

Commercialization of COVID-19 Vaccines, Treatments, and Tests: Implications for Access and Coverage

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Issue Brief

Commercialization of COVID-19 Vaccines, Treatments, and Tests: Implications for Access and Coverage

KFF

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In response to the unprecedented nature of the COVID-19 pandemic, the federal government spent billions of dollars in emergency funds between 2020 and 2022 to purchase medical countermeasures – vaccines, including boosters, treatments, and tests – and provided them free of charge to the public. In addition, Congress enacted several bills¹ that included special requirements for their coverage by both public and private insurers, and the administration issued guidance² and regulations to protect patient access and promote equitable distribution. The effective dates of many, though not all, of these requirements were tied to the public health emergency (PHE) declaration made pursuant to Section 319 of the Public Health Service Act, first declared in January of 2020 and renewed every 90 days through February 9, 2023, effectively ending the PHE on May 11, 2023. The availability of federally-purchased COVID-19 medical countermeasures ensured that they were provided free to all.

Now that the PHE has ended, the federal government has been transitioning these products to the commercial market, where their provision and availability varies by insurance status and other factors. In some cases, access will be curtailed while in others, the federal government is continuing some programs to assist those with limited coverage. This document provides a side-by-side comparison of how vaccines, treatments, and tests were provided during the PHE and with a federally purchased supply compared to the current situation, organized by payer.

Table 1: COVID-19 Vaccines

Table 2: COVID-19 Treatments

Table 3: COVID-19 Tests

Table 1: COVID-19 Vaccines

PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
MEDICARE	Medicare covered COVID-19 vaccines, including boosters, for beneficiaries at no cost in traditional Medicare and Medicare Advantage under Medicare Part B. This is due to statutory changes that were made by the CARES Act which added coverage of FDA-approved COVID-19 vaccines to Part B. In addition, CMS issued regulations requiring no-cost Medicare coverage of COVID-19 vaccines that had been granted emergency use authorization (EUA) but not yet licensed by the FDA. Medicare paid providers for COVID-19 vaccine administration, but not for the vaccine itself, since the vaccine was free to providers through the US government purchased inventory.	Medicare beneficiaries continue to have access to COVID-19 vaccines, including boosters, at no cost under Part B. With the government-purchased inventory of COVID-19 vaccines now superseded by new commercial products, Medicare determines payment rates and allowances for providers, based on 95% of the average wholesale price, and pays providers for the vaccine itself along with administration of the vaccine.

Table 1: COVID-19 Vaccines

PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
MEDICAID/CHIP	Medicaid and CHIP covered COVID-19 vaccines, including boosters, with no cost sharing for all Medicaid enrollees, including those enrolled in limited benefit coverage, except those eligible only for Medicare cost sharing assistance, per provisions in the Families First Coronavirus Response Act (FFCRA) and the American Rescue Plan Act (ARPA). States reimbursed providers for the cost of administering the vaccine and received 100% federal matching payments for these costs.	Provisions in the American Rescue Plan Act (ARPA) and the Inflation Reduction Act (IRA) require Medicaid and CHIP programs to cover all ACIP-recommended vaccines, including COVID-19 vaccines/boosters, with no cost sharing even when the PHE ends and there is no longer any supply of federally purchased vaccines. States receive 100% federal matching payments for the costs associated with administering the vaccine through the end of the last day of the first quarter that begins one year after the PHE ends (September 30, 2024). After that, state costs will be matched at the state’s regular federal matching percentage (FMAP) and enhanced FMAP for CHIP. For children on Medicaid, the Vaccines for Children Program (VFC) provides free COVID-19 vaccines. The VFC program purchases the vaccine and makes it available to VFC-registered providers. Providers can bill Medicaid for costs of administering the vaccines. For other Medicaid and CHIP

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PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
		enrollees, states will pay providers for the vaccine plus an administration fee. These state Medicaid and CHIP costs will be matched at the state’s regular and enhanced (for CHIP) FMAPs.

