COMMUNITY CATALYST

Legislative Recommendations in Response to COVID-19

An effective response to COVID-19 will address both the health and economic aspects of the crisis. One thing to bear in mind is that the particular nature of the economic challenge means that many traditional supply and even demand-side interventions will not be that effective. Below are some health care proposals to consider when crafting the stimulus package over the coming days; most are intended to meet the dual need for both an economic boost and increased health care access and consumer protection.

Priority health care proposals

There are a number of proposals that Community Catalyst views as *most urgent* given the timeline of the public health crisis and protecting people and state economies. It is clear that we must act quickly to expand access to affordable treatment, in addition to testing. Specifically, we recommend that Congress prioritize investments in the Medicaid program, which is the program most able to scale up quickly to meet the public health crisis. Further, we recommend increased access to Marketplace plans by creating a special enrollment period (SEP) to maximize enrollment of uninsured people coupled with an increase in premium support. Finally, consumers are worried about financial security and accruing medical debt. Ensuring no-cost-sharing for testing and treatment across all private products (including short-term and limited duration plans) is imperative.

One of the most effective things Congress can do is further shore up the Medicaid program. State revenues are going to decline precipitously, while demand for coverage is going up. Although the House has already passed an increase it is not enough; **a ten-percentage point increase** is more in line with what is needed at this time. Expanded Medicaid funding does triple duty – it preserves and helps expand access to health care, it protects against cuts in other vital state services that would result from declining state revenue and it stimulates the economy.

In addition, a federal medical assistance percentage (FMAP) increase can be structured to incentivize states that have not yet taken up Medicaid expansion to do so by providing **100 percent federal match for expansion**, at least for the duration of the public health emergency and through the economic recovery. A longer incentive period will be even more effective in achieving the goal. We urge Congress to restore the original three-year 100% match rate to help states expand at a time when state revenues are declining.

Congress should also consider adjusting financial assistance and coverage for Marketplace enrollees. Cost of coverage remains a barrier for many people and even those who have coverage will be reluctant to seek testing and – if necessary – care, if they face a prohibitive cost-

sharing burden. **Congress could create a Special Enrollment Period (SEP) and temporarily boost advanced premium tax credits (APTC) for all eligibles to no less than the lowest cost Bronze plan for the remainder of the calendar year.** This should be coupled with the **elimination of cost-sharing for COVID-19-related testing and treatment** (a step recently taken in Massachusetts). This step will get more people covered and also ensure that providers are paid for this treatment. Congress could couple this with reinsurance to address any adverse selection problem.

Congress should take specific action to protect people from medical debt. First, they should **eliminate COVID-19 related cost-sharing in all private plans** including STLDI plans, fully insured plans and self-insured plans. Second, Congress should **require health care providers that receive federal emergency funding to provide uninsured patients with *free* COVID-19 testing and treatment.** This reduces administrative burden and protects uninsured consumers from medical debt; the cost will likely reach as high as $20,000 for the average COVID-19 hospitalization, according to the Kaiser Family Foundation. Patients will be on the hook for over $1,000 of that total cost on average. Third, **any COVID-19-related medical debt accrued from February 1, 2020 until 60 days following the lifting of the state of emergency should be subject to consumer protections** including, but not limited to: a one-year prohibition on collection activity; a one-year prohibition on credit reporting; an extension of state and federal health insurance appeal deadlines; a prohibition on balance or "surprise" billing; a prohibition of any extraordinary collection actions as listed at 26 CFR 1.501r; and a prohibition of interest or collection fees related to these debts.

Finally, Congress should further delay scheduled cuts to disproportionate share hospital payments coupled with a **new requirement that hospitals not bill the uninsured and that they also do not bill people with high deductibles for COVID-19 treatment.** An alternative, though less far-reaching approach would be to require that hospitals not send anyone to collection for COVID-19-related treatment and determine eligibility for financial assistance based on income only for anyone treated for COVID-19, which helps address people with high deductibles and whoever remains uninsured.

Additional health care proposals

- **Revise Emergency Medicaid for suspected COVID-19 infections** to ensure that during this public health emergency, testing and treatment of health conditions is provided by Medicaid for all who need it, regardless of their immigration status.
- Require plans regulated by **ERISA to fully cover COVID testing and treatment.**
- Require non-ACA-compliant plans (including, but not limited to, short-term-limited duration plans, association health plans, transitional plans) to **fully cover COVID-19 testing and treatment with no cost-sharing.**

