Overview of Congressional Response To COVID-19 Pandemic
Updated June 5, 2020

Paycheck Protection Program Flexibility Act
Signed into Law June 5, 2020

- Extends the Paycheck Protection Program (PPP) loan forgiveness period to include costs incurred over 24 weeks after a loan is issued or through Dec. 31, whichever comes first. Businesses that received a loan before the measure is enacted could keep the current eight-week period.
- Extends to Dec. 31 from June 30 a period in which loans can be forgiven if businesses restore staffing or salary levels that were previously reduced. The provision would apply to worker and wage reductions made from Feb. 15 through 30 days after enactment of the CARES Act, which was signed into law on March 27.
- Maintains forgiveness amounts for companies that were unable to rehire employees or resume business levels as of Feb. 15, or find similarly qualified workers by the end of the year.
- Extends the deadline to apply for a PPP loan to Dec. 31 from June 30.
- Bars the SBA from limiting loan forgiveness for expenses other than payroll.
- Repeals a provision from the CARES Act that barred companies with forgiven PPP loans from deferring their payroll tax payments.
- Establishes a minimum loan maturity period of five years following an application for loan forgiveness, instead of the current two-year deadline set by the SBA.

PHASE III+ - Paycheck Protection Program and Health Care Enhancement Act
Signed into law on April 24, 2020

- $300 billion in additional funding for the Paycheck Protection Program (PPP)
- $10 Billion in additional funding for Economic Injury Disaster Loan (EIDL) emergency grants
- $75 billion for reimbursement to hospitals and healthcare providers to support the need for COVID-19 related expenses and lost revenue. Language remains the same as CARES Act. This funding is in addition to the $100 billion provided in the CARES Act.
- $25 billion for necessary expenses to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests. Specific funding is provided for:
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    - $2 billion provided to States consistent with the Public Health Emergency Preparedness grant formula, ensuring every state receives funding;
    - $4.25 billion provided to areas based on relative number of COVID-19 cases;
• $750 million provided to tribes, tribal organizations, and urban Indian health organizations in coordination with Indian Health Service
  o $1 billion provided to Centers for Disease Control and Prevention for surveillance, epidemiology, laboratory capacity expansion, contact tracing, public health data surveillance and analytics infrastructure modernization.
  o $1.8 billion provided to the National Institutes of Health to develop, validate, improve, and implement testing and associated technologies; to accelerate research, development, and implementation of point-of-care and other rapid testing; and for partnerships with governmental and non-governmental entities to research, develop, and implement the activities
  o $1 billion for the Biomedical Advanced Research and Development Authority for advanced research, development, manufacturing, production, and purchase of diagnostic, serologic, or other COVID-19 tests or related supplies.
  o $22 million for the Food and Drug Administration to support activities associated with diagnostic, serological, antigen, and other tests, and related administrative activities;
  o $825 million for Community Health Centers and rural health clinics;
  o Up to $1 billion may be used to cover costs of testing for the uninsured.
• Requires strategic plan related to providing assistance to States for testing and increasing testing capacity.

PHASE III - Coronavirus Aid, Relief, and Economic Security (CARES) Act
Signed into law on March 27, 2020

• Provides economic assistance to health care providers by temporarily lifting the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020.
• Funds a new loan product within the Small Business Administration (SBA) to provide qualified small businesses and non-profits up to $10 million to help cover payroll and overhead costs, with expanded loan forgiveness criteria.
• Provides $100 billion in direct financial support to qualifying hospitals, physician practices, and other health care providers under the Public Health and Social Services Emergency Fund.
• Grants authority for the Secretary of HHS to waive telehealth coverage requirements for new patients during a national emergency and for enhanced use of telehealth under Medicare for federally qualified health centers.
• Applies Good Samaritan protections for which we’ve long advocated to volunteers serving COVID-19 patients for the duration of the public health emergency.
• Allows a high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.
• Allows Federally Qualified Health Centers and Rural Health Clinics to furnish telehealth services to beneficiaries in their home or other setting. Medicare would reimburse for these
services at a composite rate similar to payment provided for comparable telehealth services under the Medicare Physician Fee Schedule.

- Allows physician assistants, nurse practitioners, and other professionals to order home health services for beneficiaries.
- Increases the payment that would otherwise be made to a hospital for treating a patient admitted with COVID-19 by 15 percent.
- Appropriations $16 billion to replenish the Strategic National Stockpile supplies of pharmaceuticals, personal protective equipment, and other medical supplies, which are distributed to State and local health agencies, hospitals and other healthcare entities facing shortages during emergencies.
- Require Medicare to make quicker coding, coverage, and payment determinations when the Food and Drug Administration approves truly novel drugs, biologics, and devices, such as those that will be necessary to treat COVID-19.

PHASE II – *Families First Corona Virus Act*  
Signed into law March 18, 2020

- Provides for no cost sharing or medical management techniques for COVID-19 testing and services related to testing for private health plans, Medicare, Medicare Advantage, Medicaid or CHIP plans.
- Clarifies Medicare telehealth provisions to ensure that new Medicare beneficiaries are able to access telehealth services under the emergency authority granted to the Secretary
- Amends the Family and Medical Leave Act of 1993 to provide qualified small business employees with the right take up to 12 weeks of job-protected leave if the employee due to a need for leave to care for a child.
- Mandates that employers with fewer than 500 employees provide employees two weeks of paid sick leave, paid at the employee’s regular rate, to quarantine or seek a diagnosis or preventive care for coronavirus.
- Increases federal medical assistance percentages (FMAP) for state Medicaid programs by 6.2 percentage points
- Prohibits cost sharing and prior authorization for certain coronavirus testing and related services, such as provider visits for testing
- Appropriates $1 billion for the National Disaster Medical System to reimburse costs associated with testing the uninsured.
- Adds personal respiratory protective devices as a covered countermeasure under the Public Readiness and Emergency Preparedness Act.

PHASE I - *Coronavirus Preparedness & Response Supplemental Appropriations Act*  
Signed Into law March 6, 2020
• Allocates $2.2 billion for the CDC, including $950 million for state and local preparedness grants, and $300 million for the Infectious Diseases Rapid Response Reserve Fund.
• Allocates $836 million for the National Institutes of Health, $10 million of which is to be set aside for worker-based training to prevent and reduce exposure to health workers.
• Provides $61 million for the Food and Drug Administration to respond to coronavirus, including developing medical products.
• Provides $3.1 billion for the Public Health and Social Services Emergency Fund to be used to develop and purchase vaccines and medical supplies
• Appropriates $836 million for the NIH, including $10 million for worker-based training and health worker protection;