

State Health Coverage Strategies for COVID-19: Frequently Asked Questions

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Last week, states began to take action to respond to the COVID-19 crisis. And Families USA issued a report, [State Health Coverage Strategies for COVID-19](#), that provides state advocates and policymakers with options to address the coronavirus pandemic, focusing on issues involving Medicaid and private health coverage. Families USA also hosted a [webinar](#) for state partners that supplements information in the report.

The following Frequently Asked Questions address queries that Families USA received from national and state partners on these topics. Please contact us at info@familiesusa.org if you have questions or thoughts to share.

General State Information and Questions

1. Which states are doing what? Which have applied for, and received, Medicaid waivers? Which are implementing additional consumer protections, such as those involving surprise billing and other consumer cost-sharing for treatment related to COVID-19? How can state advocates track what other states are doing?

The Families USA report referenced above includes links to documents showing some state actions, such as state insurance commissioner orders. But this area of policy is sure to change quickly. The [Commonwealth Fund](#), the [Kaiser Family Foundation](#) (which also provides regularly updated information

about Medicaid 1915(c) [Appendix K waiver approvals](#)), and the [State Health and Value Strategies](#) program at Princeton are regularly updating useful summaries of evolving state policy. The [Centers for Medicare & Medicaid Services](#) (CMS) also updates federal guidance involving COVID-19, including information about approved state Medicaid waivers under Section 1135 of the Social Security Act.

2. What flexible resources did Congress provide states as part of the recently passed [Coronavirus Aid, Relief and Economic Security Act](#) (CARES Act)? How will states make decisions about the use of those funds? How can advocates influence those decisions?

The CARES Act includes categorical funding for [particular state and local activities](#), including education, mass transit, community development, child care, housing, and other services. The legislation also provides two major new federal funding streams that are relatively open-ended.

The first is a \$150 billion Coronavirus Relief Fund, of which [\\$110 billion is expected to go to states](#), \$29 billion to localities with more than 500,000 residents, and the remainder to tribes and territories. These funds can be used to finance any “necessary expenditures incurred” between March 1 and December 30, 2020, that were not previously budgeted and were “due to the public health emergency with respect to” COVID-19. By the end of April, the federal government must make payments to states, to tribes, and to localities whose chief executives certify that the locality will use the money as provided in federal law. Governors’ offices and chief executives of municipal and county government are likely to be the focus of advocacy that shapes the use of these funds.

The second major non-categorical funding stream available to states involves an unprecedented \$45 billion “Disaster Relief Fund” for states, localities, and tribes. These flexible funds support activities under the [Robert T. Stafford Disaster Relief and Emergency Assistance Act](#), which provides for a broad range of activities when disaster or emergency strikes. The Federal Emergency Management Agency (FEMA) maintains a [regularly updated webpage with information about COVID-related emergency and disaster assistance](#). These dollars can be used to fund services that provide consumers with health care and that support health-care providers. For background information about funding under the Stafford Act, please see the Congressional Research Service [summary](#), the Association of State and Territorial Health Officials released a [toolkit](#), or an [article](#) published by the National Law Review. [Key targets of state advocacy](#) are likely to include governors’ offices and state emergency management agencies.

3. Many health care providers are unable to qualify for Small Business Administration (SBA) assistance, which they could need to survive this period. What resources and advocacy can providers and stakeholders pursue to access sorely needed funding and support?

[Providers vary](#) in terms of their access to SBA funding. They may be able to find other financial support from disaster and emergency relief funding, Medicaid waivers, the COVID Relief Fund, and [other funding sources in the CARES Act specifically focusing on health care providers](#). Providers may also qualify for the CARES Act’s considerable [additional assistance for small employers](#), including 501(c)(3) nonprofit corporations.

