

Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127

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The global pandemic of Coronavirus Disease 2019 (COVID-19) is affecting communities around the world and throughout the United States, with case counts growing daily. Containment and mitigation efforts by federal, state, and local governments have been undertaken to “flatten the curve”—that is, to slow widespread transmission that could overwhelm the nation’s health care system.

The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) was enacted on March 18, 2020. It is the second of three comprehensive laws enacted in March specifically to support the response to the pandemic.

The FFCRA, among other things, increases appropriations to the Department of Defense, the Indian Health Service, the Department of Health and Human Services Public Health and Social Services Emergency Fund, and the Veterans Health Administration for testing and ancillary services associated with the SARS-Co V-2 virus, that virus that causes COVID-19 disease. Beginning on the date of enactment through any portion of the COVID-19 public health emergency (declared pursuant to Section 319 of the Public Health Service Act), the FFCRA provides payment for or requires coverage of testing for the COVID-19 virus, and items and services associated with such testing, such as supplies and office visits, without any cost sharing, for individuals who are covered under Medicare, including Medicare Advantage, traditional Medicaid, CHIP, TRICARE, Veterans health care, the Federal Employees Health Benefits (FEHB) Program, most types of private health insurance plans, the Indian Health Service, and individuals who are uninsured (as defined under FFCRA). It prohibits private health insurance plans and Medicare Advantage plans from employing utilization management tools, such as prior authorization, for the COVID-19 test, or the visit to furnish it.

In addition, FFCRA provides for an increase to all states, the District of Columbia, and territories in the share of Medicaid expenditures financed by the federal government, subject to specific requirements. It provides additional Medicaid funding to territories. FFCRA modifies requirements related to waiving certain Medicare telehealth restrictions during the emergency. Finally, FFCRA waives liability, with a narrow exception, for manufacturers, distributors, or providers of specified respiratory protective devices used for COVID-19 response.

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Sarah A. Lister,
Coordinator

Specialist in Public Health
and Epidemiology

Paulette C. Morgan,
Coordinator

Specialist in Health Care
Financing

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Introduction

The global pandemic of Coronavirus Disease 2019 (COVID-19) is affecting communities around the world and throughout the United States, with case counts growing daily. Containment and mitigation efforts by federal, state, and local governments have been undertaken to “flatten the curve”—that is, to slow widespread transmission that could overwhelm the nation’s health care system.¹

The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) is the second of three comprehensive laws enacted specifically to support the response to the pandemic. The first law, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020, provides roughly \$7.8 billion in discretionary supplemental appropriations to the Department of Health and Human Services (HHS), the Department of State, and the Small Business Administration.² The law also authorizes the HHS Secretary to temporarily waive certain telehealth restrictions to make telehealth services more available during the emergency.³ The third law, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), was enacted on March 27, 2020. In addition to a number of economic stimulus and other provisions, the CARES Act provides payment for or requires coverage of a COVID-19 vaccine, when available, for federal health care payment and services programs and most private health insurance plans; it also provides appropriations to continue support for federal, state, and local public health efforts, and for federal purchase of COVID-19 vaccines. The act also appropriates a \$100 billion “Provider Relief Fund” to assist health care facilities and providers facing revenue losses and uncompensated care as a result of the pandemic.⁴

This CRS report describes the health provisions included in FFCRA as of the date of enactment, including relevant background information. Other divisions in the law contain provisions regarding HHS social services programs, federal nutrition programs, and other matters that are not within the scope of this CRS report. Other CRS reports summarize the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020,⁵ and the CARES Act, and will link to this report as they become available. *Some provisions described in this report have been amended by the CARES Act, and in such cases, footnotes reference the relevant CRS expert who can answer questions about the amendments.* This report will not otherwise be updated or changed to reflect subsequent congressional or administrative action related to the FFCRA health provisions. The **Appendix** contains a list of CRS experts for follow-up on further developments.

¹ For an overview of domestic COVID-19 health response efforts and a compilation of federal agency websites, see CRS Insight IN11253, *Domestic Public Health Response to COVID-19: Current Status and Resources Guide*.

² CRS Report R46285, *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123): First Coronavirus Supplemental*, and CRS Insight IN11236, *Oversight Provisions in H.R. 6074, the Coronavirus Preparedness and Response Supplemental Appropriations Act*.

³ CRS Report R46239, *Telehealth and Telemedicine: Frequently Asked Questions*.

⁴ For more information on this fund, see Health and Human Services (HHS), “CARES Act Provider Relief Fund,” April 10, 2020, <https://www.hhs.gov/provider-relief/index.html>.

⁵ CRS Report R46285, *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123): First Coronavirus Supplemental*.

FFCRA Overview

Legislative History⁶

On March 14, 2020, the House amended and passed H.R. 6201, the Families First Coronavirus Response Act, by a vote of 363–40. The House considered the measure under the suspension of the rules procedure, a process that allows for expedited consideration of measures that enjoy overwhelming support. The measure had been introduced on March 11, 2020, and referred to the Committee on Appropriations as the primary committee, as well as to the Committee on the Budget and the Committee on Ways and Means. The committees took no formal action on the legislation; the suspension of the rules procedure allows the House to take up a measure (even one in committee), amend it, and pass it, all with a single vote. To suspend the rules and pass the bill requires the support of two-thirds of those voting.⁷

On March 16, 2020, the House (by unanimous consent) considered and agreed to a resolution (H.Res. 904) that directed the Clerk to make changes to the legislation when preparing the final, official version of the House-passed bill. The process of preparing this version is called “engrossment.”⁸ The engrossed version was sent to the Senate. The Senate considered the bill under the terms of a unanimous consent agreement that allowed for the consideration of three amendments and required the support of 60 Senators to approve any amendment and for final passage of the bill. The Senate did not agree to any of the amendments but passed the bill, 90–8, on March 18, 2020. The President signed the bill into law the same day. It became P.L. 116–127.

Provisions in Brief

The Families First Coronavirus Response Act, among other things, increases appropriations to the Department of Defense, Indian Health Service (IHS), HHS, and Veterans Health Administration for testing and ancillary services associated with the SARS-CoV-2 virus, or COVID-19.⁹

Through several provisions in FFCRA Divisions A and F, the act provides payment for or requires coverage of testing for the COVID-19 virus, along with items and services associated with such testing, such as supplies and office visits, without any cost sharing, for individuals who are covered under Medicare, including Medicare Advantage, traditional Medicaid, the State Children’s Health Insurance Program (CHIP), TRICARE, Veterans health care, the Federal Employees Health Benefits (FEHB) Program, most types of private health insurance plans, the IHS, and for individuals who are uninsured (as defined under FFCRA). These coverage provisions are effective beginning on the date of enactment through any portion of the COVID-19 public health emergency (declared pursuant to Section 319 of the Public Health Service Act). The FFCRA prohibits private health insurance plans and Medicare Advantage plans from employing utilization management tools, such as prior authorization, for the COVID-19 test, or the visit to furnish it. FFCRA provides for an increase to all states, the District of Columbia, and territories in the share of Medicaid expenditures financed by the federal government, subject to specific

⁶ Section written by Elizabeth Rybicki, Specialist in Congress and the Legislative Process.

⁷ CRS Report 98-314, *Suspension of the Rules in the House: Principal Features*.

⁸ CRS Report 98-826, *Engrossment, Enrollment, and Presentation of Legislation*.