Table 1: COVID-19 Vaccines

PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
PRIVATE	No one with private insurance should have been asked to pay for federally-purchased COVID vaccines, including boosters, or for vaccine administration while there was a federal supply of vaccines. Vaccine providers participating in the CDC COVID-19 Vaccination Program (i.e., those receiving federally-purchased vaccine doses) were allowed to seek reimbursement from private health insurers for the cost of administering the vaccine, but they were prohibited from billing patients even if the patient’s health plan did not reimburse the provider or did not cover the full cost of the vaccine administration. Most private insurers reimbursed vaccine providers for administration costs, in part because the Affordable Care Act (ACA) requires most plans to cover preventive services, including any vaccine recommended by the CDC’s Advisory Committee on Immunization Practices (ACIP), as all COVID-19 vaccines in the U.S. are. While the ACA requires coverage of ACIP-recommended vaccines no later than one year after their recommendation, the CARES Act shortened this to 15 days for COVID-19 vaccines. This is irrespective of whether the	Most people with private insurance will continue to pay nothing out-of-pocket for COVID-19 vaccines/boosters, but there will be exceptions (e.g. in the case of out-of-network care and grandfathered plans) now that federally purchased vaccines are no longer available. Under the ACA, people enrolled in non-grandfathered plans (i.e., the vast majority of people with private insurance) continue to pay nothing for recommended COVID-19 vaccines and associated appointments, so long as they receive this care from an in-network provider. The requirement that private plans/issuers cover out-of-network COVID-19 vaccines without cost sharing ended when the PHE ended. However, in the unusual event the enrollee is unable to access a vaccine at any in-network provider, the ACA requires plans to cover out-of-network delivery of preventive services. The ACA’s preventive services coverage requirement does not apply to grandfathered plans and Short-Term Limited Duration

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PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
	vaccine is under an emergency use authorization or fully approved by the FDA. Even in cases when the insurer was not subject to the ACA coverage requirement (e.g. for out-of-network care or grandfathered health plans), the patient could not be billed for the vaccine, its administration, or the associated visit when the vaccine dose was purchased by the federal government. In cases when private plans did not cover or did not fully cover the cost of administering the vaccine, vaccine providers were at one point able to submit claims for reimbursement from the federal government. However, due to a lack of funding, the federal government stopped accepting these claims on April 5, 2022.	(STLD) plans. Therefore, these plans may impose cost sharing or decide not to cover vaccines at all. Private insurers will be required to take on more of the cost of vaccines (including paying for the doses themselves in the commercial market), which could have a small upward effect on premiums.

Table 1: COVID-19 Vaccines

PAYER	PRIOR STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND END OF § 319 PHE
UNINSURED	Uninsured individuals could obtain COVID-19 vaccines, including boosters, for free from any provider participating in the CDC COVID-19 Vaccination Program. To participate in the program, providers agreed to provide the vaccine at no cost to every individual regardless of insurance status. Until April 5, 2022, providers could submit claims for the costs of administering the vaccine to people who were uninsured to the HRSA COVID-19 Uninsured Program, but due to a lack of funding, this program was discontinued. Fifteen states adopted a temporary option to provide Medicaid coverage for COVID-19 vaccines, testing, and treatment to uninsured individuals and received 100% federal matching funds to cover the costs of providing care. This coverage ended when the PHE ended.	Even with commercialization of COVID-19 vaccines, the government still purchases vaccines for uninsured children to access for free through the VCF Program. VFC providers cannot charge for the cost of the vaccine but can charge an administration fee. Federal funding for this program is mandatory, meaning necessary funding is provided by Congress each year based on the number of vaccines needed to cover eligible children. Uninsured adults, however, have no guaranteed access to free vaccines recommended for routine use. To address the lack of guaranteed access to free COVID-19 vaccines, the Biden administration created the “Bridge Access Program”, a public-private partnership to provide vaccine access at local pharmacies, through existing public health infrastructure, and at local health centers. Financed with \$1.1 billion in funds already appropriated during the COVID-19 emergency, vaccines are purchased through the CDC’s Section 317 program, which

Table 1: COVID-19 Vaccines

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		provides vaccines to uninsured adults, and distributed through that network of state and local health departments and community health centers. Additionally, CDC has partnered with three pharmacy chains, providing them with a per-dose payment to support vaccine administration costs. This program will run through December 2024.

