



Recommendations in Response to COVID-19: Strengthening the Federal Approach

The federal response to date to secure public health and support state and local economies includes supplemental funding, the *Families First Coronavirus Response Act* and the *CARES Act*. These legislative actions took important steps to respond to COVID-19 and begin to address both the health and economic aspects of the crisis. However, the federal response to date is not sufficient to match the magnitude of what our country is facing. Importantly, COVID affects everyone but doesn't affect everyone equally. People who already face unfair barriers to care – including people with low incomes, [people with substance use disorders](#), [people with complex health and social needs](#), [people who identify as LGBTQ+](#), and [people of color](#) – are bearing the brunt of both the virus and the economic downturn. Indeed, COVID-19 has unveiled the pervasive and deep inequities in our society, including those rooted in racism and classism.

There are several factors that place people of color, especially Black people, at greater risk. People with low incomes and people of color are being hit harder by the COVID-19 pandemic. They are more likely to be exposed to the virus, more likely to receive bills for care they cannot afford, [less likely to have paid leave](#), and more likely to [lose their jobs](#) as a result of the economic crisis COVID-19 has caused. People of color disproportionately work in [frontline industry jobs](#) – from grocery stores to cleaning services to public transit – that put them at greater risk of being exposed to the virus. People working these essential jobs, who are disproportionately people of color and immigrants, are often providing critical service to their communities without the protective gear they need to stay out of harm's way. In total, Black people are more likely to work in occupations that are essential and/or in which they cannot physically distance themselves from others or work from home. Undocumented immigrants face [discriminatory prohibitions](#) from health care safety-net supports even though they pay taxes to support public programs. Other populations, too, face longstanding and unfair barriers to testing and treatment while more likely to be at risk of COVID-19 complications. [LGBTQ+ people are more likely](#) to work in essential jobs, live in poverty and lack access to health care, paid leave, and basic needs.

Our failure to act equitably actually puts everyone at risk. While we cannot expect to address all of these long-standing inequities in the context of a pandemic and economic contraction, our response must reflect the fact that the risks and vulnerabilities in our country are not equally distributed and that a failure to extend health and economic supports equitably will undermine our collective efforts to contain the health and economic damage of the virus. The following recommendations are essential not only to address this injustice, but also to ensure that our response to the pandemic and its economic fallout is effective for everyone. Policymakers must act. They are the only ones who have the power and the resources to do so in a way that addresses the needs of people and communities, particularly those most harmed by COVID including people of color, immigrants and other populations that are experiencing disparate trauma.



Coverage and Affordability

As people lose their jobs, they are losing their health insurance too – widening the coverage gap for people of color in this country. Even before COVID-19 hit, 29 million people in the U.S. lacked health insurance coverage, including [a disproportionate share](#) of people of color who face unjust and discriminatory barriers to health and economic security. For example, 11.5% of Black people are uninsured versus 7.5% of white people. With the COVID-19 pandemic already causing a 10% unemployment rate, [it is estimated](#) that 12 million people have lost their employer-sponsored insurance – further exacerbating the underlying coverage gap for people of color. Further, we know that uninsured [Blacks are more likely to fall in the coverage gap](#) in states that have not expanded Medicaid. Additionally, according to [Kaiser Family Foundation](#), Hispanics and Asians are more likely to be eligible for but unenrolled in coverage options. These disparities in coverage can be reduced by expanding Medicaid in non-expansion states, and improving Marketplace affordability.