⁹ SARS-Co V-2 is the technical name for the virus that causes Coronavirus Disease 2019 (COVID-19). COVID-19 is also used to refer to the outbreak, which has been determined to be a pandemic, affecting or potentially affecting all of the world.

requirements. It provides additional Medicaid funding to territories. FFCRA modifies requirements related to waiving certain Medicare telehealth restrictions during the emergency. Finally, it waives liability, with a narrow exception, for manufacturers, distributors, or providers of specified respiratory protective devices used for COVID-19 response.

The Congressional Budget Office and the Joint Committee on Taxation provided a *preliminary* estimate of the budget effects of the Families First Coronavirus Response Act.¹⁰ Overall, the act is estimated to increase discretionary spending by \$2.4 billion from emergency supplemental appropriations, to increase mandatory outlays by \$95 billion, and to decrease revenues by \$94 billion. These estimates are based on assumptions about the severity and duration of the pandemic, and they may vary substantially from final estimates to be provided later this year. Discretionary spending totals and CBO's estimates of mandatory outlays for health care programs in Division F are provided in the "Summaries of Provisions" section.

Key Definitions

Several key terms are referred to repeatedly throughout this report: emergency period, COVID-19 testing and testing-related items and services, and uninsured individuals. This section provides the technical definitions for those terms.

Duration of Emergency Period

Several provisions in Division F define the effective period of the authorized activity as "the emergency period defined in paragraph (1)(B) of section 1135(g)," or comparable construction, referring to a paragraph in Section 1135 of the Social Security Act (SSA). Section 1135 allows the Secretary of Health and Human Services (HHS Secretary) to waive specified requirements and regulations to ensure that health care items and services are available to enrollees in the Medicare, Medicaid, and CHIP programs during emergencies.¹¹ Paragraph (1)(B) of SSA Section 1135(g) refers to "the public health emergency declared with respect to the COVID-19 outbreak by the Secretary on January 31, 2020,"¹² pursuant to section 319 of the Public Health Service Act [PHSA]."¹³ *Hence, the referenced emergency period in provisions in Division F is the period during which this particular Section 319 public health emergency declaration—whether initial or renewed—is in effect.*¹⁴

¹⁰ For the complete preliminary cost estimate, see https://www.cbo.gov/publication/56316?utm_source=feedblitz&utm_medium=FeedBlitzEmail&utm_content=812526&utm_campaign=Express_2020-04-02_18:30&utm_medium=FeedBlitzEmail&utm_content=812526&utm_campaign=Express_2020-04-02_18:30.

¹¹ Social Security Act (SSA) Section 1135 (42 U.S.C. §1320b-5), "Authority to Waive Requirements during National Emergencies," https://www.ssa.gov/OP_Home/ssact/title11/1135.htm.

¹² The determination was made retroactive to January 27, 2020. HHS, "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," January 31, 2020, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>.

¹³ 42 U.S.C. §247d. The "Section 319" authority allows the HHS Secretary to implement another specified set of actions to address public health emergencies. For more information, see HHS, "Public Health Emergency Declaration," <https://www.phe.gov/Preparedness/legal/Pages/phedecoration.aspx>.

¹⁴ An emergency determination under Section 319 terminates after 90 days, unless terminated earlier by the HHS Secretary, and is renewable for additional 90-day periods. 42 U.S.C. §247d(a). Section 319 emergencies declared in response to the 2009 H1N1 influenza pandemic and the 2016-2017 Zika virus outbreak were each renewed several times. HHS, "Public Health Emergency Declarations," <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>.

However, while most Division F provisions are effective during any portion of the emergency period described above, those provisions *became effective as of the date of enactment of FFCRA*, March 18, 2020, even though the emergency period began earlier. Division F provisions with different effective dates are so noted in the descriptions of the sections below.

Definitions of COVID-19 Testing and Related Services

Through several provisions in FFCRA Divisions A and F, the act provides payment for or requires coverage of testing for the COVID-19 virus, and items and services associated with such testing, such as supplies and office visits, without cost sharing.¹⁵ These coverage requirements apply to individuals who are covered under Medicare, traditional Medicaid, CHIP, TRICARE, Veterans health care, FEHB, the IHS, most types of private health insurance plans, and individuals who are uninsured (as defined below).

COVID-19 Testing

Provisions in Division F refer to COVID-19 testing in several ways:

- “In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act [FFDCA]”;
- “COVID-19 related items and services”;
- “in vitro diagnostic products”;
- “clinical diagnostic lab tests”; and
- “any COVID-19 related items and services.”

COVID-19 stands for Coronavirus Disease 2019, the name of the pandemic disease. *SARS-CoV-2* is the scientific name of the virus that causes COVID-19. Diagnostic testing identifies the presence of the virus, which, in conjunction with clinical signs and symptoms, informs the diagnosis of COVID-19.

In Vitro Diagnostics (IVDs) are medical devices used in the laboratory analysis of human samples, including commercial test products and instruments used in testing. IVDs may be used in a variety of settings, including a clinical laboratory, a physician’s office, or in the home. IVDs are defined in FDA regulation as a specific subset of devices¹⁶ that include “reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions ... in order to cure, mitigate, treat, or prevent disease ... [s]uch products are intended for use in the collection, preparation, and examination of specimens taken from the human body.”¹⁷ As indicated by this definition, an IVD may be either a complete test or a component of a test, and in either case, the IVD comes under FDA’s regulatory purview. FDA premarket review of IVDs may include

¹⁵ The definition of the testing services that must be covered has been amended by the CARES Act (P.L. 116-136). Thus, the definition described here, from Division F, Section 6001 of FFCRA, no longer reflects current law. Congressional clients may contact author Amanda Sarata with questions.

¹⁶ As defined in FFDCA Section 201(h); 21 U.S.C. §321(h).

¹⁷ 21 C.F.R. §809.3(a).

Premarket Approval (PMA);¹⁸ notification and clearance (510(k));¹⁹ authorization pursuant to de novo classification;²⁰ or authorization for use in an emergency pursuant to an Emergency Use Authorization (EUA)²¹ based on circumstances (e.g., a public health emergency determination) and the risk the device poses.

Although the terms and definitions used to refer to COVID-19 testing vary throughout FFCRA, they do not necessarily reflect actual differences in the types of tests and ancillary services that are or must be covered. Some of these definitions and terms were amended in the CARES Act.²² *In summarizing FFCRA provisions in this CRS Report, mention of any of these definitions of a COVID-19 test, as described above, is referred to as “COVID-19 testing.”*²³

Testing-Related Items and Services

Sections in FFCRA Divisions A and F that refer to COVID-19 testing generally also refer to health care items and services furnished in relation to testing, such as supplies and office visits, although definitions vary. FFCRA Section 6001(a)(2) defines these ancillary services, in the context of private health insurance coverage, as

[i]tems and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

This definition could encompass additional diagnostic testing associated with the visit, which may include additional laboratory tests and imaging studies. *However, it would not encompass treatment for COVID-19 illnesses.* See the “Section 6001. Coverage of Testing for COVID-19” section below regarding enforcement and implementation of this section’s provisions.

Applicable References

Provisions in Division F that use language discussed above, comparable construction, or cross-reference, are as follows:

- Section 6001(a)(1)-(2), regarding specified types of private health insurance coverage.²⁴
- Section 6004(a)(1)(C), which amends SSA Section 1905(a)(3) regarding Medicaid medical assistance, and Section 6004(a)(2), which amends SSA Sections 1916 and 1916A regarding Medicaid cost-sharing. Both provisions refer to SSA Section 1905(a)(3), as amended.

¹⁸ FFDCA Section 515 (21 U.S.C. §360e); 21 C.F.R. Part 814.

¹⁹ FFDCA Section 510(k); 21 U.S.C. §360(k).

