency period, qualified facilities can request up to a six-month advance lump sum or periodic payment based on net reimbursement represented by unbilled discharges or unpaid bills.

COVID-19 Testing and Vaccines:

- If a COVID-19 vaccine is developed, the CARES Act requires that Medicare Part B and Medicare Advantage plans cover the vaccine with no cost-sharing requirements.

Extension of Funding: Extends the following programs until November 30, 2020.

- Funding for beneficiary outreach and counseling related to low-income programs.
- Provides funding for HHS to contract with the National Quality Forum (NQF), to carry out duties related to quality measurement and performance improvement.

Geriatrics Education and Training: The CARES Act also increases support for the education and training of geriatric workforce professionals and additional areas of need, including home health workers, family caregivers, and direct care workers who serve older adults.

Provisions Related to Medicaid and the Uninsured

Under the COVID-19 response legislation, Medicaid and the Children's Health Insurance Program (CHIP) are required to cover coronavirus-related testing services with no cost-sharing or utilization management. Medicaid programs are eligible to receive a 6.2 percentage point increase in their Federal Medical Assistance Percentages (FMAP) from the federal government. Additionally, Medicaid programs may elect to cover COVID-19 testing services for uninsured individuals and states that do so will receive a 100% FMAP federal match for the duration of the public health emergency period.

The Families First Coronavirus Response Act:

The bill requires Medicaid and CHIP programs to cover FDA approved testing/diagnostic services and the administration of that testing for coronavirus, as well as the associated medical visit with no cost-sharing or prior authorization/utilization management. These requirements began after the bill was enacted and will continue to apply while a public health emergency is declared.

States and territories will be provided with a temporary 6.2 percentage point increase in their regular federal matching rate. This increase does not apply to Affordable Care Act (ACA) expansion adults. States and territories must meet the following requirements to receive the matching rate increase:

- Must not be implementing higher premiums or more restrictive eligibility requirements than what was in place as of January 1, 2020.

- Must allow continuous eligibility through the end of the month of the emergency period, unless an individual actively disenrolls or is no longer a resident of the state
- Must not have cost-sharing requirements for coronavirus testing and treatments.

The bill creates an option for state Medicaid programs to cover FDA approved testing/diagnostic services and the administration of that testing for coronavirus, as well as the associated medical visit for uninsured individuals. States that take up that option will get a 100% federal match for the duration of the public health emergency period. Additionally, the bill authorizes \$1 billion for the National Disaster Medical System to pay for tests/diagnostics for coronavirus for uninsured individuals, with the Secretary of HHS responsible for determining and paying claims.

The bill defines an uninsured individual as someone not enrolled in a private health insurance plan or a federal insurance program. Under the specific definition of the bill, those people in short-term, limited duration insurance plans are considered uninsured and are covered by these provisions.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act:

Uninsured Individuals: Clarifies the language in the Families First Coronavirus Response Act of 2020 by ensuring that uninsured individuals can access COVID-19 testing and related services with no cost-sharing in any state Medicaid program that elects to offer such an enrollment option.

Federal Medical Assistance Percentages: Under the Families First Coronavirus Response Act of 2020, states are ineligible for the 6.2 percentage point increase in the FMAP funding if there are premium requirements that were added after January 1, 2020. Under the CARES Act, states are eligible for the FMAP increase if the premium requirements were in effect before the date of enactment.

COVID-19 Testing and Vaccines: Eliminates the Families First Coronavirus Response Act requirements that COVID-19 tests be FDA approved in order to be covered without cost-sharing by state Medicaid and CHIP programs.

Home and Community-Based Services: Allows Medicaid programs to pay for attendants and caregiving services to help enrollees with daily living activities to smooth the transition from acute to home and community-based care and reduce the length of stay.

Extension of Funding: Extends the following programs until November 30, 2020.

- The Money Follows the Person demonstration that helps patients transition from the nursing home to the home.

- The Medicaid spousal impoverishment protections program to help the spouse of an individual who qualifies for nursing home care to live at home.
- The Medicaid Community Mental Health Services demonstration that provides coordinated care to patients with mental health and substance use disorders.
- Delays the scheduled reductions in Medicaid disproportionate share hospital payments.

Gaps in the COVID-19 Legislation

The legislative packages to address the COVID-19 pandemic include many provisions to increase the ability of patients to access testing and to allow the health care provider industry to meet the needs of patients. An important impact of these bills is the increase in the availability of telehealth and home health services for Medicare beneficiaries, especially as they are the most at risk of a deadly COVID-19 infection. Additionally, the bills directly include coverage of coronavirus-related testing services for Medicare, Medicaid, and uninsured patients with no cost-sharing or utilization management.