Medicaid Financing

- **Shore up the Medicaid program by increasing and extending the federal matching rate.** State revenues are going to decline precipitously, while demand for coverage is going up. Although the House has already passed an increase of 6.2 percentage point in the federal matching percentage, it is not enough; [a twelve-percentage point](#) increase is more in line with what is needed at this time as recommended by the National Governor’s Association (NGA). Further, we support the inclusion of Division G, Title I, Section 70101 of the [Take Responsibility for Workers and Families Act](#), the House proposal in response to the Senate version of CARES, that addresses countercyclical funding of Medicaid.
- **At a minimum, the enhanced match and the maintenance of effort (MOE) provision should last for the duration of the economic contraction and phase back down gradually as state revenues recover.** The enhanced match should extend to the expansion population (up to a cap of 100%). The 100% federal match for non-expansion states (and the equivalent for late-expanders) should last for several years to encourage these states to expand.
- **Allow states to receive enhanced FMAP for administrative services, and in particular, for interpretation/translation services for individuals with limited English proficient (LEP).** Enhanced funding for administrative services is essential to ensure adequate support for outreach and enrollment activities, which communities will desperately need as the uninsurance rate climbs. As unemployment continues to surge, states need additional capacity to ensure the public has information and that applications are determined [within 45 days](#). In addition, while Medicaid does have a state option for reimbursement of language services, many states [have not](#) taken it up. A temporary enhanced FMAP for interpretation services under Medicaid and CHIP would assist in ensuring availability of interpretation services during the economic downturn.

- **Clarify that Emergency Medicaid covers testing and treatment of COVID-19 and suspend Public Charge rule.** The Public Charge rule, which forces immigrant families to choose between basics like food and housing and staying together, should be suspended immediately. At minimum, the rule's "public charge" test should exempt not only COVID-19 testing and treatment, but all emergency assistance received during this crisis, including cash and food assistance provided via federal, state, or local programs.
- **Allow Medicaid coverage to begin 30 days pre-release for criminal justice populations.** Congress can change federal law to permit use of federal matching funds for this purpose, and/or could allow and direct CMS to speedily approve state waiver requests to use Medicaid funds in this way. During the pandemic, uses of this funding must include COVID-19 testing and treatment, support of community-based providers with infectious disease expertise to provide treatment in jails and prisons, and facilitating warm hand-offs to community providers on re-entry.
- **Repeal the Medicaid Fiscal Accountability (MFAR) proposed rule.** The MFAR proposed rule would take billions of funding away from states at a time when our public health system needs resources most. The current proposal extremely limits existing state Medicaid financing arrangements such as provider taxes and intergovernmental transfers. This means that states will have even fewer resources available to draw down federal Medicaid matching funds. Reducing supplemental payments during a pandemic would financially destabilize hospitals and other health care providers. Finalizing the rule would do serious harm to states.

Marketplace and Private Insurance

- **Increase the income below which no premiums are required to 200% FPL and suggest a more gradual increase in premiums for low- and moderate-income households.** We appreciate the substantial improvements in premium affordability that were proposed in the [Take Responsibility for Workers Act](#), including eliminating premiums below 150% FPL, creating a cap on the percentage of income for people at or above 400% FPL and generally making premiums more affordable across the income scale. But further reductions in premiums for low- and moderate-income people are necessary in order to make coverage truly affordable. For example, we estimate that an individual with no children in Albany County NY needs approximately \$28,000 (a little over 225% FPL) per year to afford housing food and other necessities without considering the cost of health. Premiums (and cost-sharing) for people with incomes below this point undermine their ability to afford these other necessities. **We also recommend that workers whose employer-sponsored insurance costs them and their family more than the applicable percentage of a Marketplace plan be given the option of obtaining subsidized Marketplace coverage.** Finally, people who are eligible for coverage under COBRA should be able to use their APTC to maintain their group insurance rather than acquire coverage on the marketplace.