²⁰ FFDCA Section 513(f)(2); 21 U.S.C. §360c(f)(2).

²¹ FFDCA Section 564; 21 U.S.C. §360bbb-3. For information on the EUA authority, see CRS In Focus IF10745, *Emergency Use Authorization and FDA’s Related Authorities*.

²² Congressional clients may contact author Amanda Sarata with questions.

²³ See footnote 15.

²⁴ The definition of testing services that must be covered, at Section 6001(a)(1) of FFCRA, was amended by the CARES Act. Thus, the definition described here, from Division F, Section 6001 of FFCRA, no longer reflects current law. Congressional clients may contact author Amanda Sarata with questions.

- Section 6004(b)(1), which amends SSA Section 2103(c), regarding CHIP child coverage, and Section 6004(b)(2), which amends SSA Section 2112(b)(4), regarding CHIP pregnant women coverage. Both provisions reference SSA Section 1905(a)(3), as amended.
- Section 6006, regarding TRICARE, veterans health care, and federal civilian employee health coverage (FEHB), each referencing FFCRA Section 6001(a)(1)-(2).
- Section 6007, regarding IHS referencing FFCRA Section 6001(a)(1)-(2).

In addition, appropriations provided in FFCRA Division A to the Defense Health Program, Veterans Health Administration, IHS, and the HHS Public Health and Social Services Emergency Fund are to be used, in whole or in part, to pay for COVID-19 testing and related services, with reference to Section 6001(a) of the act. However, Division F sections pertaining to Medicare, Medicare Advantage, and the Medicaid and CHIP programs do not reference FFCRA Section 6001(a)(1)-(2) with respect to the definition of COVID-19 tests, administration of the tests, or related items and services, but rather amend the Social Security Act directly to require coverage of these things.

Definition of the Uninsured

Two provisions in FFCRA facilitate access to COVID-19 testing for “uninsured individuals”: Division A, Title V, and Division F, Section 6004. Title V provides funding to the National Medical Disaster System (NDMS) that can be used to reimburse health care providers for costs related to COVID-19 testing for uninsured individuals, as defined in that section (and as explained below). Section 6004 provides states an option to use Medicaid as a vehicle to provide COVID-19 testing without cost to uninsured individuals, as defined in that section. The respective definitions of uninsured individuals are similar but not identical.

In Title V, “uninsured individual” means an individual who is *not* enrolled in coverage in any of the following three categories:

- **A federal health care program, as defined:**²⁵ This includes but is not limited to Medicare, Medicaid, CHIP, TRICARE, and the VA health care system.
- **Most types of private health insurance plans:** This includes individual health insurance coverage and group plans, whether fully insured or self-insured. The explanation of these coverage types and the applicability of Section 6001 to them also apply to this provision.
- **The Federal Employees Health Benefits (FEHB) Program:** See the “Section 6006. Application with Respect to TRICARE, Coverage for Veterans, and Coverage for Federal Civilians” section below for background on FEHB.

²⁵ A federal health care program, as defined under SSA Section 1128B(f), is “any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (except for the Federal Employees Health Benefits Program).” See Department of Health and Human Services, Office of the Inspector General, “Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs,” May 8, 2013, at <https://oig.hhs.gov/exclusions/advisories.asp>. Although the Indian Health Service is a federally funded program that provides and in some instances pays for health services, it is not clear whether the term “federal health care program” includes IHS, because guidance about federal health programs generally does not explicitly mention the agency.

In other words, individuals enrolled in coverage in one of these three categories are considered insured and are not eligible for the testing assistance described in Title V. Note that individuals with certain types of private coverage may be considered uninsured, due to the coverage definitions cited. The definition of individual health insurance coverage does not include a type of coverage called short-term, limited duration insurance (STLDI) (see “Section 6001. Coverage of Testing for COVID-19”). Thus, individuals with STLDI appear to be considered uninsured for the purpose of eligibility for assistance under Title V.²⁶

Section 6004 includes additional groups in the definition of “uninsured individual” that applies under such sections.²⁷ Specifically, for the purposes of Section 6004, uninsured individuals are defined as those who are not enrolled in (1) a federal health care program, as defined; (2) a specified type of private health insurance plan; or (3) FEHB. Such individuals are also not Medicaid-eligible under one of Medicaid’s mandatory eligibility pathways (e.g., the poverty-related pregnant women and child pathways, or the Medicaid expansion pathway under the Patient Protection and Affordable Care Act [ACA; P.L. 111-148, as amended]). The first three categories are defined and referenced the same way in Section 6004 as they are in Title V, although wording and punctuation differ slightly. See the discussion of Section 6004 in this report for more information about the additional criteria related to COVID-19 testing without cost-sharing under Medicaid.

Summaries of Provisions

Division A—Second Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

This section describes the health care-related supplemental appropriations in FFCRA Division A for the Defense Health Program, the Veterans Health Administration, and HHS accounts, and applicable general provisions. All such appropriations are designated as an emergency requirement and, as a result, are not constrained by the statutory discretionary spending limits (often referred to as budget caps).²⁸

Title II: Department of Defense, Defense Health Program

The Defense Health Program (DHP) is an account in the Department of Defense budget that funds various functions of the Military Health System.²⁹ These functions include the provision of

²⁶ For more information about short-term, limited duration insurance (STLDI), see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*. Congressional clients may contact author Vanessa Forsberg with questions about the applicability of FFCRA’s definition(s) of “uninsured individuals” to other types of coverage discussed in that report.

²⁷ The definition of uninsured individuals (for purposes of this section) was amended by the CARES Act to include individuals who are eligible for Medicaid via the ACA Medicaid expansion eligibility pathway in non-ACA Medicaid expansion states, and certain specified Medicaid enrollees who by virtue of their Medicaid eligibility pathway are entitled to limited Medicaid benefits (e.g., certain low-income pregnant woman who are entitled to limited pregnancy-related services, low-income TB-infected individuals who are entitled to services related to the TB infection, and individuals eligible only for family planning services and supplies). Congressional clients may contact Evelyn Baumrucker with questions.

²⁸ For more information on budget caps and emergency designation, see CRS Report R45778, *Exceptions to the Budget Control Act’s Discretionary Spending Limits*.

²⁹ For more on the Military Health System, see CRS In Focus IF10530, *Defense Primer: Military Health System*.

health care services, certain medical readiness activities, expeditionary medical capabilities, education and training programs, medical research, management and headquarters activities, facilities sustainment, procurement, and civilian personnel. For FY2020, Congress appropriated \$34.4 billion to the DHP.³⁰

FFCRA appropriates an additional \$82 million to the DHP for COVID-19 testing, administration of the test, and related items and services outlined in FFCRA Section 6006(a). (For a summary of this section, see “Definitions of COVID-19 Testing and Related Services” and “Section 6006. Application with Respect to TRICARE, Coverage for Veterans, and Coverage for Federal Civilians.”) The additional funds are designated as emergency spending and are to remain available until September 30, 2022.

Title IV: Department of Health and Human Services, Indian Health Service

The IHS within HHS is the lead federal agency charged with improving the health of American Indians and Alaska Natives. In FY2019, IHS provided health care to approximately 2.6 million eligible American Indians/Alaska Natives.³¹ IHS’s FY2020 appropriation was \$6.1 billion, with \$4.3 billion appropriated to the Indian Health Services account, which supports the provision of clinical services and public health activities.³² The services provided at IHS facilities vary, with some facilities providing inpatient services, laboratory testing services, and emergency care, while others focus on outpatient primary care services. IHS does not offer a standard benefit package, nor is it required to cover certain services within its facilities or when it authorizes payment for services to its beneficiaries outside of the IHS system (see “Section 6007. Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care”).

