The COVID-19 pandemic has created unprecedented challenges for healthcare providers and health insurers. The following is a selection of federal and state actions as well as news and analysis articles from the Health Policy Tracking Service as published in its bi-weekly Snapshots. The selection includes Regulatory Intelligence and Reuters news coverage. More COVID-19 news and information can be found via the TRRI platform’s search facility.

Additional COVID-19 resources are also available on the Thomson Reuters COVID-19 Resource Center. For a regularly updated list of U.S. state updates on insurance-sector regulatory changes related to the COVID-19 epidemic, please click on this link: http://go-ri.tr.com/fuaD4N.

IN THIS OVERVIEW

FEDERAL AND STATE COVID-19 LEGISLATIVE AND REGULATORY ACTIONS
➢ State Legislative and Regulatory Actions on COVID-19

FEDERAL ADMINISTRATIVE ACTIONS
➢ CMS Issues Guidance for States on Resuming Normal Medicaid Operations when the COVID-19 Emergency Period Ends

OTHER NEWS AND SUMMARIES
➢ Enrollment in Government Health Program Increased During COVID-19 Pandemic
➢ Job Loss Levels Higher than Loss of Insurance

COVID-19 COVERAGE

COVID-19 LEGISLATIVE AND REGULATORY ACTIONS

STATE ACTIONS

Colorado
The purpose of this emergency regulation is to require carriers offering health benefit plans to reimburse providers for provision of telehealth services using non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. See 2020 CO REG TEXT 572523 (NS).

Florida
Emergency rule 64DER20-44 sets forth the requirements to permit the redistribution of COVID-19 vaccines between enrolled COVID-19 vaccine providers. See 2020 FL REG TEXT 572792 (NS).

1 This COVID-19 Coverage Snapshot was compiled by members of the publisher’s staff.
Illinois

- **2019 IL S.B. 4027** (NS), filed January 4, provides that capitation rates established by the Department of Healthcare and Family Services for managed care organizations shall be reduced by 20% for the duration of a disaster proclamation, and any subsequent disaster proclamation, issued by the Governor in response to the COVID-19 public health emergency. Requires the Department to reduce future capitation payments to managed care organizations on a prorated basis to reflect any amounts paid by the Department before the effective date of the amendatory Act that were in excess of the lower capitation rates authorized by the amendatory Act. Provides that the amendatory Act applies to capitation rates in effect during a disaster period established by the Gubernatorial Disaster Proclamation issued by the Governor on March 9, 2020 concerning the COVID-19 public health emergency and any subsequent Gubernatorial Disaster Proclamation issued by the Governor in response to the COVID-19 public health emergency. Effective immediately.

- **2019 IL H.B. 5867** (NS), introduced January 8, provides that capitation rates established by the Department of Healthcare and Family Services for managed care organizations shall be reduced by 20% for the duration of a disaster proclamation, and any subsequent disaster proclamation, issued by the Governor in response to the COVID-19 public health emergency. Requires the Department to reduce future capitation payments to managed care organizations on a prorated basis to reflect any amounts paid by the Department before the effective date of the amendatory Act that were in excess of the lower capitation rates authorized by the amendatory Act. Provides that the amendatory Act applies to capitation rates in effect during a disaster period established by the Gubernatorial Disaster Proclamation issued by the Governor on March 9, 2020 concerning the COVID-19 public health emergency and any subsequent Gubernatorial Disaster Proclamation issued by the Governor in response to the COVID-19 public health emergency. Effective immediately.

Indiana

- **2021 IN S.B. 3** (NS), introduced January 7, prohibits the Medicaid program from specifying originating sites and distant sites for purposes of Medicaid reimbursement and voids administrative rules with these requirements. Changes the use of the term "telemedicine" to "telehealth." Specifies certain activities that are considered to be health care services for purposes of the telehealth laws. Expands the application of the telehealth statute to additional licensed practitioners instead of applying only to prescribers. Amends the definition of "telehealth."

- **2021 IN S.B. 4** (NS), introduced January 7, adds (1) admissions to health facilities or housing with services establishments; and (2) services provided by additional health care professionals; to the definition of "health care services" for purposes of immunity for providing services during a declared disaster emergency. Provides civil immunity for the provision of certain services by persons during an event that is declared a disaster emergency. Removes the immunity requirement that the health care service be provided by a person who has an Indiana license to provide the health care service and that the service is within the scope of practice of the license. Specifies instances that do not constitute gross negligence or willful misconduct for purposes of immunity. Specifies information that must be included in a cause of action. Specifies that health care immunity provisions during a disaster emergency do not modify specified statutes.