- **Pass the Coronavirus Relief for Seniors and People with Disabilities Act (S. 3544),** including its HCBS grants to support Direct Support Professional (DSP) and Home Health Workforce and to support aging adults and people with disabilities in their homes and communities.
- **Expand access to paid leave.** The House-passed emergency bill was a good start but many provisions were walked back in the technical amendment; the exemption of large employers remains a significant problem since there are many at-risk low-wage workers who work for large companies. Access to paid leave is a priority and should be expansive and meet the needs of those disproportionately affected.
- **Require SAMHSA to consult with recovery community organizations and service providers to address COVID-19** and the disruption of existing peer services nationwide.
- **Extend the presumptive eligibility (PE) period to at least six months and increase the matching rate for administrative expenses tied to PE to 100 percent**. Increasing awareness of outreach and enrollment opportunities will take new trained staff, system changes and follow up with consumers.
- **Provide telehealth funding for substance use disorders that supports both infrastructure and training** for recovery community organizations to provide peer-based recovery services. The GOP stimulus bill would enable use of telehealth grants for substance use disorders, which is a good first step, but does not provide a path for recovery groups to obtain those funds.

Related safety-net proposals

Targeted cash assistance

While widely distributing cash assistance is gaining popularity on both sides of the aisle, it is likely to be very expensive, while providing less economic benefit than would be the case in a normal recession scenario. Much of the initial spending decline we are experiencing is not due to people lacking money, it is a side effect of "social distancing." For the same reason, "supply side" fixes targeted at putting money in the hands of business are also not likely to have a large effect, but could be very expensive. **Financial assistance to businesses should be limited to those who are providing sick leave, and who are continuing to pay workers whose hours have been cut back due to social distancing-related reductions in staffing needs.** This will ensure that the funding goes where it will do the most good.

Giving people who are still receiving their full wages additional cash is not likely to influence their spending very much. On the other hand, 1/5 of adults already report lost income due to COVID-19 and this number is sure to grow over the weeks ahead. The most important interventions here will be to preserve the essential purchasing power of these people – including many who are not eligible for Unemployment Insurance (UI) – so they can continue to afford

food, housing, utilities, etc. **Expanding UI benefits to include "gig" workers, perhaps keyed to their most recent 1099 or tax filing would be one approach, along with expanding the duration and wage replacement rate of UI**. In addition to helping address shortages of direct care workers to care for older adults and people with disabilities, **cash payments should be made available to family caregivers**.

Supplemental Nutrition Assistance Program (SNAP)

While the House-passed legislation addressed some aspects of food policy by allowing emergency SNAP assistance, we can do more to address the needs of families. In addition to reducing food insecurity, SNAP is also effective in stimulating the economy. The strongest evidence on the effectiveness of increasing SNAP benefits in times of national crisis is the large natural experiment that took place several years ago in response to the Great Recession. Starting in April 2009, SNAP benefits were increased by 13.6%t for all SNAP participants, pursuant to the American Recovery and Reinvestment Act (ARRA). This increase was in recognition of the effective and rapid stimulating effect of SNAP benefits on the economy, as well as the recognition that hard-hit families needed additional assistance. At a high level, the changes to SNAP in the House-passed bill would allow states to apply for waivers to increase access to SNAP benefits, but falls short of providing an increase similar to what was done during the 2009 stimulus package. **Congress should implement an increase in SNAP assistance similar to 2009**.

Crisis Mitigation for Justice-Involved Populations

In addition to the above proposals, **we encourage Congress to consider the particular circumstances of people who are incarcerated or otherwise involved with the criminal justice system.** Reducing the number of incarcerated individuals and better identifying and treating COVID-19 within that population will help reduce spread of the disease. Specifically, we recommend:

- Funds to set up screening in jails and prisons and to support community-based providers with infectious disease expertise going into jails/prisons to provide treatment.
- Training funds for corrections officers to learn to identify COVID-19 symptoms and respond appropriately.
- Funds to support expanding pre-arrest diversion programs to help reduce jail population size.

Housing

Finally, a glaring hole in the recently passed package is its lack of provisions for homelessness and housing stability services or any planning for when people are at risk of eviction or

foreclosure as a result of this crisis. On the homelessness front, we know homeless service providers will be facing massive challenges in reducing transmission while still offering services, so federal support there is critical. For example, **Congress should create an emergency assistance fund to help prevent evictions by providing short-term financial assistance and housing stabilization services**. This is especially important if a national moratorium on foreclosures and evictions is not implemented.

Providing short-term assistance to stabilize individuals and families is far cheaper than allowing them to become homeless. **Congress should work quickly to ensure a moratorium on foreclosures and evictions to help renters and homeowners remain stably housed during and after a COVID-19 outbreak.** At a minimum, this moratorium should extend to federally subsidized housing, including public housing, Response-to-Corona shelter, and other HUD housing, and for properties owned or insured by Fannie Mae, Freddie Mac, Federal Housing Administration (FHA), Veterans Affairs (VA), or the United States Department of Agriculture's Rural Housing Service (RHS).