FFCRA appropriates an additional \$64 million for COVID-19 testing, administration of the test, and related items and services as specified in FFCRA Section 6007. (See “Definitions of COVID-19 Testing and Related Services” and “Section 6007. Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care.”) The section also specifies that the additional funds are to be allocated at the discretion of the IHS director.³³ The additional funds are designated as emergency spending and are to remain available until September 30, 2022.

Title V. Department of Health and Human Services, Public Health and Social Services Emergency Fund

There is no federal assistance program designed purposefully to pay the uncompensated costs of health care for the uninsured and underinsured necessitated by a public health emergency or

³⁰ Department of Defense (DOD), “Defense Budget Overview,” February 2020, p. 2-4, https://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2021/fy2021_Budget_Request_Overview_Book.pdf. For FY2020, Congress appropriated DHP funds in Title VI—Other Department of Defense Programs and Title IX—Overseas Contingency Operations of the Defense Appropriations Act, 2020, which was incorporated into the Consolidated Appropriations Act, 2020 (P.L. 116-93).

³¹ HHS, Indian Health Service (IHS), FY2021, “Justification of Estimates for Appropriations Committees,” https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf.

³² P.L. 116-94, Division D, Title III.

³³ IHS is headed by a Senate-confirmed director. The current head of IHS had been nominated as permanent director but has not been confirmed. See PN1250, Michael D. Weahkee, Department of Health and Human Services, <https://www.congress.gov/nomination/116th-congress/1250?s=2&r=1>.

disaster.³⁴ In general, there has been no consensus that doing so should be a federal responsibility. Nonetheless, Congress has provided appropriations for several limited mechanisms to address uncompensated health care costs in response to previous incidents.³⁵ The health care needs of uninsured and underinsured individuals and the financial pressures many individuals and their health care providers are facing during the COVID-19 outbreak have spurred congressional interest in these approaches. Among other forms of assistance, the CARES Act (P.L. 116-136) appropriates a \$100 billion “Provider Relief Fund” to assist health care facilities and providers facing revenue losses and uncompensated care as a result of the pandemic.³⁶

FFCRA uses the National Disaster Medical System (NDMS) Definitive Care Reimbursement Program³⁷ as the mechanism for federal payment for COVID-19 testing and related services for uninsured individuals. Historically, NDMS has paid for health care items and services at between 100% and 110% of the applicable Medicare rate, and the Centers for Medicare & Medicaid Services (CMS) has processed payments.

To fund this approach, FFCRA provides \$1 billion to the Public Health and Social Services Emergency Fund (PHSSEF), an account used in appropriations acts to provide the HHS Secretary with one-time or emergency funding, as well as annual funding for the office of the HHS Assistance Secretary for Preparedness and Response (ASPR). Covered COVID-19 testing, administration of the test, and related services are as defined in Subsection 6001(a) of the act. (See “Definitions of COVID-19 Testing and Related Services.”) An uninsured individual is defined, for purposes of this section, as someone who is not enrolled in (1) a federal health care program, as defined; (2) a specified type of private health insurance plan; or (3) FEHB. (See “Definition of the Uninsured” for more information.) The additional funds are designated as emergency spending and are to remain available until expended.

Title VI. Department of Veterans Affairs, Veterans Health Administration

The Veterans Health Administration (VHA) of the Department of Veterans’ Affairs (VA) provides health care to eligible veterans and their dependents who meet certain criteria as authorized by law.³⁸ The VHA is funded through five appropriations accounts: (1) medical services, (2) medical community care, (3) medical support and compliance, (4) medical facilities, and (5) medical and prosthetic research. The first four accounts provide funding for medical care for veterans.

FFCRA provides \$60 million in supplemental appropriations for FY2020 to the VHA—\$30 million for medical services and \$30 million for medical community care—for COVID-19

³⁴ In general, federal support for uncompensated care costs are limited; however, both Medicare and Medicaid may provide payments to hospitals to support some of the costs associated with the uncompensated care they provide. In addition, the federal government supports the Federal Health Center program, which provides grants to support uncompensated care at outpatient facilities. For more information, see CRS In Focus IF10918, *Hospital Charity Care and Related Reporting Requirements Under Medicare and the Internal Revenue Code*; CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*; and CRS Report R43937, *Federal Health Centers: An Overview*.

³⁵ See, for example, CRS Report R43139, *Federal Disaster Assistance After Hurricanes Katrina, Rita, Wilma, Gustav, and Ike*, and CRS Report 94-953, *Social Services Block Grant: Background and Funding*.

³⁶ For more information on this fund, see Health and Human Services (HHS), “CARES Act Provider Relief Fund,” April 10, 2020, <https://www.hhs.gov/provider-relief/index.html>.

³⁷ Department of Health and Human Services (HHS), Assistant Secretary for Preparedness and Response (ASPR), “NDMS Definitive Care Reimbursement Program,” <https://www.phe.gov/Preparedness/responders/ndms/definitive-care/Pages/default.aspx>. The National Disaster Medical System is authorized in Section 2812 of the Public Health Service Act, 42 U.S.C. §300hh–11.

³⁸ For more information, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

testing, administration of the test, and related items and services for visits for veterans.³⁹ (See “Definitions of COVID-19 Testing and Related Services” and “Veterans.”) The additional funds are designated as emergency spending and are to remain available until September 30, 2022.

Title VII. General Provisions, Division A

This title provides a reporting requirement (Section 1701)⁴⁰ which states that each amount appropriated or made available by Division A is in addition to amounts otherwise appropriated for the fiscal year involved (Section 1703), and that unless otherwise provided, appropriations in Division A are not available for obligation beyond FY2020 (Section 1704).

Title VII also includes Section 1702. *This section was repealed in its entirety by Section 18115 of the CARES Act (P.L. 116-136), which replaced it with a requirement for all laboratories carrying out COVID-19 testing to report testing data to HHS, as specified.* An explanation of the repealed provision is provided here, for completeness.

Section 1702: Repealed

Generally, laboratories report testing results for specified diseases and conditions (called *notifiable conditions*) directly to state or territorial (jurisdictional) health departments, pursuant to requirements in jurisdictional law. Through its National Notifiable Diseases Surveillance System (NNDSS), the HHS Centers for Disease Control and Prevention (CDC) works with jurisdictions and the Council of State and Territorial Epidemiologists (CSTE) to track national notifiable conditions, mostly infectious diseases and some noninfectious conditions (e.g., lead poisoning).⁴¹ Usually, such data are provided to CDC voluntarily. COVID-19 is a reportable disease in all reporting jurisdictions, and CDC receives data on COVID-19 cases and laboratory test results through NNDSS from all jurisdictions, as well as directly from some commercial laboratories. In addition, the FDA often includes, as a condition of an Emergency Use Authorization (EUA), the requirement that laboratories carrying out the EUA test comply with all relevant state and local reporting requirements.⁴²

FFCRA Section 1702 would have required all states and local governments receiving funding under Division A to report real-time and aggregated data on both testing (tests performed) and test results to the respective State Emergency Operations Center. These data would then have been transmitted to the CDC.

Division F—Health Provisions

This section describes all of the provisions included in FFCRA Division F. *Some provisions described below have been amended by the CARES Act; in such cases, footnotes reference the relevant CRS expert who can answer questions about the amendments. In some cases, the*

³⁹ For more information, see CRS Report R46280, *Department of Veterans Affairs’ Potential Role in Addressing the COVID-19 Outbreak*.

⁴⁰ For more information, see CRS Insight IN11271, *Congressional Oversight Provisions in P.L. 116-127, the Families First Coronavirus Response Act*.