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Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
MEDICARE	Beneficiaries in traditional Medicare and Medicare Advantage paid no cost sharing for COVID-19 monoclonal antibody treatments and certain other COVID-19 treatments, including oral antiviral medications authorized by the FDA (Paxlovid and molnupiravir) during the PHE. Medicare beneficiaries with COVID-19 who received remdesivir during an inpatient stay did not pay separately for the drug, since what patients pay for inpatient hospital stays is generally unrelated to the cost of any services they receive. (Traditional Medicare beneficiaries pay a \$1,632 deductible in 2024 and daily copays for extended stays. Medicare Advantage enrollees typically pay a flat amount for each hospital stay and/or day.) Medicare paid providers for COVID-19 monoclonal antibody treatments (when it was not received by the provider for free through the US government purchased inventory) and made a separate payment for its administration. Medicare did not provide payment for the	COVID-19 oral antiviral treatments (Paxlovid, Lagevrio, and Veklury) have begun to transition to the commercial market (note that monoclonal antibody treatments are no longer being used). Paxlovid and Veklury have been approved by the FDA; Lagevrio has been authorized for emergency use. The federal government will continue to provide federally-procured Paxlovid for free to Medicare beneficiaries through the end of 2024, whether through Part D plans or a standalone patient assistance program run by the manufacturer (Pfizer). Thereafter, it will only be covered for Medicare beneficiaries in Part D plans, and they may face cost sharing. More generally, oral antivirals are covered by Part D, but beneficiaries may face cost sharing. This is the case for Lagevrio, for which there is no patient assistance program available to Medicare beneficiaries. Based on changes in the CAA 2023, oral antivirals are covered whether they are authorized for emergency use or approved by the FDA, although the allowance for coverage of drugs available under EUA expires at the end of 2024.

Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
	monoclonal antibody products to treat COVID-19 that health care providers received for free, as was the case upon the product's initial availability in response to the PHE. While physicians and other Medicare providers and suppliers could not bill Medicare for the product they receive for free, they could be paid for its administration. During the PHE, oral antiviral medications for COVID-19 were purchased by the US government and distributed directly to pharmacies. As such, there was no direct payment to providers under Medicare for these treatments. CMS issued guidance to Part D plans that they were permitted to pay dispensing fees to pharmacies that submit claims for these products, but not for the product itself if obtained from the federally-purchased supply. Typically, Part D does not cover drugs that are not approved by the FDA, such as oral antiviral drugs to treat COVID-19 that were authorized for use by the FDA under an Emergency Use Authorization (EUA) prior to receiving full approval by the	Once the supply of oral antivirals fully transitions to the commercial market, Part D plans will pay for the cost of the drug and its administration, and Part D enrollees are expected to face varying cost sharing amounts, since costs vary across Part D plans. Medicare pays providers who administer COVID-19 treatments for commercially purchased products for both the treatment and its administration.

Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
	FDA. The Consolidated Appropriations Act (CAA), 2023 made a temporary change in the definition of a covered Part D drug to explicitly include oral antiviral drugs (such as Paxlovid) authorized for use under an EUA but this coverage will end on December 31, 2024.	

Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
MEDICAID/CHIP	Medicaid and CHIP covered COVID-19 treatments with no cost sharing for full-benefit enrollees, due to provisions in the American Rescue Plan Act (ARPA). These treatments included monoclonal antibody treatments and oral antiviral medications. States reimbursed providers for COVID-19 monoclonal antibody treatments (when they are not received by the provider for free through the US government purchased inventory) and for the costs related to administering the treatments; states received federal matching payments at the regular and enhanced (for CHIP) FMAPs for these costs. Oral antivirals were paid for by the federal government, so there was no cost to Medicaid/CHIP for the medications themselves.	Provisions in the American Rescue Plan Act (ARPA) require Medicaid and CHIP programs to cover all drugs and biological products for the treatment or prevention of COVID–19 with no cost sharing for full-benefit enrollees through the end of the last day of the first quarter that begins one year after the PHE ends (September 30, 2024). In addition, the federal government will continue to provide federally-procured Paxlovid for free to Medicaid beneficiaries through the end of 2024. Once the coverage period mandated by ARPA ends, treatments that have FDA approval will be covered but could be subject to cost sharing requirements and utilization limits. However, whether treatments that are still under emergency use authorization (EUA) – that is, without FDA approval – will be covered will vary by state, based on state decisions.

Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
PRIVATE	There was no federal law specifically addressing private insurance coverage of COVID-19 treatment or setting limits on out-of-pocket costs for COVID-19 treatment. However, Affordable Care Act (ACA) requirements that non-grandfathered plans sold to individuals and small businesses cover Essential Health Benefits (like hospitalizations, laboratory services, and prescription drugs) apply to COVID-19 treatments, just as they would to other conditions. Plans may charge cost-sharing, but the ACA annual out-of-pocket maximum limits how much most insurers may impose in cost sharing for in-network services. Early in the pandemic, most insurers voluntarily waived out-of-pocket costs for COVID-19 treatment. However, most insurers began to reimplement cost sharing by late-2021. Still, oral antivirals were purchased by the federal government during this period and were provided free of charge.	Because there is no federal law specifically addressing how COVID-19 treatment should be covered by private insurance, there was no change with the end of the PHE. People with COVID-19 hospitalizations continue to face cost-sharing, which often exceeds \$1,000. As the federal supply of Paxlovid has been directed toward people who are insured through public programs or uninsured, privately insured individuals now face cost-sharing for these oral antivirals in accordance with their health plan requirements. Paxlovid’s manufacturer (Pfizer) will operate a copay assistance program for those who are commercially insured through 2028. With commercialization, private insurers will take on more of the cost of medications like Paxlovid that had previously been supplied by the federal government, and this transition could have a small upward effect on premiums.