- **Create a Special Enrollment Period (SEP).** A special enrollment period will get more people covered and also ensure that providers are paid for delivery care. The emergency SEP should be open to anyone who wishes to enroll. Limiting the SEP to defined groups who must verify eligibility would not only delay care, it would deter enrollment by healthy consumers, endangering the individual-market risk pool.
- **Eliminate cost sharing for COVID-19 related treatment in all private health plans, including short-term limited duration insurance (STLDI) plans and other coverage arrangements not subject to federal coverage standards.** According to a recent study, the cost for COVID-19 related treatment during an average hospitalization stay could reach as [high as \\$20,000](#) with privately insured patients on the hook for over \$1,000 of the total cost, on average. While the previous relief efforts require private health plans to cover testing and the associated visit related to the diagnosis of COVID-19 without cost sharing for patients, the legislation does not address costs associated with treating the virus. During this time of extreme financial uncertainty, **Congress must take the next step and require all private health plans – including short-term plans, health care sharing ministries and farm bureau plans – to cover COVID-19 related treatment without cost sharing.** This standard should apply even in cases where due to a testing shortage a formal COVID-19 test is not administered, but a patient is treated as if they tested positive. The requirement to cover treatment without cost sharing should be coupled with a [risk mitigation program](#) for insurers to keep markets stabilized.
- **Provide additional resources to support multilingual enrollment assistance.** Enrollment assistance has a proven track record, helping states track consumer complaints and identify problems to strengthen enrollment and programs and provide consumers clear information about their rights. Congress should provide at least \$400 million in funding, which represents double the last House proposal for both navigators and outreach, given the spike in demand. Funding should require: 1) at least two entities serve as assisters per state, one of which is community-based; 2) coverage is provided statewide; 3) allowance of in-person options ; 4) inclusion of Medicaid enrollment with language and physical access; and 5) providing year-round assistance. In addition, Congress should fund consumer assistance programs (CAPs) for states that maintain these entities, appropriating at least \$30 million in grant funds.

In addition to the above policies addressing Medicaid and private insurance, Congress should:

- **Protect people from medical debt.** Congress should require health care providers that receive federal emergency funding to provide uninsured patients with *free* COVID-19 testing and treatment. In addition, any COVID-19-related medical debt incurred or accrued from February 1, 2020 until 60 days following the lifting of the state of emergency should be subject to enhanced 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 billing for *all* health care services (including testing, treatment and preventive services) provided to COVID-19 patients; 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. While HHS has announced that healthcare providers receiving funding through the [Provider Relief Fund](#) must abstain from "balance billing" for any patient receiving COVID-related treatment, Congress should require these providers, as well as insurers, to notify consumers of their rights and this consumer protection. **Suspend legal actions to collect any medical debt.** While the state of emergency is in place until 60 days after it is lifted, suspend all legal actions such as wage garnishments, court-ordered payment plans or liens on personal property or accounts for all medical debt.

- **Provide a continuous special enrollment period (SEP) for dual eligible beneficiaries.** Dually eligible beneficiaries are currently only able to change their Medicare Advantage or Part D plan enrollment once per quarter. These individuals, who are already living in poverty, do not have the financial resources to weather any disruption or denial of care when in a plan that does not meet their needs. This is particularly problematic during this current crisis when their care and treatment needs are extremely likely to change. Providing a continuous SEP would reduce administrative complexity and mitigate disruptions and access to care.

Access and Quality

While coverage and affordability are key components of responding to the public health crisis, it is vital to ensure access to high quality care—and advance policies that specifically address inequity in access to resources and support populations that are left behind. We know that some populations are disproportionately affected by COVID-19. People who work in jobs that are deemed “essential” have greater exposure to the virus – many of these jobs lack any guaranteed health insurance and are low-wage professions leaving people without savings, paid leave and social supports. According to the Bureau of Labor Statistics, Black and Hispanic workers are [two times as likely](#) to earn wages below the poverty level and Blacks, Hispanics, AIANs, and Native Hawaiians Other Pacific Islanders (NHOPIs) are [more likely to be uninsured](#) to Whites—taken together, these place people of color at greater risk. We must use policy interventions to address these inequities by directing resources to where they are needed, building infrastructure that reorients our systems toward equity and reversing policies that perpetuate inequity. These recommendations include:

Targeted Resources

- **Direct additional funding to under-resourced communities to support health and financial security of essential workers.** Essential workers are defined as those who are working to ensure that daily life continues – from home health workers who care for older people and people with disabilities to grocery store, delivery and transportation



workers. They also include our community health workers, peer support workers and others who provide front line care. Essential workers are [disproportionately people of color and survive on minimum wage](#); they live in low-resourced communities with limited access to health care services.