⁴¹ CDC, “National Notifiable Diseases Surveillance System (NNDSS),” <https://wwwn.cdc.gov/nndss/>.

⁴² See for example, FDA, Letter of Authorization to Ipsum Diagnostics, LLC, April 1, 2020. “[The manufacturer] will ensure that the authorized laboratories using your product have a process in place for reporting test results to healthcare providers and relevant public health authorities, as appropriate,” <https://www.fda.gov/media/136618/download>.

amendments made by the CARES Act are substantial, in which case, the footnote may also provide a brief description of the amendment.

Section 6001. Coverage of Testing for COVID-19

Private health insurance is the predominant source of health insurance coverage in the United States. In general, consumers may obtain individual health insurance coverage directly from an insurer, or they may enroll in a group health plan through their employer or another sponsor. Group health plan sponsors may finance coverage themselves (self-insure) or purchase (fully insured) coverage from an insurer.⁴³

Covered benefits and consumer costs may vary by plan, subject to applicable federal and state requirements. The federal government may regulate all the coverage types noted above, and states may regulate all but self-insured group plans. Federal and state requirements may vary by coverage type. Some federal requirements apply to all coverage types noted above, while other federal requirements only apply to certain coverage types.⁴⁴

Prior to the enactment of FFCRA, there were no federal requirements specifically mandating private health insurance coverage of items or services related to COVID-19 testing.⁴⁵ In recent weeks, some states have announced relevant coverage requirements, and some insurers have clarified or expanded their policies to include relevant coverage.⁴⁶

FFCRA newly requires most private health insurance plans to cover COVID-19 testing, administration of the test, and related items and services (see “Definitions of COVID-19 Testing and Related Services”).⁴⁷ The coverage must be provided without consumer cost-sharing,

⁴³ Employers and other plan sponsors may purchase coverage from state-licensed health insurance issuers and offer it to their employees or other groups. Health plans obtained in this way are referred to as *fully insured*. Health insurance coverage provided through a group also may be self-insured. Employers or other plan sponsors that self-insure set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

⁴⁴ For more information about types of plans and regulation of them, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

⁴⁵ There is a federal requirement that certain plans cover a core set of 10 categories of *essential health benefits* (EHB). However, states, rather than the federal government, generally specify the benefit coverage requirements within those categories. On March 12, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a document stating that “EHB generally includes coverage for the diagnosis and treatment of COVID-19,” while also confirming that “exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered.” See *FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)* at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf>. *The information in that FAQ about COVID-19 testing may not reflect current law, given the subsequent enactment of FFCRA.*

⁴⁶ Several organizations are tracking these announcements by states and/or insurers. See, for example, the National Association of Insurance Commissioners (NAIC), at https://content.naic.org/naic_coronavirus_info.htm, and the Association of Health Insurance Plans (AHIP), at <https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/>.

⁴⁷ The definition of testing services that must be covered, at Section 6001(a)(1) of FFCRA, was amended by the CARES Act. Congressional clients may contact author Amanda Sarata with questions.

including deductibles, copayments, or coinsurance.⁴⁸ Prior authorization or other utilization management requirements are prohibited.⁴⁹

These requirements apply to individual health insurance coverage and to group plans, whether fully insured or self-insured. This includes plans sold on and off the individual and small group exchanges.⁵⁰ Per the definition of individual health insurance coverage cited in the act, the requirements do not apply to short-term, limited-duration plans.⁵¹

The requirements do apply to *grandfathered plans*, which are individual or group plans in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010), and that continue to meet certain criteria. Plans that maintain their grandfathered status are exempt from some federal requirements, but FFCRA specifies that Section 6001 applies to them.

The coverage requirements in this act apply only to the specified items and services that are furnished during the emergency period described in the act (see “Duration of Emergency Period”), as of the date of enactment (March 18, 2020).

Subsection (b) states that the Secretaries of HHS, Labor, and the Treasury are required to enforce this section’s provisions as if the provisions were incorporated into the PHSA, Employee Retirement Income Security Act (ERISA), and Internal Revenue Code (IRC), respectively. Subsection (c) states that those Secretaries also have authority to implement the provisions of this section “through sub-regulatory guidance, program instruction, or otherwise.”

CBO preliminarily estimates that Section 6001 will decrease federal revenues by \$4 million and increase federal outlays by \$7 million over the FY2020–FY2022 period.⁵²

Section 6002. Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19

Medicare Part B covers physicians’ services, outpatient hospital services, durable medical equipment, and other medical services. Most physicians, providers, and practitioners are subject to limits on amounts they can bill beneficiaries for covered services, and they can bill the beneficiary for only the 20% coinsurance of the Medicare payment rate plus any unmet deductible. Part B also covers outpatient clinical laboratory tests provided by Medicare-participating laboratories, such as certain blood tests, urinalysis, and some screening tests, including the test for the coronavirus that causes COVID-19. These services may be furnished by labs located in hospitals and physician offices, as well as by independent labs. Beneficiaries have no coinsurance, co-payments, or deductibles for covered clinical lab services.

⁴⁸ In general, private health insurance cost-sharing includes deductibles, coinsurance, and copayments. A deductible is the amount an insured consumer pays for covered health care services before coverage begins (with exceptions). Coinsurance is the share of costs, figured in percentage form, an insured consumer pays for a health service. Co-payment is the fixed dollar amount an insured consumer pays for a health service.

⁴⁹ For brief discussion of prior authorization and other utilization management requirements (medical management, as termed in FFCRA) that some insurers may use, see the appendix of CRS Report RL32237, *Health Insurance: A Primer*.

⁵⁰ The health insurance exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*. In general, small groups are those with 50 or fewer individuals (e.g., employees).

⁵¹ For more information about STLDI, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*. Congressional clients may contact author Vanessa Forsberg with questions about the applicability of FFCRA Section 6001 to other types of coverage discussed in that report.

⁵² See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

FFCRA eliminates the Medicare Part B beneficiary cost-sharing for provider visits during which a coronavirus diagnostic test is administered or ordered during the emergency period (see “Duration of Emergency Period”). Beneficiaries are not responsible for any coinsurance payments or deductibles for any specified COVID-19 testing-related service, defined as a medical visit that falls within the evaluation and management service codes for the following categories: office and other outpatient services; hospital observation services; emergency department services; nursing facility services; domiciliary, rest home, or custodial care services; home services; or online digital evaluation and management services.

The elimination of beneficiary cost-sharing for COVID-19 testing-related services applies to Medicare payment under the hospital outpatient prospective payment system, the physician fee schedule, the prospective payment system for federally qualified health centers, the outpatient hospital system payment system, and the rural health clinic services payment system. The HHS Secretary is to provide appropriate claims coding modifiers to identify the services for which beneficiary cost-sharing is waived. The HHS Secretary is allowed to implement this section by program instruction or otherwise.

CBO preliminarily estimates that enacting Sections 6002 and 6003 will increase direct spending by \$6.7 billion over the FY2020-FY2022 period.⁵³

Section 6003. Coverage of Testing for COVID-10 at No Cost Sharing Under the Medicare Advantage Program

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. In general, cost sharing (copayments and coinsurance) under an MA plan must be actuarially equivalent to cost sharing under original Medicare, but cost sharing for a specific item or service may vary from amounts required under original Medicare.⁵⁴ Private plans may use different techniques to influence the medical care used by enrollees, such as requiring enrollees to receive a referral to see specialists, or requiring prior approval or authorization from the plan before a service will be paid for.