Table 2: COVID-19 Treatments

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
UNINSURED	Uninsured individuals in the 15 states that had adopted the temporary Medicaid coverage option were able to obtain COVID-19 treatment services, including oral antivirals and monoclonal antibodies, with no cost sharing. Uninsured individuals in other states were not required to pay for the costs of government-purchased COVID-19 treatments, including oral antivirals and monoclonal antibodies; however, they could be charged for any necessary physician or hospital outpatient visit to obtain a prescription or to administer the treatment, though some were able to access care provided on a sliding-scale from safety-net providers.	With the end of the PHE, the temporary Medicaid coverage option also ended, and uninsured individuals in the states that had adopted the option would face costs for related visits and treatments. However, in the case of Paxlovid, the federal government announced that those who are uninsured will have free access to federally-procured Paxlovid through 2024, via a patient assistance program and thereafter, the manufacturer (Pfizer) will run a patient assistance program to provide free Paxlovid to uninsured individuals through 2028. For other oral antivirals, there are also patient assistance programs available.

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Table 3: COVID-19 Tests

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
MEDICARE	Clinical diagnostic testing, including testing for COVID-19 (as distinct from rapid antigen at-home tests) was covered at no cost for traditional Medicare beneficiaries under Medicare Part B. In addition, under a Biden Administration initiative, beneficiaries in traditional Medicare and Medicare Advantage had no cost sharing for COVID-19 at-home testing (up to eight tests per month) during the PHE. A provision in the Families First Coronavirus Response Act (FFCRA) eliminated beneficiary cost sharing for COVID-19 testing-related services, including the associated physician visit or other outpatient visit (such as hospital observation, E-visit, or emergency department services). A testing-related service is a medical visit furnished during the PHE that results in ordering or administering a COVID-19 lab test. The law also eliminated cost sharing for Medicare Advantage enrollees for both the COVID-19 lab test and testing-related services and prohibited the use of prior	Beneficiaries in traditional Medicare continue to receive clinical diagnostic testing for COVID-19 at no cost since Medicare covers their diagnostic lab testing under Part B, but they face cost sharing for testing-related services. However, they have faced the full cost of at-home tests since the PHE ended. Beneficiaries in Medicare Advantage plans may face cost sharing for clinical diagnostic testing for COVID-19, depending on whether their plan charges cost sharing for this service, and face cost sharing for testing-related services. Some Medicare Advantage plans may cover the cost of at-home COVID-19 tests through an over-the-counter benefit or other coverage approach.

Table 3: COVID-19 Tests

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
	authorization or other utilization management requirements for these services during the PHE.	
MEDICAID/CHIP	Under the American Rescue Plan Act (ARPA), Medicaid and CHIP programs were required to cover FDA-authorized COVID-19 tests, including at-home COVID-19 tests, without cost sharing for full-benefit enrollees. States could require a prescription for the at-home test or apply medical necessity criteria.	Medicaid and CHIP programs must cover COVID-19 testing and testing-related services, including at-home tests, for full-benefit enrollees at no cost through the end of the last day of the first quarter that begins one year after the PHE ends (September 30, 2024). Once the mandated coverage period ends, states will continue to cover COVID-19 testing as a mandatory laboratory service if the test is ordered by a physician and provided in an office or similar facility. States may continue to cover COVID-19 tests provided without a physician’s order, including at-home tests, as an optional service, but coverage could vary by state. States may also impose cost sharing for the tests and/or testing-related services.

