



Outlook: Phase 4 House Proposal and NCHC Recommendations

Public Memorandum

05/07/20

Table of Contents

Introduction and Chronology.....	1
Summary of anticipated House proposal for COVID-19 response.....	1
Summary of NCHC recommendations for next COVID-19 bill	3
Immediate priorities	3
Long-term recovery and preparedness.....	4

Introduction and Chronology

The CARES Act, (H.R. 748, *Coronavirus Aid, Relief, and Economic Security Act*) was signed into law on March 27. The CARES Act foremost provided financial relief to hospitals, small businesses, and individuals through direct payments. The CARES Act (“Phase 3”) also built on the previous “Phase 2” legislation, H.R. 6201, American Families First Coronavirus Act to expand the role of Medicaid, waive cost-sharing for essential COVID-19 testing, and other provisions across Medicare and commercial markets. See the previous [NCHC memo](#) for a summary of key CARES Act provisions, or Healthspieren’s [full summary](#).

The House plans to unveil a new “Phase 4” package next week (week of May 11), in response to calls for greater relief to health care stakeholders, small businesses, and individuals, particularly individuals that are losing health care coverage through their employers. Another disturbing trend, hopefully to be addressed in the next COVID-19 package is the dire impact on primary care and independent physicians, which has substantial implications for cost and access in the wake of COVID-19, either through small practices closing entirely or consolidating with larger systems.

Summary of anticipated House proposal for COVID-19 response

Although specific details have yet to be released, news from the Hill indicates that the House is actively working on the next bill, to be released next week. Broadly, we anticipate the bill will be a similar proposal to the original H.R. 748 proposed the Monday before CARES Act was passed – a number of the health provisions were not taken up in the final Senate version – with a few additional policies that often mirror 2009 economic recovery bills. The main proposals include:



- **Expanding Medicaid** – the previous House proposal included an incentive for states to expand Medicaid (return FMAP to 100% for expansion populations in states that decide to expand). We anticipate similar provisions will carry over.
- **Increase Medicaid Matching To 12%** -- related, stakeholders such as [the National Governor's Association](#) and other bipartisan groups have called for increases to Medicaid FMAP during the public health emergency or some other duration, similar to the 2009 American Recovery and Reinvestment Act in the wake of the 2008 financial crisis.
- **Special Enrollment Period (SEP)** for federally facilitated exchanges – [while many states have done so for their own exchanges](#), thus far the administration has not been receptive to a new SEP for people in states who receive coverage through federally facilitated exchanges. The proposed SEP would likely cover the extent of the public health emergency and allow people who are currently uninsured (in addition to those who lose job-based coverage) to apply for new coverage. Some advocates would want this SEP to be automatically triggered by a public health emergency declaration.
- **Reinstate Risk Corridors Or Reinsurance Program For COVID-19 Expenses** – Although costs for major commercial health plans are [down](#), uncertainty about future costs could lead to premium increases in the commercial market or Medicare Advantage. Policymakers have been discussing whether a one- or two-sided risk corridor, or a reinsurance program, would stabilize premiums post-COVID. Given the low costs that health plans are facing, MLR rebates are possible.
- **Waive Cost-Sharing for Treatment** – the Families First Coronavirus Response Act and CARES Act did include provisions to waive cost-sharing for COVID-19 testing. However, these bills did not extend cost-sharing waivers across Medicare and Medicare Advantage, commercial, and Medicaid *for treatment* of COVID-19. Although [private plans](#) in Medicare Advantage and commercial market have done so, this is not the case universally, nor across Medicare fee-for-service or Medicaid. Nearly 6 Million beneficiaries in Medicare do not have supplemental coverage, which could lead to [\\$1,400 or more](#) in out-of-pocket expenses for hospitalization related to COVID-19.
- **COBRA Subsidies** – there has long been [discussion](#) of issuing subsidies for COBRA, including a bill released in mid-April ([H.R. 6514](#), *Worker Health Coverage Protection Act*). COBRA can expose people who have been laid off or furloughed to unaffordable coverage costs without employer contributions. [Similar provisions](#) were included in the American Recovery and Reinvestment Act of 2009. Speaker Pelosi indicated this was a top priority, in conjunction with further paycheck protection relief for maintaining employment in the first place.



