

Issue Brief

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NTU's Health Policy Menu for Phase 4

Congress passed a historic \$2 trillion bill last week to stem the devastating public health and economic impacts of the COVID-19 (coronavirus) pandemic. This 'Phase 3' package followed much smaller Phase 1 and Phase 2 efforts passed by lawmakers, and Congressional leaders are already turning their focus to a Phase 4 package.

It is unclear as of now whether the Phase 4 package will be another multi-trillion dollar bill, but NTU is offering a menu of health policy options meant to accomplish one (or more) of three goals: 1) provide relief for front-line workers during the pandemic; 2) provide relief for COVID-19 patients; and 3) incentivize the rapid supply of necessary medical goods and services. A few of these options (cash or vouchers for child care, for example) will have a fiscal impact, but most are regulatory changes meant to reconfigure the public health system for the present and future challenges posed by COVID-19.

For more detail on some of the below recommendations, see some of our earlier issue briefs [here](#) and [here](#).

Key Facts:



Congress is already beginning its work on a fourth legislative package to tackle the economic and public health challenges posed by COVID-19.



Lawmakers and regulators should pull from this menu of policy options to help meet the surging demand across the country for doctors, hospital beds, drugs, and more.



While some of these options will have a fiscal impact, most are focused on the regulatory flexibility states and providers need to respond quickly and effectively.

Menu

Providing Relief for Front-Line Workers

- Pass the Physician Pro Bono Care Act
- Put cash or vouchers for child care in the hands of health care workers with children
- Suspend the Social Security earnings limit for early retirees who rejoin the workforce
- Encourage CMS to issue more blanket Section 1135 waivers

Providing Relief for Patients

- Ensure no patient cost-sharing for COVID-19 hospitalizations under Medicare Part A

Incentivizing the Rapid Supply of Necessary Medical Goods and Services

- Pass the RESULTS for Coronavirus Patients Act
- Pass the Creating Capacity for Communities in Need Act
- Pass the Increasing Hospital Capacity to Fight the Coronavirus Act
- Clarify that CBP should prioritize the assessment and approval of imported medical goods

Providing Relief for Front-Line Workers

Pass the Physician Pro Bono Care Act

This legislation ([H.R. 856](#)) would allow doctors to deduct the value of charity care they provide to Medicaid and Children's Health Insurance Program (CHIP) patients from their taxable income. The deduction would be valued at the unreimbursed Medicare fee-for-service (FFS) value of physicians' services for most doctors, and the value of direct primary care (DPC) arrangements for direct primary care physicians.

Why is this legislation helpful? Because some doctors are reluctant to sign up for reimbursement from Medicaid and CHIP due to administrative burdens. This means they are less likely to furnish care to Medicaid and CHIP patients, because they cannot be paid for it. A charitable deduction for care, though, means doctors could provide care to these vulnerable populations without jumping through federal and state hoops to join Medicaid. As a [coalition letter](#) signed by NTU put it:

“In sum, this legislation creates an opportunity for doctors to help respond to a critical need for healthcare services in their communities by offering the incentive of a simple tax deduction rather than burdensome reimbursement paperwork for Medicaid and CHIP programs.”

There is a critical need for doctors right now, and the Physician Pro Bono Care Act could help more patients receive the care they need.

Put cash or vouchers for child care in the hands of health care workers with children

NTU has a detailed [Issue Brief](#) out that tackles a critically important topic: how to help health care workers access expensive child care providers as they put in extra hours to fight the pandemic, especially at a time when their children may not be in school.

We offered three options to lawmakers, noting some pros and cons for each:

- Extra cash payments to health care professionals with children: while most taxpaying adults will receive \$1,200 from the federal government under the Phase 3 package, lawmakers may consider an extra cash payment to help health care workers with children cover child care expenses. It may be difficult to determine who is an eligible health care professional and who is not, and there is no guarantee these cash payments would be diverted to child care. Nonetheless, this option could get cash into the hands of health care workers more quickly than the next two options.
- Expand the child and dependent care tax credit (CDCTC), and/or make it refundable: 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). There are a number of ways lawmakers could expand the CDCTC for health care workers with children, including making it refundable so that the value of the credit can exceed a taxpayer's federal income tax liability.
- Increase funding for the Child Care Entitlement to States (CCES): Lawmakers already took a step in this direction with the Phase 3 bill, by granting states [\\$3.5 billion](#) “for immediate assistance to child care providers...and to otherwise support child care for families.” An additional supplemental appropriation, though, could be set aside specifically for vouchers for health care workers with children *who wouldn't otherwise qualify* for participating in CCES.

Suspend the Social Security earnings limit for early retirees who rejoin the workforce

If someone retires before 67, they [lose \\$1](#) from their Social Security benefits for every \$2 they earn over \$18,240. Lawmakers could incentivize recent retirees in the health care or first responder workforce to rejoin the workforce during the pandemic by temporarily suspending the annual Social Security earnings limits for these workers. New York has [similar legislation](#) for its retirees pending in the State Assembly.

Encourage CMS to issue more blanket Section 1135 waivers

Under Section 1135 of the Social Security Act, states can request temporary waivers from Medicare and Medicaid requirements during public health emergencies. Some of these are “blanket” waivers issued by the Centers for Medicare and Medicaid Services (CMS) that do not require a separate application for approval from individual states, while some are case-by-case waivers that require a state application and subsequent CMS approval.

CMS has issued [blanket waivers](#) that will certainly help in this crisis, including:

- Waiving the 3-day prior hospitalization requirement for a Medicare recipient to be covered for a skilled nursing facility (SNF) stays;
- Waiving the 25-bed and 96-hour stay limits for critical access hospitals (CAHs);
- Waiving the 25-day average length of stay requirements for long-term care hospitals (LTCHs);

- And allowing Medicare to reimburse for telehealth visits and check-ins anywhere in the country.

