

Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

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No Other Medicine But Hope – Updates on Health Care Access in the Coronavirus Crisis

As we all continue to adjust to life in the age of coronavirus, governmental response to the threat continues to crescendo on an unprecedented scale. As of the time of publication, the United States House of Representatives is in the process of sending the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#), the largest [economic rescue](#) legislation in American history, to the President’s desk for signature. Meanwhile, advocates are still working through [last week’s enormous appropriation](#) to promote awareness and ensure sound implementation of the many and varied health care access measures contained within it. [The President’s original fiscal proposal](#) to combat the coronavirus – offered just one month ago – feels like it comes from a long time ago in a galaxy far, far away. Whatever our strange new reality brings to us in the future, *Health Care in Motion* will continue to provide you with up-to-date accurate information you can use to advocate for improved access to care for low-income and chronically ill individuals. Here are the most important updates that have occurred since our March 20 edition.

Medicaid Eligibility

The [Families First Coronavirus Response Act](#) – signed into law on March 18 – contains significant provisions affecting Medicaid eligibility. As discussed in last week’s [Health Care in Motion](#), the Act provides a higher matching rate of federal Medicaid dollars for states that agree to more expansive eligibility and termination provisions. This week, the Centers for Medicare and Medicaid Services (CMS) released a “[Frequently Asked Questions](#)” document to explain the effects of the new law and the conditions that states must meet in order to qualify for the enhanced federal match. Some states – including Massachusetts – are already getting out the word on the new rules that Medicaid enrollment will continue from now until the end of the state of emergency. [Last week’s Act](#) also enables states, at their discretion, to use Medicaid funding to cover COVID-19 testing for uninsured individuals. As of this writing – before the CARES Act has passed – there is [some confusion](#) surrounding how the new legislation amends the Families First Act on this point. We will keep *Health Care in Motion* readers updated as the CARES Act makes its way to final passage. Suffice it to say that widespread, free diagnostic testing for COVID-19 is an issue that rightfully enjoys broad bipartisan support. We can also expect CMS to continue publishing guidance expressing its own understanding of the new laws and how they relate to Medicaid program options in states. Much more to come.

The action in Congress is not the only development to occur in the arena of Medicaid eligibility this week. On March 24, [CMS withdrew a proposed rule](#) that would have permitted states to impose a number of new bureaucratic roadblocks to getting and keeping Medicaid. While the [specifics of the rule were never made public](#), its withdrawal represents tacit acknowledgement by the Trump Administration that pushing low-income people off of health coverage is ill advised in the midst of a public health emergency. Even as the federal government makes some concessions in this vein, it continues to enforce other preexisting rules that may aggravate the crisis. For example, the [public charge rule](#) –

intended to make it tougher for immigrants to become legal permanent residents if they have made use of public benefits like Medicaid – is [likely to discourage](#) many individuals from freely seeking care for coronavirus symptoms. While the immigration agency has [tried to soften fears associated](#) with the rule, the [rhetoric of Administration officials](#) will reap what it has sown: Widespread fear in immigrant communities likely to dissuade many individuals from seeking health care in the midst of an infectious disease pandemic. As we careen further into the throes of this crisis, the federal government is still not pushing all available policy levers to limit the [damage effected](#) by the coronavirus.

Medicaid Waivers

Among the strongest of such policy levers is the flexibility built into the Medicaid program. The measures promoted in our prior [Health Care in Motion dispatches](#) are now being executed by federal and state Medicaid officials acting in concert with one another. Roughly half of all states are now taking advantage of a so-called “[Section 1135 waiver](#)” to relax regular Medicaid rules around provider enrollment, prior authorization, appeals and long-term care oversight. An excellent summary of state 1135 waiver activity is available from Kaiser Family Foundation [here](#). More of this type of activity is certain to follow, as states determine exactly how best to adapt their Medicaid program to the outbreak.

Prescription Drug Access

Health Care in Motion is pleased to report that the CARES Act now making its way out of Congress appears likely to include an important prescription drug measure we have identified as a priority. Responding to more frequent reports of individuals with chronic conditions having trouble accessing their prescriptions due to social distancing and strain on the health system, advocates sent letters to both [Secretary Azar](#) and [congressional leadership](#) asking them to address this issue in federal programs, specifically calling out Medicare Part D as a key consideration. Section 3714 of the CARES Act mandates Medicare Part D plans allow beneficiaries to access an extended, 90-day supply of their regular prescriptions. [As many as 16 states](#) have issued similar directives to private insurers within their purview. Advocacy works.