- **Increase State and Local Aid** – similar stakeholders have requested [additional aid](#) to states to bolster community health workers, contact tracing, public health infrastructure, and shore up significant revenue declines.

Summary of NCHC recommendations for next COVID-19 bill

The final CARES Act left out provisions we highlighted in our letters to Congress on [March 19](#) and [April 6](#). We will urge Congress to consider these provisions in future COVID-19 legislation, to mitigate the short- and long-term impacts of COVID-19.

Immediate Priorities:

- **Ban Surprise Billing for COVID-19 Testing and Treatment** – in our letters to Congress, NCHC highlighted the need to make clear that out-of-network, surprise medical bills should be prohibited during the COVID-19 outbreak, at least with respect to COVID-19 testing **and treatment**. Waiving cost-sharing for testing may not be sufficient to prevent the type of surprise bills that have been reported extensively in the last 18 months. Patients should be held harmless for seeking COVID-19 care immediately, including protection against surprise medical bills related to COVID-19 related testing such as influenza test. We also urge Congress to take this opportunity to find a compromise on surprise billing for all services.
- **Direct Financial Assistance For Non-Hospital Based, Primary Care Providers** – the CARES Act provides significant relief to hospitals, which has been distributed over the last month, but does little to address independent physicians and primary care providers facing a [significant disruption to outpatient visits](#). Given commonly cited recommendations to first contact your primary care physician if you develop symptoms, America's family physicians are on the frontlines of the COVID-19 outbreak as well. The Primary Care Collaborative [survey](#) indicates that financial strain on primary care practices is impacting their ability to keep their doors open in the coming weeks, which may have long-term impacts on the health care system beyond COVID-19. Current capitation and fee-for-service rates will not sufficiently compensate these critical professionals in the short term.
- **Enhance Medicaid FMAP and Eligibility** – Lack of coverage poses a significant risk to the public health of this country as the uninsured population is far less likely to seek testing and treatment. Reducing financial barriers via cost-sharing would only impact those who have coverage already. We encourage lawmakers to increase FMAP to 12%, aligned with recommendations from other stakeholders, to improve immediate response. Further, the CARES Act does not include a provision to extend eligibility for Medicaid 30 days prior to release for incarcerated individuals. The justice involved population are significantly more likely to have and to spread infectious diseases, within and outside correctional facilities, and a gap in coverage for those already eligible for Medicaid can pose a significant risk to the public's health and exacerbate underlying social determinants of health that have led to massive racial disparities in COVID-19 mortality.
- **Waive Cost-Sharing for Seeking COVID-19 Treatment** – The CARES Act focuses on costs associated with testing for COVID-19 but does not comprehensively or clearly waive treatment



costs associated with COVID-19 or its complications. Given the stage of the disease spread, there is an immediate public health imperative to unequivocally signal that patients will not be responsible for cost-sharing associated with testing or treatment of COVID-19. We applaud private efforts from health plans like Humana, Cigna, and UnitedHealth to do so without Congressional action. Furthermore, such changes should extend beyond federal programs and should also include individual market plans, plans regulated by ERISA, short-term limited-duration plans, governmental plans, association health plans, and other forms of health coverage.

- **Ensure Continuity of Coverage:**

- a. **Open A Special Enrollment Period for Federally Facilitated Exchanges** to ensure those without insurance or who fall through the cracks of existing enrollment periods after losing their job can seek already subsidized insurance options on the individual market.
- b. **Implement COBRA Subsidies** to ensure people who have job-based coverage can afford to maintain their coverage.
- c. **Increase Health Plan Flexibility To Delay Coverage Termination On The Exchanges** – The Affordable Care Act requires health plans offering insurance on the Exchanges to terminate coverage for enrollees who miss premium payments within 90 days, and are not allowed to re-enroll those enrollees for the rest of the year. Given the extensive economic consequences of COVID-19, including lost wages and unemployment, we urge Congress to extend the 90-day grace period for both subsidized and unsubsidized consumers to improve continuity of coverage during this crisis. Health plans should be given the flexibility to retain these enrollees throughout the National Emergency Declaration and for consumers to reinstate their coverage.
- d. **Ensure Individual Market Stability** – health insurance companies have benefited thus far from lower costs due to fewer elective procedures and people avoiding routine care, which will have mixed effects on health costs post-COVID. Uncertainty could lead to premium increases, which can be mitigated by implementing a federal risk corridor or reinsurance program. A federal reinsurance program, during or after COVID-19 emergency, would put downward pressure on marketplace premiums for those not currently enrolled or those enrolled without subsidies, who tend to find individual coverage unaffordable already.