FFCRA requires MA plans to cover COVID-19 testing, the administration of the test, and related items and services during the emergency period (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”). Plans are prohibited from charging cost sharing for those items and services, and are prohibited from using prior authorization or other utilization management techniques, with respect to the coverage of the test or ancillary services. The HHS Secretary is allowed to implement this section by program instruction or otherwise.

CBO preliminarily estimates that enacting Sections 6002 and 6003 will increase direct federal spending by \$6.7 billion over the FY2020-FY2022 period.⁵⁵

⁵³ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

⁵⁴ Social Security Act (SSA) Section 1852(a)(1)(B)(i).

⁵⁵ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

Section 6004. Coverage at No Cost Sharing Under Medicaid and CHIP

Medicaid Background

Medicaid is a federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population. Medicaid is financed jointly by the federal government and the states.

States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs.

Medicaid coverage includes a variety of primary and acute-care services, as well as long-term services and supports (LTSS). Not all Medicaid enrollees have access to the same set of services. An enrollee's eligibility pathway determines the available services within a benefit package.

Most Medicaid beneficiaries receive services in the form of what is called traditional Medicaid. In general, under traditional Medicaid coverage, state Medicaid programs must cover specific required services listed in statute (e.g., inpatient and outpatient hospital services, physician's services, or laboratory and x-ray services) and may elect to cover certain optional services (e.g., prescription drugs, case management, or physical therapy services). Under alternative benefit plans (ABPs), by contrast, states must provide comprehensive benefit coverage that is based on a coverage benchmark rather than a list of discrete items and services, as under traditional Medicaid. Coverage under an ABP must include at least the essential health benefits (EHBs) that most plans in the private health insurance market are required to furnish. States that choose to implement the ACA Medicaid expansion are required to provide ABP coverage to the individuals eligible for Medicaid through the expansion (with exceptions for selected special-needs subgroups), and are permitted to extend such coverage to other groups.

Beneficiary cost sharing (e.g., premiums and co-payments) is limited under the Medicaid program. States can require certain beneficiaries to share in the cost of Medicaid services, but there are limits on (1) the amounts that states can impose, (2) the beneficiary groups that can be required to pay, and (3) the services for which cost sharing can be charged.

CHIP Background

The State Children's Health Insurance Program (CHIP) is a federal-state program that provides health coverage to uninsured children and certain pregnant women with annual family income too high to qualify for Medicaid. CHIP is jointly financed by the federal government and states, and is administered by the states. Like Medicaid, the federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's framework. As a result, CHIP programs vary significantly from state to state.

States may design their CHIP programs as (1) a CHIP Medicaid expansion, (2) a separate CHIP program, or (3) a combination approach, where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently.

CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing. For separate CHIP programs, the benefits are permitted to look more like private health insurance, and states may impose cost sharing, such as premiums or enrollment fees, with a maximum allowable amount that is tied to annual family income. Regardless of the choice of program design, all states

must cover emergency services, well-baby and well-child care including age-appropriate immunizations, and dental services.

FFCRA Provision

FFCRA adds COVID-19 testing and related services to the list of Medicaid mandatory services under traditional Medicaid benefits for the period beginning March 18, 2020, through the duration of the public health emergency as declared by the HHS Secretary pursuant to Section 319 of the PHSA (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”).⁵⁶ States and territories are prohibited from charging beneficiary cost sharing⁵⁷ for such testing, or for testing-related state plan services⁵⁸ furnished during this period.

FFCRA also permits states to extend COVID-19 testing, testing-related state plan services, testing-related visit and the administration of the testing without cost sharing (as referenced earlier in this provision) to uninsured individuals during the specified public health emergency period. For the purposes of this provision, uninsured individuals⁵⁹ are defined as those who are not Medicaid-eligible under one of Medicaid’s mandatory eligibility pathways (e.g., the poverty-related pregnant women and child pathways, or the ACA Medicaid expansion pathway), and who are not enrolled in (1) a federal health care program (e.g., Medicare, Medicaid, CHIP, or TRICARE); (2) a specified type of private health insurance plan (e.g., individual health insurance coverage and group plans, whether fully insured or self-insured); or (3) FEHB (see “Definition of the Uninsured”). The law provides 100% federal medical assistance percentage (FMAP or federal matching rate) for medical assistance and administrative costs associated with uninsured individuals who are eligible for Medicaid under this provision.

The law also requires CHIP programs (regardless of program design) to cover COVID-19 testing for CHIP enrollees for the period beginning March 18, 2020, through the duration of the public health emergency period as specified (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”).⁶⁰ States are prohibited from charging beneficiary cost sharing for such testing, or for testing-related visits furnished to CHIP enrollees during this period.

⁵⁶ The provision is silent about the addition of this benefit under Medicaid Alternative Benefit Plans.

⁵⁷ The provision applies to traditional cost sharing state plan authority, as well as to the state option for alternative cost sharing that permits states to charge higher cost-sharing amounts (subject to a specified cap) for individuals with higher annual income.

⁵⁸ CMS interpreted COVID-19 testing-related services to include items and services for which payment is available under the Medicaid state plan that are directly related to the administration of COVID-19 testing, or for the evaluation of an individual to determine the need for COVID-19 testing (e.g., an X-ray). For more information, see Centers for Medicare and Medicaid Services (CMS), *Families First Coronavirus Response Act (FFCRA)*, P.L. 116-127; *Coronavirus Aid, Relief, and Economic Security (CARES) Act*, P.L. 116-136; *Frequently Asked Questions (FAQ)*, April 13, 2020.

⁵⁹ The definition of uninsured individuals (for purposes of this section) was amended by the CARES Act to include individuals who are eligible for Medicaid via the ACA Medicaid expansion eligibility pathway in non-ACA Medicaid expansion states, and certain specified Medicaid enrollees who by virtue of their Medicaid eligibility pathway are entitled to limited Medicaid benefits (e.g., certain low-income pregnant woman who are entitled to limited pregnancy-related services, low-income TB-infected individuals who are entitled to services related to the TB infection, and individuals eligible only for family planning services and supplies). Congressional clients may contact Evelyn Baumrucker with questions.

⁶⁰ This provision was amended by the CARES Act to remove language regarding FDA-approved testing. Congressional clients may contact Evelyn Baumrucker with questions.

CBO preliminarily estimates that Section 6004 will increase direct federal spending by a total of \$1.9 billion in FY2020 and FY2021.⁶¹

Section 6005. Treatment of Personal Respiratory Protective Devices as Covered Countermeasures

In 2005 Congress passed the Public Readiness and Emergency Preparedness Act (PREP Act), which authorizes the federal government to waive liability (except for willful misconduct) for manufacturers, distributors, and providers of medical countermeasures, such as drugs and medical supplies, that are needed to respond to a public health emergency.⁶² The act also authorizes the federal government to establish a program to compensate eligible individuals who suffer injuries from administration or use of products covered by the PREP Act's immunity provisions.⁶³

FFCRA explicitly adds to the list of PREP Act-covered countermeasures any personal respiratory protective device that is (1) approved by the National Institute for Occupational Safety and Health (NIOSH); (2) subject to an emergency use authorization (EUA); and (3) used for the COVID-19 response, retroactive from January 27, 2020, and through October 1, 2024.⁶⁴ The CARES Act, Section 3103, amends this provision to define a covered personal respiratory protective device as one that “is approved by [NIOSH], and that the Secretary determines to be a priority for use during a public health emergency declared under section 319.” This amendment removes the requirement for an FDA authorization and extends PREP Act authority to these devices during both the COVID-19 emergency period and any future public health emergencies declared pursuant to PHSA Section 319.⁶⁵

CBO did not provide an estimate of this provision.⁶⁶

Section 6006. Application with Respect to TRICARE, Coverage for Veterans, and Coverage for Federal Civilians

TRICARE

Under Chapter 55 of Title 10, *U.S. Code*, the Department of Defense administers a statutory health entitlement to approximately 9.5 million beneficiaries (i.e., servicemembers, military

⁶¹ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

⁶² HHS, ASPR, “Public Readiness and Emergency Preparedness Act,” <https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx>.