And the need for advocacy remains. The federal government has yet to activate the [Emergency Prescription Assistance Program](#), which holds the potential to alleviate widespread concern over access to medication for uninsured individuals. Where a significant number of Americans are subject to widespread social disruption, stay-at-home orders or self-isolation requirements, reducing obstacles to critical medication for vulnerable populations would appear to be an easy fix. Nor has the federal government yet made the most use of the [National Disaster Medical System](#). If properly executed, the NDMS has [the power to eliminate any potential for surprise billing or cost-sharing](#) associated with COVID-19 testing or treatment.

Private Insurance

Marketplace insurance – made available under [the Affordable Care Act](#) – is also illustrating its flexibility in the face of a crisis. Advocates are reminding us in the face of [historic job losses](#) that being laid off [constitutes a qualifying event](#) for a Special Enrollment Period to gain new coverage. Even for those who have not lost a job, an [increasing number of states](#) have created new Special Enrollment Periods in response to the coronavirus in order to make private coverage more accessible.

It remains true that private insurance coverage and cost for testing and treatment related to the outbreak will vary according to plan type and, in many instances, rest on individual insurer decisions. [Unsurprisingly](#), private insurance in the category of short-term limited duration plans have COVID-19 coverage that [ranges from bad to worse](#). While the Administration has largely been silent on these deficiencies, its attorneys practiced social distancing and phoned into a federal appeals court last week to [continue its defense of these plans](#). With respect to employer-sponsored and private insurance, the March 18 [Families First Coronavirus Response Act](#) eliminated patient cost-sharing for testing, although that requirement does not extend to treatment or vaccinations. The [IRS](#) and [CMS](#) are *encouraging* but not requiring high deductible health plans to cover testing and treatment.

Availability of Health Care

Last, significant developments – both positive and negative – are occurring with respect to the availability of health care during the outbreak. [States](#) are now in the process of [operationalizing](#) the [early steps](#) the federal government has taken to promote telehealth initiatives. With telehealth’s methodology falling in [synchronicity](#) with social distancing measures, [pundits have begun to wonder](#) whether the change may stick. Other developments are less welcome. Some chronically ill patients are finding that access to a prescription drug necessary to treat lupus is now subject to [coverage and availability restrictions](#), due to its role in COVID-19 experimental trials.

Less beneficial, health care access advocates are seeing new bioethical debates spring up related to the impending shortage of ventilators for COVID-19 care that has been in [news headlines](#). This week, disability rights advocates have begun to [raise the alarm](#) concerning hospital policies that have the potential to discriminate. A group of leading advocates have filed [an administrative complaint](#) with the [HHS Office of Civil Rights](#) (OCR) seeking enforcement of federal law against Washington State and a group of hospitals there. The target of the complaint is a ventilator rationing scheme that will deprioritize patients based on [“loss of reserves in energy, physical ability, cognition and general health”](#) [“in determining who will get access to full care and who will merely be provided comfort care, with the expectation that they will die.”](#) Whatever terrible decisions face health care providers in the thick of the COVID-19 front lines, disability-based discrimination remains illegal. Policymakers should not offer a license to discriminate by enacting categorical exclusions from care. We will keep a careful eye on this OCR Complaint in the coming weeks and months.

Coronavirus is also serving as pretext for [some state officials](#) to continue ongoing efforts to block access to abortion services, suggesting that abortion-related health care is “non-essential” during the outbreak. In response to these measures, providers and their allies are pushing back, determined to show that [“abortion is essential health care. Period.”](#) As much as the coronavirus has thoroughly upended American life, it is also just a new lens through which old schisms are emerging, as bitter as ever. The [more things change](#), the more they stay the same.

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Today’s historic spending bill in Congress represents a beginning, not an end. As federal dollars begin to flow to state, local and private entities, the number of opportunities to put the money to good use for increased access to health care are so vast as to defy enumeration. So too will there be countless opportunities to close off chronic illness communities from health care. At *Health Care in Motion*, we will keep working to identify both of these types of developments to keep advocates informed. Please keep an eye out for our upcoming edition offering specific requests for federal and state officials to make sure that the needs of the chronic illness community are not forgotten in the chaos of coronavirus.

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Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Staff Attorney; Maryanne Tomazic, Senior Clinical Fellow; and Rachel Landauer, Clinical Fellow.

For further questions or inquiries please contact us at chlpilaw@law.harvard.edu.