Costs of COVID-19 Treatment:

Currently there is no known treatment for COVID-19, but those who get seriously ill may require hospitalization and various outpatient services. As others have [noted](#), neither bill includes coverage for any coronavirus infection related treatments, leaving patients, especially those who are uninsured or underinsured, at risk of incurring significant costs. [One study](#) of the potential costs of coronavirus treatment for people with employer coverage, found that the total cost of inpatient admissions for treatment could be more than \$20,000 if there are complications and even without complications could be around \$10,000. Even individuals who are insured could face high deductibles and out-of-pocket costs. This study found that without complications, those with employer-sponsored insurance could face an average out-of-pocket cost of \$1,464 for treatment.

For Medicare beneficiaries, the risk of complications or death from a coronavirus infection is especially high. Among adults over the age of 60, [more than half](#) have an underlying serious medical condition and are at a high risk of developing severe symptoms if they are infected with the virus. Besides the higher risk of life-threatening symptoms, this also means that older Americans or those with underlying conditions or long-term disabilities may face even greater costs for coronavirus treatment, including longer hospitalizations and more intense treatment. Although the Medicare program will be providing testing services with no cost-sharing, the treatment could be extremely costly, especially for beneficiaries in traditional Medicare without supplemental insurance who have no out-of-pocket limit. In 2016, [over 6 million](#) beneficiaries lacked supplemented coverage.

Medicaid and the Uninsured:

The CARES Act includes \$150 billion in a Coronavirus Relief Fund that states and local governments (with populations over 500,000) can utilize to mitigate the negative economic impacts of COVID-19. Although this will provide much-needed relief, it will likely not be enough because the impacts of the economic downturn are likely to be long-lasting. Medicaid is a significant portion of many state budgets and will be critical in protecting low-income individuals from the devastating financial and health impacts of COVID-19. Although the legislation includes increases in the FMAP to help fund state Medicaid programs, that increase is only for the duration of the emergency period, but state economies are not likely to be recovered yet and will likely need additional relief.

The legislative response packages do not include incentives for states to adopt or immediately implement the ACA expansion of Medicaid to low-income adults. This leaves [over 2 million](#) in the Medicaid coverage gap across the country. Although the legislation increases state Medicaid funding and includes provisions to allow Medicaid programs to cover COVID-19 testing and related services for the uninsured, none of the bills cover treatment costs for uninsured individuals, leaving uninsured individuals in grave financial risk if hospitalized.

Additionally, the legislative bills do not include provisions to strengthen the ACA individual market. As many Americans across the country are losing their jobs and/or employer-sponsored health coverage, those who do not qualify for Medicaid in their state are turning to the ACA individual market for health coverage. Before the pandemic, the ACA was already facing premium affordability issues for many consumers, especially those who do not qualify for premium tax credits. Policymakers could implement a number of proposals to strengthen the ACA marketplaces during this crisis, including enhancing the marketplace subsidies and/or federal funding for reinsurance or emergency risk mitigation programs to keep insurer costs and premiums down.

Surprise Medical Billing:

Receiving a surprise medical bill can be a financially devastating shock for patients, especially those with low-incomes, and resolving balance billing has been a recent interest of policymakers on both sides of the political aisle. Nearly [two-thirds](#) of Medicare beneficiaries worry about receiving surprise medical bills. For low-income individuals with Medicaid, receiving a surprise medical bill can be especially financially devastating. Surprise medical bills mainly happen during emergency care or during hospitalization, when patients are not able to research and make sure that the doctors that treat them are in-network. Many patients will be in this scenario as they seek emergency care and treatment in hospitals during the COVID-19 pandemic. Although the CARES Act includes provisions that [attempt to limit surprise bills](#)

related to testing for COVID-19, those provisions only apply to privately insured patients and there is no guarantee that a provider or facility will not surprise bill patients.

Discussion

The three pieces of COVID-19 relief legislation are an important step forward to improve access to testing and care for vulnerable patients, address medical supply shortages, and support the health care workforce and system as a whole. The bills include many provisions to support the Medicare and Medicaid programs and provide greater access to testing for uninsured patients. However, there are still major gaps related to coverage of COVID-19 treatment, affordability of health coverage, and surprise medical billing.

Policymakers are likely to continue working to ensure patients have access to and can afford needed health care services during this global COVID-19 pandemic. With rising novel coronavirus cases in the U.S., it is essential for Americans to have access to testing and treatment in order to prevent further spread. Older individuals, those with long-term disabilities and underlying health conditions, and those with lower-incomes are particularly vulnerable to becoming seriously ill if they are infected, and are at risk of incurring significant costs for COVID-19 related testing and treatments.