- **Increase funding for PPE for health care and essential workers by passing [S. 3570](#).** It is [well-documented](#) that there continues to be a shortage of personal protective equipment (PPE) for our health care workers and our essential workers. Congress must direct the President to use the Defense Production Act to require U.S. companies to produce PPE to meet the demands of the pandemic. Funds for this directive are available under section 304 of the Defense Production Act of 1950 ([50 U.S.C. 4534](#)).
- **Provide at a minimum, \$150 billion to states and localities to help ramp up testing centers** in communities that are disproportionately affected and/or are medically underserved health areas.
- **Create a Heroes Fund to provide premium pay to essential workers** through the end of the calendar year. Frontline workers would also be granted the new benefit of up to \$25,000. See [here](#).
- **Direct OSHA to investigate complaints of essential workers.** The agency announced that it [would not require](#) employers outside health care, emergency response or corrections to formally investigate whether COVID-19 cases among employees are work-related unless there is a clear cluster of illness. There must be stricter protections for essential workers that are not medical workers.
- **Support frontline health workers and communities disproportionately impacted by COVID-19.**
 - **Increase funding for the Coronavirus Provider Relief Fund and direct at least 30 percent to non-Medicare providers.** Currently, the Coronavirus Provider Relief Fund [leaves out needed support](#) for pediatricians, OBGYNs, substance use treatment providers, providers of long-term services and supports (LTSS) and other Medicaid providers to maintain access for Medicaid patients; this is because to date, funding is distributed through the Medicare payment system. More congressional guidance is needed to ensure that we maintain health system infrastructure in states and localities. Congress should direct HHS to reserve 30 percent of provider relief funds to support providers who serve a disproportionate share of low income and uninsured patients and include community-based service providers receiving state-only funding (e.g. certain SUD treatment providers, doulas, Community Health Workers (CHWs), LTSS providers and others).
 - **Invest [\\$4.5 billion](#) in state and local public health infrastructure.** As part of the public health response, infrastructure is necessary to collect data, analyze, monitor and support quarantine and recovery for both individuals and communities. As part of this investment, contact tracing is vital for the economy

to recover. However, contact tracing requires a workforce with deep connections to community. Public health funding should promote the hiring community health workers (CHWs) and other community workers (doulas, peer supports and others); funding should require bias training for all workers.

- **Enhance funding for the Coronavirus relief fund for units of government with a population of 500,000 or less, and for other purposes, see [here](#).**
- **Provide at least \$250 million of new funds in the Substance Abuse Prevention and Treatment (SAPT) Block Grant Program.** This mechanism can get money quickly to all 50 states with lots of flexibility in how states spend the money, including for prevention, treatment and recovery services. Also, allow carryover into FY 2021 of any unspent funds in existing substance use disorders or mental health block or discretionary grants.
- **Pass the Coronavirus Relief for Seniors and People with Disabilities Act ([S. 3544](#)),** including its HCBS grants to support the Direct Support Professional (DSP) and Home Health Workforce. This bill is vital to supporting older adults and people with disabilities in their homes and communities, keeping them out of congregate spaces that are high risk.
- **Provide \$58 million to the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention** for grants to states, territories, tribes, counties, and local health departments and to community-based organizations to provide, sustain, and expand essential harm reduction and overdose prevention services, including syringe services programs, and overdose education and naloxone distribution.
- **Provide \$15 billion for a separate Safety Net Coronavirus Provider Relief Fund for front-line health workers that include doulas, peer support, dental therapists, community health workers and others who are providing important care to communities of color.** HHS should deliver to states based on rates of COVID among racial and ethnic minorities for the purpose of supporting frontline health professionals focused on community caregiving.
- **Guarantee Patient Access to Telehealth.**
 - **All health plans and all levels of care.** All health insurance plans, including all ERISA plans, Medicare and state Medicaid programs, must cover telehealth at parity with in-person care. This must include all levels of mental health and addiction outpatient care, including intensive outpatient and partial hospitalization care, as well as other types of screening, assessment, treatment, and recovery services.
 - **Equitable access and payment for telehealth services.** To ensure equitable access, audio-only should be fully reimbursed at the same rate as a telehealth visit to ensure that poor internet connectivity or lack of video conferencing ability by seniors and others do not inhibit access to care. Finally, out-of-network restrictions and penalties should be temporarily waived for telehealth services.