- **2021 IN H.B. 1002** (NS), prefiled December 30, protects health care providers from professional discipline for certain acts or omissions related to the provision of health care services during a state disaster emergency. Provides that the protection applies to the provision of health care services after February 29, 2020, and before April 1, 2022. Provides that a health care provider is not protected from professional discipline if the
health care provider's action, omission, decision, or compliance constitutes gross negligence or willful misconduct. Provides that a health care provider is not protected from professional discipline for actions that are outside the skills, education, and training of the health care provider, unless the health care provider's actions are undertaken in good faith and in response to a lack of resources caused by a state disaster emergency. And, additional provisions.

- Temporary Licensing of Health Care Workers Extended. As provided by Executive Orders 20-13, -19, -21, -33 and -45, any individual in the below categories may apply for an initial temporary health care license if he or she is not currently licensed to practice in the state, either because his or her Indiana license is no longer active or they are licensed by another state to provide health care services during this public health emergency. See 2020 IN REG TEXT 573318 (NS).

- Massachusetts
  Chapter 101 CMR 420.00 governs the payment rates for adult long-term residential services provided to publicly aided individuals by governmental units. See 2020 MA REG TEXT 570271 (NS).

- Michigan
  - 2019 MI S.B. 920 (NS), amended/substituted December 18, health occupations: pharmacists; enhancements to operational capacity, flexibility, and efficiency of pharmacies; provide for during a declared emergency.
  - 2019 MI S.B. 1185 (NS), enrolled December 18, torts: liability; pandemic health care immunity act; create.

- Minnesota
  2021 MN H.F. 3 (NS), introduced January 7, COVID-19; long-term care protection and support, temporary staffing, emergency housing services, isolation spaces, and housing support funding provided; and money appropriated.

- Missouri
  This emergency rule would allow pharmacy technicians to administer vaccines as authorized by the U.S. Department of Health and Human Services during the COVID-19 pandemic. See 2021 MO REG TEXT 573364 (NS).

- New Jersey
  2020 NJ A.B. 5203 (NS), introduced January 4, requires DOH to establish public awareness campaign regarding potential fraud related to COVID-19 vaccine.

- New York
  - 2021 NY S.B. 614 (NS), introduced January 6, provides for the authorization and regulation of visitation of personal care visitors and compassionate care visitors at nursing homes and residential health care facilities.
  - 2021 NY A.B. 737 (NS), introduced January 6, permits any uninsured individual to receive free coronavirus disease 2019 (COVID-19) testing.
  - 2021 NY A.B. 750 (NS), introduced January 6, requires that nursing home patients who previously tested positive for COVID-19 shall produce a negative test result before he or she can be readmitted to such nursing home.
  - 2021 NY A.B. 1010 (NS), introduced January 7, directs the department of health to publish the results of inspections conducted by the department in residential health care facilities in the state during the COVID-19 state disaster emergency.
• 2021 NY A.B. 1052 (NS), introduced January 7, provides for the authorization and regulation of visitation of personal care visitors and compassionate care visitors at nursing homes and residential health care facilities.

• 2021 NY A.B. 1070 (NS), introduced January 7, relates to providing a patient of a residential health care facility essential caregiver visitation during COVID-19.

• 2021 NY S.B. 1080 (NS), introduced January 6, relates to establishing requirements for residential healthcare facilities during a state disaster emergency involving a disease outbreak.

• 2021 NY S.B. 1177 (NS), introduced January 7, rules and regulations requiring nursing homes and residential health care facilities to test all residents of such nursing homes and residential healthcare facilities for the novel coronavirus (COVID-19).

• 2021 NY A.B. 1253 (NS), introduced January 7, relates to the confidentiality of contact tracing information.

• To require immediate coverage, without cost-sharing, for COVID-19 immunizations and the administration thereof. See 2021 NY REG TEXT 573642 (NS).

Ohio

• 2019 OH S.B. 310 (NS), adopted December 30, to provide for the distribution of some federal coronavirus relief funding to local subdivisions and businesses, to revise the formula used to determine Medicaid rates for nursing facility services, to exclude loan amounts forgiven under the federal CARES Act from the commercial activity tax, to apply the Prevailing Wage Law to transportation improvement district projects under certain circumstances, to allow certain state employees’ salaries and pay supplements to be frozen during the pay period that includes July 1, 2020, through the pay period that includes June 30, 2021, to temporarily expand the use of certain tax increment financing payments, to exempt certain political subdivision purchases from competitive bidding requirements during the COVID-19 emergency, to suspend certain county hospital bidding requirements during the COVID-19 emergency, to allow a county, township, or municipal corporation appointing authority to establish a mandatory cost savings program in response to COVID-19, to make capital reappropriations for the biennium ending June 30, 2022, to make other appropriations, and to declare an emergency.

• 2019 OH H.B. 412, adopted December 21, to establish the Rare Disease Advisory Council, to authorize the Emergency Response Commission to exempt a local emergency planning committee from conducting certain annual exercises, and to declare an emergency.