CMS has also issued case-by-case waivers for a few dozen states on the following requirements (according to the [Kaiser Family Foundation](#)):

- 20 states have received approval to waive certain provider screening requirements (for participation in Medicare and Medicaid);
- 20 states have received approval to *allow* out-of-state providers with equivalent licensing in another state, and to *permit* them to provide care to their Medicaid enrollees;
- 19 states have received approval to postpone deadlines for revalidation of providers;
- And 15 states have received approval to allow service provision in alternative settings, including unlicensed facilities.

CMS and the states can do more, though. Congress should consider instructing or encouraging CMS to issue blanket waivers for some of the popular waivers they have approved on a case-by-case basis above. Both CMS and the states should consider additional Section 1135 waivers - one could cover Stark Law requirements, for example (Stark Law bans physicians from referring patients to services in which they have a financial relationship). The Congressional Research Service (CRS) [noted](#) that Congress could also:

“...consider additional waivers related to COVID-19 specifically, such as waivers of federal health care fraud and abuse provisions that can, in some cases, limit a health care entity’s ability to waive cost-sharing obligations, or provide reduced price services to federal health care program beneficiaries.”

Providing Relief for Patients

Ensure no patient cost-sharing for COVID-19 hospitalizations under Medicare Part A

The [Phase 2 legislation](#) ensured that all health insurers covered COVID-19 testing without cost-sharing, that Medicare covered COVID-19 testing *and* services that led to a COVID-19 test without cost-sharing, and that Medicaid and CHIP covered COVID-19 testing without cost-sharing. The Phase 3 legislation ensured that any COVID-19 [vaccine would be covered](#) under Medicare Part B without cost-sharing.

If a COVID-19 patient has severe symptoms, though, they may face significant cost-sharing requirements for a hospitalization related to COVID-19. Aetna, which covers almost 18 million people, has announced it will [waive cost-sharing](#) for “certain Aetna plan members who are admitted to the hospital for COVID-19 treatment or health complications associated with the disease.”

While the government should not mandate that private insurers cover hospitalizations with no cost-sharing, it *can* extend this guarantee to seniors on Medicare, many of whom are on fixed incomes. Given the Medicare Part A deductible is [\\$1,408 in 2020](#), and millions of Medicare beneficiaries lack supplemental coverage like a Medigap plan, such a guarantee could help many sick seniors avoid thousands of dollars in out-of-pocket expenses as a result of COVID-19 complications.

Incentivizing the Rapid Supply of Necessary Medical Goods and Services

Pass the RESULTS for Coronavirus Patients Act

NTU has written on this legislation ([S. 3545](#) and [H.R. 6260](#)), from Sen. Ted Cruz (R-TX) and Rep. Chip Roy (R-TX), [many times before](#). During the COVID-19 pandemic, the RESULTS for Coronavirus Patients Act would help in two major ways:

- By ensuring a drug or device approved to test for or treat COVID-19 that is *approved* in one or more allied countries gets put on a fast-track for Food and Drug Administration (FDA) approval here in the U.S.
- By helping an overwhelmed FDA, which has been slow at times in responding to [private sector pleas during the crisis](#), focus its efforts and limited resources on the most promising tests, treatments, and cures.

Pass the Creating Capacity for Communities in Need Act

This legislation ([S. 3547](#)), also from Sen. Cruz, would temporarily suspend a provision in the Affordable Care Act (ACA) that effectively stopped the growth of physician-owned hospitals (POHs). [According to Physician Hospitals of America](#), “37 planned hospitals have not been constructed, and over 30,000 planned healthcare jobs have gone uncreated” because of these legal restrictions. Temporarily lifting this cap on growth could allow POHs to ramp up and meet the surging demand for hospital beds and facilities.

Pass the Increasing Hospital Capacity to Fight the Coronavirus Act

This legislation ([H.R. 6336](#)) from Rep. Dan Bishop (R-NC) would remove Medicare and Medicaid payment reductions levied against hospitals that expand capacity in violation of a state’s certificate of need (CON) program. Thirty-five states and Washington, D.C. have these harmful programs in place, which serve to effectively block facilities like hospitals, nursing homes, and long-term care facilities from adding beds or capacity in times good and bad. During this pandemic in particular, hospitals should not be punished by states or the federal government for rising to meet the [nationwide need for more hospital beds](#).

Clarify that CBP should prioritize the assessment and approval of imported medical goods

The Congressional Research Service (CRS) has [noted](#) that Customs and Border Protection (CBP) “may be able to create a ‘green lane’ system, similar to those described above, to reduce processing times for medical goods” used to combat the pandemic. However, going through a rulemaking process could take several months. Instead, CRS suggests, Congress could “more quickly implement new customs prioritization procedures.” One way to do so is to instruct CBP to prioritize the assessment and approval of imported medical goods through the end of the COVID-19 public health emergency.

Unfortunately, the need for such a provision is not purely theoretical. Just last week, CBP [released](#) 41.3 million medical gloves that had been held at ports in California and Maryland for months. These kinds of delays will be unacceptable for newly imported medical goods that are critical for our nation’s health care workforce, like masks and gloves.

Conclusion

Congress and the Trump administration have worked at breakneck speed over the last few weeks to give the economy and the country's public health care system the resources they need to recover from the challenges of a lifetime. More can be done though, particularly when it comes to giving health care facilities and providers the flexibility they need to quickly and effectively respond to the COVID-19 pandemic. NTU stands ready to work with both branches of government to advance these priorities and more in the weeks and months ahead.

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