- **Increase access to provider types and services.** For example, open more [teledentistry codes](#) for oral health providers so that they can begin to serve patients who are awaiting treatment.
- **Reduce the number of individuals incarcerated in federal prisons, and in state prisons and jails.** Congress can expand eligibility for release, order streamlined review and set hard deadlines to speed releases from federal prisons of people who do not pose a threat of violence to communities. Following Congressional direction in COVID-3, the DOJ and Bureau of Prisons began this process but it is moving far too slowly to save lives, and the criteria may reinforce racial disparities in the prison system. To reduce incarceration in state prisons and jails, Congress can double funding for pre-arrest diversion programs offered through the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) that provide people with needed community services instead of incarceration.
- **Improve prevention, identification and treatment of COVID-19 among people incarcerated as well as prison and jail employees.** Congress can fund an expansion of screening in jails and state and federal prisons, including all employees and people incarcerated who may be exposed. Congress can also fund community-based providers with infectious disease expertise to provide treatment in jails/prison.

Build Infrastructure

- **Require U.S. Department of Health and Human Services (HHS) and its sub-agencies, such as the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), U.S. Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ), and other relevant agencies, to monitor and address racial and other disparities in our nation's response to the coronavirus disease 2019 (COVID19) public health emergency.** Congress should appropriate at least \$100 million to support infrastructure and capacity needs of departments of public health. Without demographic data, policy makers and researchers will have no way to identify and [address ongoing disparities](#) and health inequities that risk accelerating the impact of the novel coronavirus and the respiratory disease it causes. Disaggregated data should include: race, ethnicity, geographic location, primary language, socioeconomic status, gender identity, sexual orientation, age, and disability status of patients being tested, the rate of positive test results for each group, insurance coverage status and outcomes for those diagnosed with COVID-19. As a corollary to this funding, Congress should pass a community-based research grant program as outlined in the Data to Save Moms Act, [H.R. 6165](#), that would promote greater levels of community engagement in data collection, reporting and analysis. We applaud the community engagement approaches in the Data to Save Moms Act, H.R. 6165, and encourage an expansion to engage all pregnant people, not only cis-gendered women, as involving people from all impacted communities in data collection and research is paramount.

- **Make funding for rapid build of digital infrastructure available to groups working to meet demand for health services.** For example, programs should direct funding to substance use and mental health Recovery Community Organizations (RCOs) for immediate purchasing of items to support telehealth services and infrastructure, such as cell phones, tablets, cell service, and internet accessibility. This include passing the Tech to Save Moms Act, [H.R. 6138](#) that establishes a grant program to promote digital tools designed to improve maternal health outcomes for minority women.
- **Provide \$20 million in funding to sustain school-based health centers so they are able to reopen alongside schools.** Young people are experiencing increased trauma, depression, anxiety, and substance misuse as a result of COVID-19. Investing in school-based health centers increases access to critical mental health care as well as substance use prevention and early intervention services.

Address Barriers to Quality Care

- **Direct the Office of Civil Rights (OCR) to issue guidance on what constitutes unlawful discrimination** on the basis of disability and age as it relates to the allocation of limited resources due to the COVID-19 pandemic, including in determinations concerning the denial, removal, or suspension of health care and services based on perceptions concerning quality of life or the intensity of services needed, and the provision of reasonable modifications under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116). The guidance should give due consideration to medical expertise and necessity.