Table 3: COVID-19 Tests

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
PRIVATE	In most cases, people with private insurance were able to receive COVID-19 testing without cost sharing during the PHE. If the COVID-19 test was considered to be medically appropriate (e.g., for diagnostic purposes or out of a reasonable concern for COVID-19 exposure), private health plans – including grandfathered plans – were required to cover the cost of the test and the associated visit without cost sharing for the duration of the PHE. This coverage requirement applied to both rapid antigen and PCR COVID-19 tests performed or ordered by a provider. During the PHE there was no limit to the number of tests an individual can receive if deemed medically appropriate. Insurers were also required to reimburse for tests performed by out-of-network providers during the PHE. Additionally, beginning January 15, 2022 and lasting for the duration of the PHE, people with private insurance plans were able to order or seek reimbursement for eight (8) FDA-authorized rapid at-home COVID-19 tests per month. No prescription or medical management was required.	Now that the PHE has ended, most people with private insurance are likely subject to cost sharing for COVID-19 tests. The typical price of a COVID-19 test is roughly \$45, and private health plan enrollees will often have to pay at least some portion of that out-of-pocket, and may also face cost-sharing for the physician visit to receive the test. There is no longer a requirement that at-home (over-the-counter) COVID-19 tests continue to be covered. The Affordable Care Act (ACA) requires non-grandfathered plans sold to individuals and small businesses to cover laboratory services as an Essential Health Benefit (EHB), which includes lab-based or provider administered COVID-19 testing. However, the ACA allows insurers to impose cost sharing (deductibles, coinsurance, and copayments). Insurers may also limit coverage of COVID-19 testing to in-network providers, require a prescription or physician's order for COVID-19 testing, and impose cost sharing for the associated physician visit. Insurers may also limit the number of tests that are covered.

BioNTech-Pfizer Exhibit 1294

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Table 3: COVID-19 Tests

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
	Federal guidance allowed for a reimbursement cap of \$12 per test in certain circumstances. If testing was done for a reason that was not medically indicated (e.g., a work-place testing requirement or for public health surveillance purposes), the health plan was allowed to apply cost sharing or refuse to cover the cost of the test altogether. Through the end of the PHE, providers were required to make public the cash price of COVID-19 tests on their websites. The COVID-19 testing coverage requirements did not apply to Short-Term Limited Duration (STLD) plans, as enrollees in these plans are considered uninsured.	Although the ACA requires non-grandfathered health plans to cover <i>without cost sharing</i> any preventive service with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF), to date, the USPSTF has not considered, for purposes of rating, any COVID-19 test, meaning that plans <i>may</i> impose cost sharing for the test and the associated visit. Grandfathered plans are exempt from both the ACA’s EHB and preventive service coverage requirements. With the end of the PHE, these plans can impose cost sharing or stop covering the cost of COVID-19 tests. STLD plans are exempt from the requirement.

Table 3: COVID-19 Tests

PAYER	CURRENT STATUS (WITH FEDERAL SUPPLY & § 319 PHE IN PLACE)	END OF FEDERAL SUPPLY AND/OR END OF § 319 PHE
UNINSURED	Uninsured individuals in the 15 states that had adopted the temporary Medicaid coverage option were able to obtain COVID-19 testing services, including at-home tests, with no cost sharing. This coverage ended when the PHE ended. Uninsured individuals in other states were not charged for the cost of any test purchased by the federal government but likely paid full cost for any testing-related services. Uninsured individuals could get COVID-19 tests at no cost or on a sliding-scale from local health departments or certain safety providers; however, individuals without access to these providers paid full cost for the test and any testing-related services.	Uninsured individuals have to pay the full cost of COVID-19 tests and testing-related services, although they may be able to obtain free or reduced-cost tests from local health departments or safety net providers. In addition, the CDC operates the Increasing Community Access to Testing (ICATT) for COVID-19 program, which provides no-cost COVID-19 testing for people who are uninsured who are symptomatic or have been exposed to COVID-19.

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Endnotes

1. Families First Coronavirus Response Act (FFCRA), <https://www.congress.gov/bill/116th-congress/house-bill/6201> and KFF summary of FFCRA, <https://www.kff.org/coronavirus-covid-19/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>; The Coronavirus Aid, Relief, and Economic Security (CARES) Act, <https://www.congress.gov/bill/116th-congress/house-bill/748> and KFF summary of the CARES Act, <https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/>; The American Rescue Plan Act of 2021 (ARPA), <https://www.congress.gov/bill/117th-congress/house-bill/1319/text> and KFF brief on ARPA Medicaid provisions, <https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/>; The Inflation Reduction Act of 2022(IRA), <https://www.congress.gov/bill/117th-congress/house-bill/5376/text> and KFF summaries of health provisions in the IRA, <https://www.kff.org/medicare/understanding-the-health-provisions-in-the-senate-reconciliation-legislation/>, and Medicaid changes, <https://www.kff.org/policy-watch/medicaid-and-the-inflation-reduction-act-of-2022/>.

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2. See, for example, <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/other-agency-guidance/cms-guidance/index.html> and <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf>.

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