Oregon

• The Oregon Department of Human Services (ODHS), Office of Developmental Disabilities Services (ODDS) needs to permanently amend OAR 411-375-0070 about Inactivation and Termination of Independent Providers to allow ODDS to immediately inactivate or terminate the provider number for an independent provider who knowingly engages in activities that may result in exposure of an individual to COVID-19. See 2020 OR REG TEXT 567142 (NS).

• These rules are necessary to ensure continued access to health services for OHP members enrolled in CCOs. Revisions are to align with changes in the CCO contracting cycle beginning January 1, 2021 and to facilitate continued access to needed telephone and telemedicine services. The change helps mitigate the risk of financial harm to providers and reduce barriers to provision of key services with less risk of spread of COVID-19. See 2020 OR REG TEXT 568304 (NS).

• The Oregon Department of Human Services (Department) is adopting rules in OAR chapter 411, division 60 to establish COVID-19 testing requirements for all residents and staff in nursing facilities, assisted living facilities, and residential care facilities. These long-term care facilities are at high risk for severe COVID-19 outbreaks due to their
congregate nature and vulnerable population. A primary strategy for reducing the likelihood and severity of outbreaks is testing of both residents and staff. The rules were developed at Governor Kate Brown’s direction and in collaboration with OHA. See 2021 OR REG TEXT 569928 (NS).

- The Oregon Health Authority, Public Health Division needs this rule to support appropriate response during an outbreak or epidemic of an infectious disease. The rule allows Newborn Nurse Home Visiting services provided under OAR 330-006-0120 to be provided by telehealth during the COVID-19 pandemic to protect the health and safety of the home visiting workforce and families receiving the services. See 2020 OR REG TEXT 573076 (NS).

Rhode Island

- To allow EMS practitioners to collect specimens to test for COVID-19 in order to restrict the spread of the disease. See 2020 RI REG TEXT 552437 (NS).
- Establishes routine testing for COVID-19 of all personnel which includes employees, as well as volunteers, students, trainees or any individual whether paid or unpaid directly employed by or under contract with the assisted living residences on a part time or full-time basis. By testing all personnel routinely, the transmission of COVID-19 in assisted living residences can be reduced. See 2020 RI REG TEXT 573159 (NS).

Texas

- The Department of Aging and Disability Services is renewing the effectiveness of emergency new s.19.2802 for a 60-day period. The text of the emergency rule was originally published in the August 21, 2020, issue of the Texas Register (45 TexReg 5711). See 2020 TX REG TEXT 563116 (NS).
- The Texas Health and Human Services Commission (HHSC) adopts in Texas Administrative Code (TAC) Title 1, Part 15, Chapter 355, Subchapter B, new s.355.205, concerning Rule for Emergency Temporary Reimbursement Rate Increases and Limitations on Use of Emergency Temporary Funds for Medicaid in Response to Novel Coronavirus (COVID-19). Section 355.205 is adopted without changes to the proposed text as published in the October 23, 2020, issue of the Texas Register (45 TexReg 7513). Therefore, the rule will not be republished. See 2020 TX REG TEXT 568384 (NS).
- The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) adopts on an emergency basis in Title 26 Texas Administrative Code, Chapter 558 Licensing Standards for Home and Community Support Services Agencies, new s.558.950, concerning an emergency rule in response to COVID-19, in order to describe requirements for visitation in a hospice inpatient unit. As authorized by Government Code s.2001.034, HHSC may adopt an emergency rule without prior notice or hearing upon finding that an imminent peril to the public health, safety, or welfare requires adoption on fewer than 30 days’ notice. See 2020 TX REG TEXT 572587 (NS).

Washington

- 2021 WA H.B. 1127 (NS) prefiling January 8, protecting the privacy and security of COVID-19 health data collected by entities other than public health agencies, health care providers, and health care facilities.
- The department is extending the amendment of the rules listed below to ensure nursing homes are not significantly impeded from admitting and caring for residents during the COVID-19 outbreak. These amendments will continue to align state nursing home rules with federal rules that were suspended or amended to help facilitate care during the COVID-19 pandemic. The federal rules were amended to allow physicians to delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist. Current
state rules specify physicians must perform some tasks. See 2021 WA REG TEXT 554950 (NS).

- The department is extending the amendment of the rules listed below to assure nursing homes are not significantly impeded from admitting and caring for residents during the COVID-19 outbreak. These amendments will continue to align state nursing home rules with federal rules that are suspended or amended to help facilitate care during the COVID-19 pandemic. The federal rules were amended to remove the timelines for completing and transmitting resident assessments, and to delay the requirement by thirty days for a preadmission screening and resident review (PASRR) screening prior to admission. See 2021 WA REG TEXT 563902 (NS).