Long-term Recovery and Preparedness:

- **Reform Prescription Drug Pricing** – We applaud legislation waiving Part B cost-sharing for COVID-19 vaccinations, which will improve access. Phase 4 legislation could also include critical, and broader, drug pricing reform proposals such as the Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, passed by the House in 2019, or the Prescription Drug Pricing Reduction Act (PDPRA) which will lower prices and improve market-based competition. Reasonable drug pricing legislation is an important component of the COVID-19 response



because the gap between what everyday Americans can afford and out-of-pocket costs will continue to widen as the current COVID-19 economic retraction continues. Unsustainably high prices are a threat to our economic and public health recovery.

- **Increase Medicaid Funding to Encourage States to Expand** – The original House proposal for CARES Act included a larger role for Medicaid to reduce the spread of COVID-19 and mitigate the economic downturn. The House bill would increase FMAP to 2014 levels (100%) for the expansion population and automatically bump FMAP for the traditional population as a state’s unemployment increases. In our letter to Congress we asked lawmakers to do so and go even further to extend presumptive eligibility and retroactive coverage during national emergencies.
- **Increase Funding for Public Health Infrastructure** – In the short run, the public health infrastructure in the United States is or will quickly be overstretched. We urge Congress to substantially increase funding for state and local health department personnel to fill in current crisis needs, with a plan to keep these employees to expedite future pandemic responses. Funding and personnel are key to monitoring diseases, and any policymaking in the face of an infectious disease is slowed without the ability to gather, share, and process data. We also urge Congress to create a CDC grant program to allow for better coordination and information flow between local public health departments, state health departments, and schools.
- **Bolster Community Health Center (CHC) Funding** – Community health centers provide critical services to millions of low-income Americans and will serve as a crucial safety net provider for patients with COVID-19. We applaud Congress extending CHC funding in CARES Act, but the additional funding was insufficient to meet frontline needs. We recommend an additional \$76 Billion in CHC funding to ensure that safety net providers have the resources they need to mitigate the disproportionate effect the virus is having on low-income communities.
- **Establish Medicaid to Medicare Payment Parity for Primary Care** – Congress could reinstate payment policies that elevate Medicaid payment rates for all evaluation and management services provided by family physicians and other primary care clinicians to Medicare levels. Medicaid beneficiaries are among the most vulnerable and this policy will ensure that they have access to the primary care system, especially during national emergencies
- **Examine which Medicare Telehealth Flexibilities to Extend Beyond Emergency period** – Telehealth services address gaps in access to health care for rural and underserved populations, which will continue to persist after the emergency declaration. Telehealth also allows providers to use resources more efficiently. We urge Congress to direct the Secretary of Health and Human Services to examine which temporary flexibilities should remain post-COVID-19.
- **Expand Funding for Social Services, Beyond the American Families First Coronavirus Act** – COVID-19 is likely to undermine social safety net programs and further exacerbate disparities. A comprehensive package to address the economic and health consequences of the pandemic



should include expanded funding for programs that provide housing and other direct assistance to vulnerable populations. We applaud the inclusion of SNAP funding in the bill passed by the Senate on March 18.

- **Fund Mental Health Services to Address Social Isolation and Loneliness** – We urge Congress to consider additional federal funding streams to address social isolation and loneliness as we continue to practice social distancing and, later, recover from the losses suffered. Congress could institute an Inter-Departmental and Agency National Coordinator of Social Isolation and Loneliness to lead and coordinate administrative efforts, identify and leverage current federal resources, and make recommendations to cabinet officials and the White House to address the emerging epidemic of health consequences as the result of isolation.
- **Strengthen the Supply Chain for Generics and Biosimilars To Prevent Future Shortages of Affordable Medications** – Nine out of ten prescriptions in the United States are filled as generics. [During a pandemic](#), consumers should be able to rely on continued access to affordable medications, many of which are critical for people with chronic conditions or disabilities. While NCHC does not support the administration’s proposed “Buy American” executive order, Congress could work with generic medicine manufacturers to improve supply chain readiness for future pandemics and other national emergencies.