⁶³ HHS, Health Resources and Services Administration (HRSA), “Countermeasures Injury Compensation Program (CICP),” <https://www.hrsa.gov/cicp/index.html>.

⁶⁴ For more information, see Food and Drug Administration (FDA), “Coronavirus (COVID-19) Update: FDA and CDC take action to increase access to respirators, including N95s, for health care personnel,” March 2, 2020, <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-and-cdc-take-action-increase-access-respirators-including-n95s>. For more information on the PREP Act, see CRS Legal Sidebar LSB10443, *The PREP Act and COVID-19: Limiting Liability for Medical Countermeasures*, by Kevin J. Hickey. Also of note, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, P.L. 116-123 (the first supplemental appropriation for the COVID-19 response), and the CARES Act authorize the HHS Secretary to transfer an unspecified amount of appropriated funds to the Covered Countermeasure Process Fund, which funds compensation for injury claims against covered countermeasures.

⁶⁵ Congressional clients may contact Sarah A. Lister with questions.

⁶⁶ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

retirees, and family members).⁶⁷ These entitlements are delivered through the Military Health System (MHS), which offers health care services in military hospitals and clinics—known as military treatment facilities—and through civilian health care providers participating in TRICARE.⁶⁸ With the exception of active duty servicemembers, MHS beneficiaries may have a choice of TRICARE plan options depending on their status and geographic location. Each plan option has different beneficiary cost-sharing features, including annual enrollment fees, deductibles, copayments, and an annual catastrophic cap.⁶⁹

FFCRA requires the Secretary of Defense to waive any TRICARE cost-sharing requirements related to COVID-19 testing, administration of the test, and related items and services provided during an associated health care office, urgent care, or emergency department visits during the emergency period (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”).

Veterans

All veterans enrolled in the VA health care system are eligible for a standard medical package that includes laboratory services.⁷⁰ Currently, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of a nonservice-connected condition.⁷¹ Any health service or medication provided in connection to the treatment of a service-connected condition⁷² or disability is always furnished without cost sharing. In addition, the VA does not charge copayments for preventive screenings, such as those for infectious diseases; cancers; heart and vascular diseases; mental health conditions and substance abuse; metabolic, obstetric, and gynecological conditions; and vision disorders, as well as regular recommended immunizations.⁷³ Generally, laboratory services are also expressly exempt from copayment requirements.⁷⁴

FFCRA requires the VA Secretary to waive any copayment or other cost-sharing requirements related to COVID-19 testing, administration of the test, and related items and services for visits during the emergency period (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”).⁷⁵

⁶⁷ Defense Health Agency, “Patients by Beneficiary Category,” accessed March 19, 2020, <https://www.health.mil/I-Am-A/Media/Media-Center/Patient-Population-Statistics/Patients-by-Beneficiary-Category>.

⁶⁸ For more on the Military Health System, see CRS In Focus IF10530, *Defense Primer: Military Health System*, by Bryce H. P. Mendez.

⁶⁹ For more on TRICARE cost-sharing features, see Defense Health Agency, TRICARE Fact Sheet, *TRICARE Costs and Fees 2020*, January 2020, https://tricare.mil/-/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2020.pdf.

⁷⁰ 38 C.F.R. §17.38. Not all veterans are eligible to receive VA health care services. See CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

⁷¹ “The term ‘non-service-connected’ means, with respect to disability or death, that such disability was not incurred or aggravated, or that the death did not result from a disability incurred or aggravated, in line of duty in the active military, naval, or air service” (38 U.S.C. §101(17)).

⁷² “The term ‘service-connected’ means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service” (38 U.S.C. §101(16)).

⁷³ The Veterans Millennium Health Care and Benefits Act (P.L. 106-117) authorized the VA to establish outpatient copayment amounts by regulation. Currently codified at 38 C.F.R. §17.108.

⁷⁴ 38 C.F.R. §17.108(e)(14).

⁷⁵ See also CRS Report R46280, *Department of Veterans Affairs’ Potential Role in Addressing the COVID-19 Outbreak*.

Federal Civilians

The FEHB Program provides health insurance to federal employees, retirees, and their dependents. Cost-sharing requirements (e.g., deductibles, co-payments, and coinsurance amounts) vary by plans participating in the FEHB Program. For some services, such as the preventive care services outlined in the ACA, plans are not allowed to impose cost sharing.⁷⁶

FFCRA requires that no federal civil servants enrolled in a health benefits plan or FEHB enrollees may be required to pay a copayment or other cost sharing related to COVID-19 testing, administration of the test, related items and services for visits during the emergency period (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”).

Section 6007. Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care

IHS provides health care to eligible American Indians/Alaska Natives either directly or through facilities and programs operated by Indian tribes or tribal organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA).⁷⁷ IHS also provides services to urban Indians through grants or contracts to Urban Indian Organizations (UIOs). The services provided vary by facility, and IHS does not offer a standard benefit package, nor is it required to cover certain services that its beneficiaries may receive at facilities outside of IHS. When services are not available at an IHS facility, the IHS facilities may authorize payment through the Purchased Referred Care Program (PRC).⁷⁸ Generally, PRC requires prior approval except in cases of emergency. PRC funds are limited, and as such, not all PRC claims are authorized and PRC is not available to UIOs. To be authorized, claims must meet medical priority levels, individuals must not be eligible for another source of coverage (e.g., Medicaid or private health insurance), and individuals must live in certain geographic areas.

FFCRA requires IHS to pay for the cost of COVID-19 testing and related items and services, as described in Section 6001(a), without any cost-sharing requirements, from the date of enactment (i.e., March 18, 2020) throughout the emergency period (see the sections “Definitions of COVID-19 Testing and Related Services” and “Duration of Emergency Period”). This requirement applies to any Indian⁷⁹ receiving services through the IHS⁸⁰ including through UIOs. It also specifies that the requirement to waive cost-sharing requirements applies regardless of whether the testing and related services were authorized through PRC.

⁷⁶ 42 U.S.C. §300gg-13.

⁷⁷ P.L. 93-638; 25 U.S.C. §§450 et seq.

⁷⁸ Indian Health Service, “Purchased/Referred Care (PRC),” <https://www.ihs.gov/prc/>. Purchased Referred Care was previously named “Contract Health Service.” IHS now refers to the program as “Purchased Referred Care,” the program’s name has not been changed in statute (i.e., in Indian Health Care Improvement Act [P.L. 94-437], as amended; 25 U.S.C. §§1601 et. seq.).

⁷⁹ This section defines Indian with reference to Section 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603(13)).

⁸⁰ The phrase “receiving services through the IHS” is not defined but has been used in prior federal guidance to refer to non-IHS facilities that have care coordination agreements with IHS facilities to treat American Indians and Alaska Natives. See Letter to State Health Official: Re: Federal Funding for Services “Received Through” an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002), February 26, 2016, <https://www.medicare.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho022616.pdf>.

Section 6008. Temporary Increase of Medicaid FMAP

Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP) rate, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes).⁸¹ Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.