In addition, the CARES Act established a [\\$100 billion Public Health and Social Services Relief Fund](#) to help hospitals and other providers cope with increased costs and reduced revenue associated with the COVID-19 epidemic. Eligible providers include for-profit, public, and nonprofit providers that offer testing, diagnosis, or care for people with actual or suspected cases of COVID-19. The Secretary of Health and Human Services has broad discretion over the distribution of these resources. One key statutory limit is that the fund may not be used to cover services for which providers obtain or are seeking reimbursement.

Individual Payments and Eligibility Implications

4. How exactly does the CARES Act provide individuals and families with money? Will this money count as income for tax purposes, thus raising recipients’ federal or state income tax liability? Could it disqualify people for Medicaid or

the Children’s Health Insurance Program (CHIP) by raising income above the maximum eligibility levels for those programs? By raising countable income, would this money reduce the premium tax credits (PTCs) for eligible consumers or take away cost-sharing reductions (CSR) for which they would otherwise qualify?

The CARES Act gives individuals two categories of income support:

- » An emergency increase in unemployment compensation provides recipients with an additional \$600 per week. The supplemental benefit ends after four months. That payment does not count as income for purposes of calculating Medicaid and CHIP eligibility, but it does count as income in determining eligibility for PTCs and CSRs. It is also counted as taxable personal income under federal law.
- » Recovery rebate checks of \$1,200 per adult and \$500 per child will go to most income tax filers and people with Social Security numbers attached to programs like Supplemental Security Income (SSI). Checks fall by \$5 for each \$100 by which income exceeds \$75,000 a year for a single filer and \$150,000 for married couples filing jointly. Refund amounts do not count as income for tax purposes. The IRS will determine payment amounts based on 2019 or 2018 income. Tax filers can receive additional payments in 2021 based on year-end returns filed for 2020, but overpayments this year will not be “clawed back” at tax time. These rebates most likely do not count as income for purposes of determining tax liability or eligibility for Medicaid, CHIP, PTCs, or CSRs.

Enrollment and Coverage Transitions

5. Will Medicaid enrollees in each state be protected from involuntary disenrollment?

The second COVID bill passed by Congress, the [Families First Coronavirus Response Act](#), increases each state Medicaid program’s standard federal matching rate by 6.2 percentage points. To qualify for that enhanced match, a state must abide by “Maintenance of Effort” (MOE) requirements that, among other things, forbid terminating Medicaid coverage (unless an enrollee gives permission or moves to another state), between March 18, 2020, and the end of the month in which the COVID-19 public health emergency ends.

6. What must states do for individuals who were already disenrolled from Medicaid?

Under the Families First MOE, a state that accepts the enhanced federal match must make a good faith effort to find and re-enroll anyone who was involuntarily terminated on March 18, 2020, or thereafter. The MOE does not require states to reinstate coverage for people whose eligibility ended before that date.

7. People can enroll in marketplace coverage outside annual open enrollment periods only if they qualify for a Special Enrollment Period (SEP). What SEPs are available during the COVID-19 national emergency?

A [number of states](#) that operate their own exchanges have created emergency SEPs that let the uninsured enroll for a specified period. The federally facilitated exchange, [healthcare.gov](#), does not currently provide such a COVID-related SEP. Though, individuals may qualify for a 60-day SEP if their layoff ends their employer-funded health insurance. People also qualify

for an SEP if their [income drops](#) enough to qualify them for PTCs and they had minimum essential coverage for at least one day during 60 days before their income fell. The latter SEP is triggered whenever expected annual income falls from above to below 400% of the federal poverty level (FPL).

8. Many consumers now covered in qualified health plans (QHPs) offered in health insurance exchanges are losing income and should be eligible for Medicaid or CHIP. How can advocates make sure this transition to much more affordable and comprehensive coverage actually takes place?

Consumers should report a loss of income to the exchange and request a determination of Medicaid or CHIP eligibility based on their current monthly income without taking into account the \$600 weekly increase in unemployment compensation described above.

9. If someone loses employment or income and it appears they may qualify for Medicaid, should they apply directly to the Medicaid program, or should they apply for health coverage through their health insurance exchange?

