NTU
NATIONAL TAXPAYERS UNION

Issue Brief

MARCH 25, 2020
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Policy Options to Support the Health Care Workforce

The COVID-19 (coronavirus) pandemic poses unprecedented economic and public health challenges for the United States. Over the last several days, two emerging problems have presented particularly daunting scenarios for federal and state policymakers: 1) the lack of child care options available for health care workers whose kids are home from school, and 2) the constraint this pandemic will put on the number of hospital beds available around the country. ProPublica, the New York Times, and the Harvard Global Health Institute have written extensively on the hospital bed challenge, noting that even 20 percent of Americans contracting the virus in the next six months would lead to bed shortages in almost every part of the country.

Federal and state policymakers need quick policy options to ramp up the supply of both the health care workforce (by offering child care services to those workers who need them) and hospital beds (to ease burdens on hospitals across the country and the staff who work there). National Taxpayers Union (NTU) has been active in providing economic, fiscal, and health policy options for federal and state lawmakers over the last several weeks, and we outline some additional proposals below to help ease supply constraints in the American health care system. As the taxpayer's

Key Facts:

The COVID-19 pandemic poses unprecedented challenges to the health care workforce, and threatens America's supply of hospital beds.

Policymakers need to enhance the ability for health care workers to obtain emergency child care services, and for child care providers to meet demand.

Federal and state governments also need to take a variety of statutory and regulatory measures to drastically increase the number of available hospital beds.

advocate, NTU has a deep interest in limiting the size and scope of the pandemic's economic and public health impacts, and doing so in a way that makes governments more efficient and flexible in this time of crisis.

Sizing Up the Health Care Workforce

According to the Kaiser Family Foundation (KFF), as of May 2018 there were around 16.86 million people working in health care in the United States. Roughly one in five work in one of the three states dealing with the most COVID-19 cases right now: California (1.67 million workers, or 10 percent), New York (1.25 million workers, 7.5 percent), and Washington (333,000 workers, or two percent).

KFF's count does not even include non-health care professionals working in insurance, or those working for biopharmaceutical companies. But their count does include three broader categories that encompass many frontline health care workers:

- **Ambulatory health care services**: physicians, dentists, other health practitioners, outpatient care centers, medical and diagnostic labs, home health care services, all other ambulatory health care services
- **Hospitals**: general and medical surgical hospitals, psychiatric and substance abuse hospitals, special hospitals
- **Nursing and residential care facilities**: nursing care facilities, residential mental retardation, mental health, and substance abuse facilities, community care facilities for the elderly, other residential care facilities

Putting 16.86 million health care workers on constant call, with schools closed around the country for potentially months to come, could lead to significant demand- and supply-side concerns at child care facilities. The health care workforce may face financial strains trying to place their young children in daily care facilities for several months, while child care facilities that have to comply with hundreds of regulations - many of them in place for good reasons - will face challenges staffing and scaling up to meet demand.

Sizing Up the Supply of Hospital Beds

A related concern affects the health care workforce and the patients they serve: a dwindling supply of hospital beds around the nation. ProPublica, citing Harvard's new data on hospital bed supply, put the dire situation best:

> "Even in a best-case scenario, with cases of coronavirus spread out over 18 months, American hospital beds would be about 95% full. (This assumes that hospitals don't free up already occupied beds or add more beds, as some elected officials have called for.) Some regions would have the capacity to handle the surge in hospitalizations without adding new beds or displacing other patients.
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> But in most other scenarios where the virus spreads faster or infects more people, hospitals would quickly fill their available beds with patients, and they would be forced to either expand capacity, limit elective surgeries and other non-necessary treatments, or make life-and-death decisions about care, similar to what has happened in the worst-hit regions of Italy, where some doctors have received guidance to only treat patients 'deemed worthy of intensive care.'"

The American health care system could be tens of thousands of health care workers and millions of beds short in a few months, depending on the spread and severity of the virus. Federal and state policymakers need to consider, debate, and implement thoughtful and creative solutions to the crisis now, not a few weeks or months from now. NTU offers some statutory and regulatory policy options below, with the intention of starting a longer conversation about how to best help the health care workforce during this stressful time.

Supporting the Workforce: Child Care Policy Options

As mentioned above, two major issues may face health care professionals with children at this time: 1) an inability to afford child care services they had not budgeted for due to unexpected school closures and the nature of the pandemic, and 2) constraints on child care providers due to an influx of parents unexpectedly requiring those services.