FEDERAL ADMINISTRATIVE ACTIONS

CMS Issues Guidance for States on Resuming Normal Medicaid Operations when the COVID-19 Emergency Period Ends
The Secretary of Health and Human Services declared a public health emergency at the start of the COVID-19 pandemic in this country. He has extended the emergency period three times, in April 2020, July 2020, and October 2020. The October extension was effective on October 23, 2020, and it lasts for 90 days. It is unclear whether the period will be extended again. The Centers for Medicare and Medicaid Services (CMS) indicates that managing health care during the emergency period is its priority; however, the agency granted many waivers and flexibilities during the emergency period, which will eventually end. In anticipation of that, CMS has issued guidance, in the form of a State Health Official letter, advising states how to proceed once the emergency period ends. First, it outlines when each of the flexibilities is set to expire. It then addresses situations in which a state opts to terminate the use of a flexibility before the emergency period ends or continue its use after the period ends. The guidance sets out the regulatory requirements a state must follow when it discontinues use of a flexibility. CMS explains that, typically, a state need not take action when it terminates the use of a flexibility unless doing so results, in, say, terminating coverage or a reducing benefit. In those cases, the state may have to comply with certain federal regulatory requirements. The letter also addresses how to handle the transition back to normal program activities – how to handle applications in process and so forth. Finally, the letter explains that CMS will be issuing later guidance on program integrity considerations states must make as they contemplate making permanent changes to their programs.

OTHER NEWS AND SUMMARIES

Enrollment in Government Health Program Increased During COVID-19 Pandemic
The Centers for Medicare & Medicaid Services (CMS) released the enrollment trends for Medicaid and the Children’s Health Insurance Program (CHIP) showing continued increases in enrollment in the programs during the COVID-19 pandemic.


The trend of increased enrollment in Medicaid and CHIP during the pandemic first showed up in the Enrollment Trends Snapshot in September 2020.

The latest release included a summary of the total number of applications submitted for the programs for the first time. Early in the pandemic, applications declined for months. Applications began increasing in June.

Applications began to significantly increase between July and August 2020.

From February 2020 to August 2020, enrollment in Medicaid and CHIP increased by almost 5.9 million people, or nearly 8.3%. Medicaid enrollment increased by over 5.8 million people, 9.1%, and CHIP enrollment increased by 33,000 people, 0.5%.

The COVID-19 public health emergency and the enactment of the Families First Coronavirus Response Act (FFCRA) continuous enrollment (maintenance of effort) requirement largely drove the increase in enrollment.

The requirement temporarily allows for a 6.2% increase in federal matching funds through Federal Medical Assistance Percentages (FMAP) for some state expenses associated with the programs.

It also requires states to maintain Medicaid enrollment for beneficiaries in most circumstances.

The data on the trend in applications showed that new enrollment was not the largest impact on the overall increase in Medicaid and CHIP numbers during the pandemic. Enrollment was growing at a significantly greater rate than applications.

The key driver of enrollment increases is likely existing enrollees remaining eligible for and enrolled in the programs.

CMS attributed the trend to maintenance of effort requirements and indicated that it would continue to monitor enrollment.

"Over the last four years, the Trump Administration has shined a bright light on the Medicaid program because we know that transparency promotes accountability," said CMS Administrator Seema Verma. "In the midst of a pandemic of generational scope and fury, it has never been more important to understand the underlying drivers of enrollment trends and the impact of new congressional requirements."

According to CMS, "Medicaid and CHIP play a vital role in helping states and territories respond to public health events, like COVID-19. To assist states and territories in their response to COVID-19, CMS developed numerous strategies to support Medicaid and CHIP operations and enrollees in times of crisis, including granting states more flexibility in their Medicaid and CHIP operations."

CMS pointed to the importance of both programs for providing health insurance coverage during the pandemic. The increased flexibility and policy options, including presumptive
eligibility and continuous eligibility were implemented to keep enrollment steady and retention high.³

**Job Loss Levels Higher than Loss of Insurance**

Early indications regarding enrollment numbers for health insurance plans through the ACA exchanges showed that the number of new people signing up for health insurance was similar to new enrollments last year, despite significantly increased unemployment due to the COVID-19 pandemic.

According to Karen Pollitz of the Kaiser Family Foundation, a reason that the number of people losing health insurance is lower than predicted is “most of the people who have lost jobs during the pandemic didn’t have health insurance to begin with.”

Many of the jobs lost were in the restaurant and service sector that commonly do not offer employer-sponsored health insurance coverage.

Pollitz indicated that many people who lost employer coverage were able to find coverage through government programs. “People have been figuring out if they did lose job based coverage and if they still make too much for Medicaid, but they did have a qualifying event, they’re figuring out how to sign up for marketplace coverage.”⁴

---