In theory, the Affordable Care Act's (ACA) "no wrong door" rules require a full Medicaid eligibility determination, even if the consumer applies for coverage through the exchange. In practice, consumers who lose income are often better off if they apply directly to Medicaid, which is accustomed to determining eligibility based on current monthly income. (By contrast, exchanges focus on eligibility for PTCs, which is based on current-year projected annual income.)

Long before the current public health emergency, application assisters in many states have thus urged clients experiencing job loss to go directly to Medicaid. A new factor making that advice well-taken is that even exchanges that have historically done a good job with "no wrong door" procedures must now reprogram their eligibility rules engines to handle the \$600 weekly increase in unemployment compensation. Such programming must include the income in determining PTC and CSR eligibility but exclude it in determining eligibility for Medicaid and CHIP.

Here are a few things advocates can do:

- » See whether phone assisters in their states can guide people through the process. If so, help publicize those phone numbers.
- » Ensure that Medicaid eligibility offices are in fact taking phone and online applications and processing them quickly. In view of the COVID epidemic's potential impact on state agency workers, [federal officials have suspended normal timeliness requirements](#) for processing Medicaid and CHIP applications. Advocates could argue that expedited processing of applications for health coverage are especially important during a pandemic, when prompt provision of Medicaid lets low-income consumers immediately seek care when they first get sick, enabling the rapid detection of COVID-19 and combatting the pandemic's spread.
- » Check how well state-based marketplaces are determining eligibility for Medicaid and CHIP and advising consumers who may qualify for these programs. Make sure that marketplace enrollment hotlines have up-to-date information on who might qualify for Medicaid based on monthly income.

10. What best practices and lessons can we learn about effective outreach and enrollment?

We do not yet know what has proven effective during the current, unique environment. For example, telephonic or other electronic outreach and assistance now must play a more central role than in the past due to social distancing requirements. If you have examples of local success in conducting effective outreach and enrollment during the COVID-19 emergency, we hope you will share that information with us and with other advocates via info@familiesusa.org.

Past efforts to reach and enroll laid-off workers may yield helpful guidance, despite the unique circumstances under which we are operating. This population has proven very challenging to reach. The emotional aftershocks of job loss and the practical challenges of claiming unemployment compensation, applying for the Supplemental Nutrition Assistance Program (SNAP), and looking for a new job rarely leave the bandwidth required to learn about complex health programs and enroll. [Laid-off workers have received health coverage](#) historically only when unions or state agencies have invested considerable resources in providing individualized assistance with guiding families through the enrollment process, completing paperwork on the families' behalf, and trouble-shooting emerging problems.

One particularly effective program asked laid-off workers for their consent to have the state workforce agency share contact information with other government agencies, which would then help those workers qualify for and enroll in free or low-cost health insurance. Under current conditions,

a similar approach would routinely ask applicants for unemployment compensation to authorize sharing their contact information with agencies that can help them enroll in free or low-cost health insurance. Officials in Maryland and New Mexico have indicated interest in such steps. Please contact us at info@familiesusa.org for more information about the specifics of a consent-based approach, using applications for unemployment insurance as a springboard to health coverage.

11. Can you share more information on federal funding that is available for uninsured populations affected by COVID-19? Who is covered, and what services do they receive?

The Families First COVID bill created a new category of Medicaid eligibility to cover COVID-19-related testing for those who are uninsured. This coverage includes medical visits and other services directly related to the test. The federal government pays 100% of the cost of this new optional coverage category. This new Medicaid eligibility category is limited to testing-associated services and does not cover COVID-19 treatment.

Disaster relief funding and resources from the Coronavirus Relief Fund, described above, can potentially be used to finance state and local programs to help the uninsured with a broad range of COVID-19-related care. Securing that funding may require advocacy directed at governors or officials at local agencies, including counties. In addition, resources from the Public Health and Social Services Emergency Fund could pay for health care services furnished to the uninsured for which providers do not anticipate seeking reimbursement.