To tackle the affordability of unexpected child care for health care professionals, policymakers have several options at hand. Each has their pros and cons. We consider them below:

- **Extra cash payments to health care professionals with children**: This is perhaps the simplest, quickest, and most predictable funding stream to provide immediate relief to the health care workforce. As proponents of cash payments have noted during the current debate on Capitol Hill, these payments are relatively easy to administer, and the Treasury Department could put extra cash into the hands of health care professionals in a matter of weeks. Some obvious disadvantages of this proposal are the difficulty in verifying who is an eligible health care professional, and the fact that even a $1,000 cash payment - if utilized by a health care professional exclusively for child care - would cover only a few weeks to two months of child care costs, depending on the state.

- **Temporary expansion and/or refundability of the child and dependent care tax credit (CDCTC)**: The child and dependent care tax credit (CDCTC) is currently a nonrefundable credit for up to 35 percent of employment-related child and dependent care expenses. The credit applies to up to $3,000 in expenses for one child (so a credit equal to $1,050) or $6,000 in expenses for two or more children (a credit equal to $2,100). Starting with an adjusted gross income level of $15,000, the credit begins phasing down from a 35-percent rate to a 20-percent rate, where it remains at 20 percent beyond $43,000 AGI. Policymakers could expand the CDCTC in a number of ways for health care professionals, such as applying the credit to a higher level of expenses than $3,000 or $6,000 per year, raising the credit from 35 percent of expenses to some other number, or suspending or eliminating the income phase-down for health care professionals. Policymakers could also make the credit refundable for the health care workforce (meaning "if the amount of the credit exceeds the taxpayer's Federal income tax liability, the excess is treated as an overpayment of tax payable to the taxpayer," according to JCT). While this is relatively easy to administer as an existing tax credit, and is more directly tied to the issue of child care affordability than direct cash payments, the glaring weakness in this approach is that it would be an end-of-year tax benefit. Health care workers with children will need some relief now, not in April 2021.

- **Increasing funding for the Child Care Entitlement to States (CCES), and temporarily extending eligibility to the children of health care professionals**: CCES funds child care for low-income families at the state and tribal level. There are three primary funding sources for CCES: mandatory federal spending (around $2.9 billion in FY 2019), mandatory state matching (around $2.1 billion in FY 2019), and discretionary federal funding through

the Child Care and Development Block Grants (CCDBG; around $5.2 billion in FY 2019). Funds from the CCES flow to families in the form of vouchers, which allow families to select a child care provider of their choice. CCES served 1.3 million children in FY 2017, and eligibility is limited by four primary criteria: 1) the child is under age 13; 2) the parent is working; 3) the family's income is no greater than 85 percent of the state's median income; and 4) the family has no more than $1 million in assets. CCES vouchers could temporarily be expanded to health care workers with children, using supplemental funding appropriated by Congress through CCDBG. While this funding could be easy to put in the hands of struggling families, it is unclear whether existing child care providers have the capacity to handle a rapid influx of children.

That precise issue - whether child care providers can handle a sudden influx of children whose parents need to work around the clock to meet America's health care needs - applies no matter what relief Congress attempts to put in the hands of the health care workforce. Here are a few options federal and state lawmakers can consider to rapidly increase the supply of both child care facilities and providers, while maintaining high health and safety standards for the children being served:

- **Relax provider licensing requirements that are unrelated to the health and safety of children**: Stakeholders who have advocated for child care policy reform much longer than NTU have pointed out some areas for licensing reform. The White House wrote in December 2019 that "[s]ome regulatory practices, such as local zoning laws, inadvertently drive up price and reduce availability but do not necessarily create a more safe or nurturing environment for children." The American Enterprise Institute (AEI) has pointed to Wisconsin inspection requirements calling for "various types of play equipment shall be provided to allow for large and small muscle activity, dramatic play, creative expression and intellectual stimulation." And the Mercatus Center has identified onerous staff-to-child ratios and provider education requirements that constrain growth in both facility capacity and provider supply.

- **Consider state-to-state licensing reciprocity, and re-licensure for recently retired providers**: Just as states and the Department of Health and Human Services (HHS) have loosened health professional licensing restrictions across state lines and with recently retired workers, states and the federal government should consider doing the same for child care providers who are in good standing in their primary state (or were in good standing upon retirement).

- **Two ideas from the Bipartisan Policy Center (BPC): 1) make sure small child care providers can access emergency Small Business Administration (SBA) loans, and 2) enable for-profit child care providers to access Public Assistance Program funding**: BPC's Linda Smith, Kathlyn McHenry, and Megan Campbell go into more detail here, and it seems that either proposal would give struggling child care providers access to valuable capital to stay afloat or expand capacity in this time of dire need.