In the past, there were two temporary FMAP exceptions to provide states with fiscal relief due to recessions. They were provided through the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JRTTRA, P.L. 108-27) and the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). To be eligible for both of these temporary FMAP increases, states had to abide by some requirements. These requirements varied in the two FMAP increases, but for both increases, states were required to maintain Medicaid "eligibility standards, methodologies, and procedures" and ensure that local governments did not pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required.

FFCRA provides an increase to the FMAP rate for all states, the District of Columbia, and the territories of 6.2 percentage points for each calendar quarter occurring during the period beginning on the first day of the emergency period (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the last day of the public health emergency period ends (see "Duration of Emergency Period").

States, the District of Columbia, and the territories will not receive this FMAP rate increase if (1) the state's Medicaid "eligibility standards, methodologies, or procedures" are more restrictive than what was in effect on January 1, 2020;⁸² (2) the amount of premiums imposed by the state exceeds the amount as of January 1, 2020;⁸³ (3) the state does not maintain eligibility for individuals enrolled in Medicaid on the date of enactment (i.e., March 18, 2020) or for individuals who enroll during the emergency period through the end of the month in which the emergency period ends (unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state); or (4) the state does not provide coverage (without the imposition of cost sharing) for any testing services and treatments for COVID-19 (including vaccines, specialized equipment, and therapies).

FFCRA adds another condition for the FMAP rate increase. Specifically, states, the District of Columbia, and the territories cannot require local governments to fund a larger percentage of the

⁸¹ For more information about the federal medical assistance percentage, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

⁸² A similar provision was in place prior to FFCRA for Medicaid and the State Children's Health Insurance Program (CHIP) children. Under SSA Section 1902(gg)(2) and SSA Section 2105(d)(3), states are required to maintain the Medicaid and CHIP eligibility standards, methodologies, and procedures for children in place on the date of enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) through FY2027. The penalty to states for not complying with either the Medicaid or the CHIP maintenance of effort requirements for children would be the loss of all federal Medicaid funds.

⁸³ This provision was amended by the CARES Act to delay the application of the premium requirement for 30 days after March 18, 2020 (i.e., the date of enactment for FFCRA). Congressional clients may contact author Alison Mitchell with questions.

state's nonfederal Medicaid expenditures for the Medicaid state plan or Medicaid disproportionate share hospital (DSH) payments than what was required on March 11, 2020.⁸⁴

CBO preliminarily estimates that Section 6008 will increase direct spending by about \$50.0 billion over the FY2020-FY2022 period.⁸⁵

Section 6009. Increase in Medicaid Allotments for Territories

Medicaid financing for the territories (i.e., American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands) is different than the financing for the 50 states and the District of Columbia.⁸⁶ Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal capped funding.

Federal Medicaid funding for the territories comes from different sources. The permanent source of federal Medicaid funding for the territories is the annual capped funding. Currently, the Medicaid annual capped funding for the territories is supplemented by additional funding for FY2020 and FY2021 that was provided through the Further Consolidated Appropriations Act, 2020 (P.L. 116-94).

FFCRA increases the additional funding available for each territory for FY2020 and FY2021. The aggregate additional funding for the territories increases from \$3.0 billion to \$3.1 billion for FY2020 and \$3.1 billion to \$3.2 billion for FY2021.

CBO preliminarily estimates that Section 6009 increases the allotment amount, and thus direct spending, by \$204 million over the FY2020-FY2021 period.⁸⁷

Section 6010. Clarification Relating to Secretarial Authority Regarding Medicare Telehealth Services Furnished During COVID-19 Emergency Periods

Medicare coverage under Part B (fee-for-service) for telehealth services is defined under SSA Section 1834(m), which places certain conditions on such care including who can furnish and be paid for the service, where the patient is located (the originating site), where the physician is located (the distant site), and the types of services that are covered. Recent legislation has modified some of the conditions under which telehealth services may be furnished under Medicare. The Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), Division B, Section 102, added certain Medicare telehealth restrictions to the list of applicable conditions for which the Secretary could temporarily waive or modify program requirements or regulations during the COVID-19 emergency period. (See "Duration of Emergency Period.") The provision also defined a qualified telehealth provider, requiring a prior relationship within the past three years between the patient and the provider under Medicare.

FFCRA expands the definition of a qualified provider to include those who had provider-patient relationships within the past three years outside of Medicare.⁸⁸

⁸⁴ See CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

⁸⁵ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

⁸⁶ For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Funding for the Territories*.

⁸⁷ See <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>.

⁸⁸ This provision was amended by the CARES Act to, among other changes, eliminate the requirement that a provider have three years of prior experience before treating a patient through telehealth. Congressional clients may contact author Jim Hahn with questions.

Appendix. CRS Experts

Below is a list of the health care provisions in FFCRA with the name of the CRS expert on that provision. In some cases, more than one expert contributed to a section, in which case their topics of expertise are also included.

Table A-1. Health Care-Related Provisions Included in the Families First Coronavirus Response Act, and CRS Experts

Division and Title or Section Number	Section Title	Contact
Div. A, Title II	Department of Defense, Defense Health Program	Bryce H. P. Mendez Defense Health Alan Ott Defense Health backup
Div. A, Title IV	Department of Health and Human Services, Indian Health Service	Elayne Heisler
Div. A, Title V	Department of Health and Human Services, Public Health and Social Services Emergency Fund	Sarah A. Lister
Div. A, Title VI	Department of Veterans Affairs, Veterans Health Administration	Sidath V. Panangala
Div. A, Title VII	General Provisions	Sarah A. Lister
Div. F, Sec. 6001	Coverage of Testing for COVID-19	Amanda Sarata COVID-19 testing Vanessa Forsberg Private health insurance
Div. F, Sec. 6002	Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19	Jim Hahn
Div. F, Sec. 6003	Coverage of Testing for COVID-10 at No Cost Sharing Under the Medicare Advantage Program	Paulette C. Morgan
Div. F, Sec. 6004	Coverage at No Cost Sharing Under Medicaid and CHIP	Evelyn Baumrucker
Div. F, Sec. 6005	Treatment of Personal Respiratory Protective Devices as Covered Countermeasures	Sarah A. Lister

Division and Title or Section Number	Section Title	Contact
Div. F, Sec. 6006	Application with Respect to Tricare, Coverage for Veterans, and Coverage for Federal Civilians	Bryce H. P. Mendez Defense Health Alan Ott Defense Health backup Sidath V. Panangala Veterans Health Noah Isserman Federal Civilian Healthcare Ryan Rosso Federal Civilian Healthcare backup
Div. F, Sec. 6007	Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care	Elayne Heisler
Div. F, Sec. 6008	Emergency FMAP Increase	Alison Mitchell
Div. F, Sec. 6009	Increase in Medicaid Allotments for Territories	Alison Mitchell
Div. F, Sec. 6010	Clarification Relating to Secretarial Authority Regarding Medicare Telehealth Services Furnished During COVID-19 Emergency Periods	Jim Hahn

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Author Information

Sarah A. Lister, Coordinator
Specialist in Public Health and Epidemiology

Noah D. Isserman
Analyst in Health Insurance and Financing

Paulette C. Morgan, Coordinator
Specialist in Health Care Financing

Bryce H. P. Mendez
Analyst in Defense Health Care Policy

Evelyne P. Baumrucker
Specialist in Health Care Financing

Alison Mitchell
Specialist in Health Care Financing

Vanessa C. Forsberg
Analyst in Health Care Financing

Sidath Viranga Panangala
Specialist in Veterans Policy

Jim Hahn
Specialist in Health Care Financing

Ryan J. Rosso
Analyst in Health Care Financing

Elayne J. Heisler
Specialist in Health Services

Amanda K. Sarata
Specialist in Health Policy

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