Private Coverage

12. What are states doing to make marketplace coverage more affordable in light of COVID-19?

For households with incomes at or below 200% of FPL who buy exchange coverage, Washington State has proposed a Medicaid waiver under Section 1115 of the Social Security Act that would [pay the consumers' share of premiums and out-of-pocket cost-sharing](#). If the waiver is approved, standard federal Medicaid matching rates will apply, leaving the state responsible for funding a share of coverage costs. Some states are considering expanding Medicaid adult coverage above 138% of FPL, which would qualify for standard Medicaid matching rates, now enhanced by 6.25 percentage points, as noted earlier.

Many states are barring individual market insurance, including exchange plans, from imposing certain charges for COVID-19-related services. Families USA's [recent report](#) on state options describes state policies enacted by the time of that report, and the [Commonwealth Fund](#), [Kaiser Family Foundation](#), and [State Health & Value Strategies](#) websites track evolving state policy in this area.

13. State-regulated commercial insurance comprises a relatively small slice of private insurance markets. Is any federal action being considered to require self-insured employer plans, which are exempt from state regulation under ERISA, to cover COVID-19-related services free of cost-sharing?

The [House](#) version of the CARES Act would have required all private coverage of COVID-19 care to be exempt from out-of-pocket cost-sharing. This provision did not make it into the bill that went to President Trump for signature, but Congress is still considering it for future COVID-related legislation.

14. Is there any significant federal advocacy on reinstating premium stabilization programs (“3 Rs”) and/or adjusting them to help deal with higher claims for COVID-19 patients?

Fully-funded risk corridors were part of the House version of the CARES Act until the House dropped them from the legislation before it was signed into law. Risk corridors address situations when insurance carriers find it hard to accurately forecast covered claims, which is surely the case today. COVID-19-related costs could be significant, but other services are being deferred to leave provider capacity free to treat COVID-19 patients. Under the House bill, federal payments would have covered 75% of claims incurred that exceeded by more than 5% the amounts foreseen when plan rates were being developed for 2020 and 2021.

Medicaid Expansion and Waivers

15. What can a state that has not expanded Medicaid do to help adults in the coverage gap — that is, those who are ineligible for Medicaid and have income below 100% of FPL and so do not qualify for PTCs — during the COVID crisis? Could it cover just COVID-19-related services for such adults? Could it provide adult Medicaid up to 100% of FPL, leaving the exchange to cover people with incomes above that threshold?

The optional Medicaid category for COVID-19 testing, noted above, is available for non-expansion states to use in serving adults in the coverage gap. However, this new category of optional Medicaid eligibility is limited to services related to COVID-19 testing. It does not include treatment of COVID-19 or other diagnosed illness, as explained earlier.

Since the ACA's enactment, states have always had the option to provide income-based Medicaid eligibility

to adults up to thresholds below 138% of the FPL. However, a state does not qualify for the enhanced 90% federal matching funds for expansion unless eligibility reaches 138% of FPL.

16. Can states that have not expanded Medicaid enact an expansion that is limited to the duration of the COVID-19 emergency? Can such states use the 1115 streamlined waiver or State Plan Amendment (SPA) forms developed by CMS to provide such time-limited eligibility?

Yes. Any state that has not taken up the ACA Medicaid expansion can do so immediately and for a limited duration if they so choose. States have always had the ability to expand Medicaid for a finite period. Some states created [sunset clauses](#) for Medicaid expansion, requiring state legislative approval for eligibility to continue. Others expanded Medicaid with a [trigger](#) that would end coverage if specified events occurred. Similar options remain available to states wishing to expand adult eligibility but only for the duration of the COVID-19 emergency, without any need to use new 1115 templates or new SPA forms.

17. In states that have already expanded Medicaid, how soon will information be shared with communities describing the new plans and coverage?

Many states are already enhancing coverage and benefits during this public health emergency. Most states have a dedicated website for COVID-19-related news or are posting updates on their regular Medicaid website.