Policymakers should also consider any creative ways to match idle supply (such as primary or secondary school teachers who are out of work) with surging demand at child care centers, though the health, safety, and well-being of the children being served will always be paramount.

Supporting the Workforce: Increasing Hospital Beds

Amid a supply crunch that is impacting nearly every corner of the American health care sector, no supply crunch is perhaps more concerning in the long term than the lack of hospital beds. It's a

problem that, as ProPublica notes, could touch just about every county in the country in six to 18 months.

Below is a policy menu for federal and state lawmakers and regulators to consider, some of which can be found in our existing Issue Brief, "Health Policy Options Congress and State Lawmakers Should Consider to Combat COVID-19."

- **Repeal or suspend state certificate of needs (CON) laws**: NTU pointed out earlier this week that 38 states and D.C. have CON programs, which prevent new hospitals and facilities from being built without assent from regulators and incumbents. These laws should be relaxed or repealed, especially in the 14 states that have specific restrictions for expanding items like hospital beds, long-term care beds, and nursing home beds. If Congress is so inclined, they could condition state-level relief on the temporary relaxation of these laws during this public health emergency.

- **Repeal or suspend the ACA's ban on the expansion of physician-owned hospitals**: As we wrote on March 18, the Affordable Care Act "effectively halted the construction of new [physician-owned hospitals] POHs and 'generally prohibited [existing POHs] from expanding facility capacity.' The Trump administration has called for repealing the rules, writing that according to the Physician Hospitals of America '37 planned hospitals have not been constructed, and over 30,000 planned healthcare jobs have gone uncreated' because of these restrictions. For lawmakers who don't have the appetite to repeal the ban, a temporary suspension could help physicians rapidly stand up temporary facilities to treat COVID-19 patients.

- **Encourage states to convert university dorms and other appropriate, vacant facilities to temporary beds for mild COVID-19 patients**: In New York, which now has thousands of confirmed COVID-19 cases, the mostly-vacant New York University (NYU) is preparing to convert dorms into temporary hospital beds. "There are significant indications that the State, as part of its contingency planning, is looking at university dormitories as settings for overflow beds from hospitals," the university said. While public and private actors will need to determine the answers to some sticky questions, like who pays for utility bills in buildings that would have otherwise been idle, university dorms could provide for temporary space much quicker than public or private actors could construct new hospitals. Cruise ships are another possibility, as Carnival Corporation just offered to make ships available to serve as temporary hospitals.

- **Ramp up construction of temporary hospitals**: Governors in New Jersey and New York have asked the Trump administration to unlock the U.S. Army Corps of Engineers' potential to rapidly build temporary facilities that can house COVID-19 patients. Officials have pointed out that this would probably involve "converting an existing building into a clinic" rather than constructing new facilities. Gov. Phil Murphy (D-NJ) is also asking hospital CEOs in his state to "consider "re-opening eight hospitals in New Jersey that have closed in recent years, as well as wings of other hospitals that have been closed." States are already finding innovative sites for temporary facilities, such as idle fairgrounds and school soccer fields. State lawmakers should work actively with the private sector and contractors, with support from the federal government.

Federal and state policymakers should also take several steps to staff up hospitals and facilities for the coming surge in demand, including 1) establish licensing reciprocity between the states, 2) establish a voluntary re-licensure path for recently retired health professionals in good standing, 3) temporarily suspend or relax certain scope of practice laws and regulations, 4) ramp up telehealth services, and 5)

give health professionals volunteering their services during the emergency certain liability protections or even a tax incentive. While hospital beds are in short supply and deserve special attention from policymakers, successfully ramping up the supply of hospital beds will also require a surge in providers.

Conclusion

The above policy options are by no means an exhaustive list, but are meant to continue a conversation happening on Capitol Hill and in states across the country as the nation deals with an unprecedented public health and economic emergency. NTU remains a group committed to lower taxes, free markets, and limited government, but this is an extraordinary time that requires an extraordinary response. Policymakers would be wise to choose policy that provides immediate, temporary, and targeted relief to health care workers on the front lines, and relaxes regulations enough to provide for a surge in child care providers, hospital and facility beds, and health care providers. With a fast, cohesive, and efficient response, the public and private sectors can work together to mitigate the negative economic and health impacts of the COVID-19 pandemic.

About the Author

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