Social Determinants of Health

The social determinants of health — poverty, unequal access to care, housing, geography, employment, education, and structural racism — must be confronted as they are significant contributing factors to worsening health disparities, as well as obstacles to the coverage and quality objectives in addressing the COVID-19 pandemic. As such, individuals and families need their most basic needs fulfilled during this crisis in order to mitigate spread, allow people to recover and ensure long-term health and economic security.

Targeted cash assistance

- **Require businesses that receive financial assistance to provide sick leave, and continue to pay workers whose hours have been cut back due to physical distancing-related reductions in staffing needs.** This will ensure that the funding goes where it will do the most good. The most important interventions here will be to preserve the essential purchasing power of people earning low-wages – including many who are not eligible for Unemployment Insurance (UI) – so they can continue to afford food,

housing, utilities, etc. While the CARES Act included robust additions to the UI system, the expanded benefits are short-term and do not address the continued need for economic assistance after the pandemic passes. Instead, duration could be tied to economic conditions via automatic 'triggers.' Additional benefits could then automatically kick in in response to an uptick in the unemployment rate. Funding for state and local governments should also be provided to better administer gravely overburdened UI systems, and get cash into the hands of consumers faster. 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** or any family members who provide care that would otherwise be provided by a home health worker. Cash assistance and UI benefits should be disregarded as income for the purposes of any means tested programs including Medicaid and Marketplace subsidies.

- **Expand access to paid leave and eliminate exemptions.** Legislation should provide paid family leave support for the family care needs of all workers in addition to funding to meet other basic necessities. Paid leave should be available to individuals who must attend to their own medical conditions and those who have been advised to self-quarantine due to exposure or high-risk status. Paid sick, family and medical leave should be available to individuals employed by businesses with more than 500 employees, businesses with fewer than 50 employees, and federal agencies. This can be done by eliminating existing carveouts and OMB authority to exempt federal agencies.
- **Include all immigrant workers and tax filers in the tax rebate so that people can receive vital cash assistance.** Cash rebates are available to recent tax filers based upon their taxpayer identification numbers, but limited to those using Social Security numbers (SSNs). Many people file their tax returns using an Individual Taxpayer Identification Number ([ITIN](#)). Under the CARES Act, if ITIN users file jointly with a spouse or child with an SSN, everyone in the household will be denied access to the cash assistance. Cash assistance is not available to many immigrant workers who are risking their health as essential worker without access to COVID-19 testing and care.

Housing Stability

- **Ensure a national, uniform moratorium on evictions and foreclosures.** Several [states and localities have instituted eviction and foreclosure moratoriums](#). Congress should implement a uniform policy that assures that renters will not lose their homes during a pandemic where our collective health depends on each of us staying home. The law should prohibit rent arrears accumulated during the period covered by the moratorium from forming the basis of an eviction.
- **Provide Emergency Solutions Grants (ESG): At least \$11.5 billion.** Congress provided \$4 billion in ESG funds in the CARES Act; [additional funds are needed to respond to coronavirus](#) among people experiencing homelessness, who are at particularly high risk for infection, hospitalization and death.



- **Pass emergency rental assistance and eviction prevention: [\\$100 billion](#).** A moratorium on evictions, on its own, is not enough. Congress must also provide rental assistance to avoid creating a financial cliff for renters when eviction moratoria are lifted and back-rent is owed. This assistance can be provided through a combination of Emergency Solutions Grants, Housing Choice Vouchers, Section 521 Rural Rental Assistance, or the Disaster Housing Assistance Program (DHAP).

Supplemental Nutrition Assistance Program (SNAP)

- **Boost SNAP [maximum benefits](#) by 15 percent, increase the minimum SNAP benefit from \$16 to \$30; and suspend all SNAP administrative rules that would terminate or weaken benefits.** As businesses shut their doors and lay off workers, many are struggling to access nutritious food. Systemic discrimination and inequalities cause higher rates of food insecurity for people of color. The COVID pandemic worsens this reality and leaves even more people of color food insecure. Research shows that SNAP plays a [critical role](#) in keeping families healthy and secure, and expanded SNAP coverage would play a pivotal role in stopping hunger during the pandemic.