18. How quickly does CMS process SPA proposals?

The speed depends on the SPA's complexity, among other factors. Straightforward SPAs are often approved quickly.

Immigrant Populations

19. What limits apply to immigrant populations (undocumented and lawfully present) under Medicaid given the new waiver flexibilities, emergency funding, and disaster relief funding?

The National Immigration Law Center has released a [comprehensive analysis of the federal COVID-19 relief legislation's impact on immigrants](#). Following are some key points:

- » The Families First Act provides additional funding to pay for coronavirus testing for anyone who is uninsured. The funding will pay for testing at community health centers, outpatient clinics, and doctors' offices.
- » Immigrants can continue to access services at community health centers, regardless of their immigration status, at a reduced cost or free of charge, depending on their income. The CARES Act provided such centers with additional funding, increasing their capacity to help vulnerable patients. However, people should call first to find out the availability of COVID-19 screening and testing. Health centers may do patient assessments over the phone or using telehealth.
- » The CARES Act delays cuts to funding for hospitals that serve a disproportionate share of the poor and uninsured. This gives safety net hospitals modest additional resources with which to serve patients, including immigrants.
- » [Immigrants' eligibility](#) for Medicaid, CHIP, PTCs, and CSRs has not changed.
- » U.S. Citizenship and Immigration Services (USCIS) recently [posted an alert](#) clarifying that it will not consider testing, treatment, or preventive care (including vaccines if a vaccine becomes

available) related to COVID-19 in a public charge inadmissibility determination, even if the health care services are covered by Medicaid.

In addition, the two open-ended funding sources described above — the Coronavirus Relief Fund and Emergency and Disaster Relief funding — may be able to fund support for a broad range of immigrant populations, though specific guidance has not yet been released. The \$100 billion Public Health and Social Services Relief Fund can fund immigrants' health care for which providers would not otherwise seek reimbursement.

20. What materials (including social messaging and videos) can be used for outreach to immigrant communities?

The National Immigration Law Center has [good materials for service providers](#). Massachusetts' Health Care for All webpage contains [links to a useful video](#).

Telemedicine

21. Are any states looking at expanding telemedicine to permit out-of-state providers to serve their residents? Do telemedicine expansions include non-physician providers, like community health workers and doulas?

To date, [42 states](#) have expanded the use of telemedicine in their Medicaid programs in response to COVID-19, and [45 states](#) have introduced licensure flexibilities. The Commissioner of the Massachusetts Department of Public Health issued an [order](#) that allows reciprocity for out-of-state health care providers, including community health workers. Such reciprocity lets providers receive a Massachusetts license and provide care to Massachusetts residents both in-person and remotely via telemedicine where appropriate.

22. Regarding provider reimbursement for telemedicine, can insurers pay less for a telemedicine visit than for an in-office visit? Can Medicaid lower provider reimbursement for telemedicine? Can states require fees to be the same?

Medicaid programs have more flexibility to proceed without special federal approval if rates are the same for telemedicine and in-person visits. If a state wants to pay less for telemedicine, it must submit a SPA. [More details](#) are available from CMS.

Telemedicine payment parity ensures that providers receive the same reimbursement for telehealth visits and office visits. Without state laws or regulations requiring payment parity, health plans can pay less for telehealth visits than for office visits. At this time, [33 states](#) require payment parity in Medicaid, and [34 require it for private coverage](#). More [detailed information about state laws and regulations governing telemedicine](#) in Medicaid and private insurance markets is available from the Center for Connected Health Policy.

23. For those looking at telehealth, what systems or software programs are federally qualified health centers using for telehealth and teledentistry?

Families USA cannot make software or system recommendations, but the District of Columbia has suggested [telemedicine platforms](#) that are free or charge low prices.

As state and federal policy landscapes continue to shift, feel free to follow up. Please contact us at info@familiesusa.org if you have questions or thoughts to share as this work continues.

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