



To: The Biden-Harris Transition Team
From: Emily Barson, Executive Director
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Subject: Administrative & Legislative Health Policy Priorities for 2021 and Beyond

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Introduction

United States of Care is a non-partisan non-profit with a mission to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We were established by a diverse [Board of Directors and Founders Council](#) to advance state and federal policies that solve the challenges people face with our health care system. We seek to understand people's unique needs to drive health policy innovation, and partner with elected officials and stakeholders to pass and implement those ideas.

In order to expand access to health care for all people, we must build a better, more equitable health care system in the wake of COVID-19. Coming out of this year's elections, we know the largest concerns among voters are all related to health: the coronavirus pandemic (which, depending on the poll, ranks either first or third among voters' concerns) and the economy, which has been deeply impacted by the pandemic itself.

United States of Care collaborates with local and national leaders to support and build campaigns to move policies over the finish line. Our team takes a multi-faceted approach to providing tools, resources, and technical assistance, while sharing best practices both with our partners and policymakers. Throughout this work, we prioritize efforts that address the barriers people face in accessing health care; our work is informed by understanding those barriers and developing policies to fix them.

Building a Better Health Care System During & in the Wake of COVID-19

We understand that we have a moment to create a better health care system in the wake of the pandemic. In a public opinion survey commissioned by USofCare in November 2020, 84 percent of those polled agreed with the statement, "We must build a better, more equitable health system in the wake of the COVID-19 pandemic." In addition, 83 percent of those polled, "feel it is more important that we make changes to our current health care system as a result of the pandemic."

United States of Care [has undertaken a variety of research efforts](#) to better understand the shared and disparate needs and experiences of people. Our research has illuminated the public's interest in building toward a system in which:

1. People have certainty that they can afford their health care.
2. People have the security and freedom that dependable health care coverage provides as life changes.
3. People can get the personalized care they need, when and how they need it.
4. People experience a health care system that's understandable and easy to navigate.

To identify key priorities for the incoming Biden Administration and the 117th Congress, USofCare brought together over 20 members of our [Board, Founders and Entrepreneurs Councils](#). The recommendations below are informed both by their expertise and that of our in-house [staff](#).

Immediate COVID-19 Public Health and Economic Response

With the nation experiencing the worst wave of the COVID-19 pandemic to date, immediate and large scale action is essential. The ability of our economy to recover from the pandemic is directly linked to the quality of our public health response and investment in public health infrastructure. People who have to go to work, or keep their restaurant, bar, bowling alley, gym, or other establishment open to earn a living, likely will do so even when faced with escalating pandemic spread. That is why we must accept the undeniable link between individuals' personal financial situations and slowing the spread of COVID-19. For the sake of public health and the overstressed institutions of our health care system, we must invest in necessary public health responses and make additional financial assistance available.

Our recommendations are grounded in the ongoing public opinion research we have conducted over the last several months (national surveys in May and November 2020). There is broad support across Americans to address four critical shared needs when responding to the pandemic:

1. A reliable health care system that is fully resourced to support essential workers and available when it is needed, both now and after the pandemic.
2. A health care system that cares for everyone, including people who are vulnerable and those who were already struggling before the pandemic hit.
3. Accurate information and clear recommendations on the virus and how to stay healthy and safe.
4. Being able to provide for ourselves and our loved ones, especially as we are worried about the financial impact of the pandemic.

Administrative and Regulatory Measures

Vaccine Distribution and Rebuilding Public Health Infrastructure

Within the past few weeks, pharmaceutical manufacturers have released data showing encouraging COVID-19 vaccine efficacy in their clinical trials. With efficacy rates of over 90 percent, it is possible some people will begin receiving COVID-19 vaccinations in late December 2020. Without additional federal investment and leadership, United States of Care remains apprehensive about the ability of local, state and county public health infrastructure to widely distribute a vaccine in a way that both inoculates as many people as quickly as possible but is also completed in an equitable manner.

The federal government has already shared specific [federal guidance](#) and its decision-making [framework](#) about vaccine distribution and the Advisory Committee on Immunization Practices (ACIP) recently added [nursing home residents and health workers](#) to the population which should receive vaccinations first. We believe additional consideration should be given to people with disabilities, those at high risk of contraction of COVID-19, and for populations with higher morbidity and mortality rates.

Improved Testing Ability and Capacity

The nation's public health infrastructure has also struggled to return tests for COVID-19 [quickly enough](#) to be effective - defined as receiving results in 48 hours or less - in slowing the spread. If we are to continue to rely on private testing companies to do this work we must also send the proper demand signals to the industry for them to build capacity and return tests quickly.

1. The Biden administration should either press Congress for, or implement administratively, a structure similar to that contained in [H.R. 8496](#), which pays for COVID-19 testing on a defined scale depending how quickly results are returned.
 - a. This measure includes language requiring no payment if results come back 72 hours or more after they are taken.
 - b. Labs returning tests in 72 hours or later are required to continue to process those results and return them to patients under threat of not being able to participate in Medicare.
 - c. Notably, this legislation offers a clear incentive to return tests in 24 hour or less by offering a 25 percent bonus to do so.

Rapid and reliable testing should be deployed to help both reopen K-12 education in a more permanent way and also obtain valuable tracking information about where the virus is within a region. The CDC recommends in Phase 1b that school based personnel receive priority for vaccination. This would help the education system safely return to normal functioning which will have the additional effect of also boosting the economy. Compared to the general population, we have seen some colleges and universities successfully control COVID-19 on their campuses by routinely testing students once or twice per week. Routine testing in K-12 schools would provide the added benefit of identifying positive yet asymptomatic people, many of which are children, and help slow the spread to vulnerable populations from those who are not exhibiting symptoms.

Immediate Congressional Initiatives to Combat COVID-19

Legislative Measures

1. **Appropriate \$75 billion for contact tracing, testing and isolation efforts across the country.** Whether through shoe leather, technology, or both, this tried and true public health strategy is inextricably linked to the employee and consumer confidence necessary to keep our economy open. Failure to execute these steps on the scale needed has resulted in the very surges we have been working so hard to prevent, erasing the sacrifices people, communities, and businesses have made. Contact tracing workers are also essential in connecting vulnerable populations to care, particularly if they are recruited from – and trusted by – the communities in which they work. Due to the mental health impact of COVID, contact tracing and vaccination efforts should also include mental health screening, services, and referral.
2. **Increase Medicaid's Federal Matching Assistance Percentage (FMAP).** This federal funding helps states pay for their Medicaid programs. While federal legislation provided a temporary 6.2 percentage point increase in states' FMAPs through at least

March 31, 2021, states continue to face budget crises that, without additional federal funding, may lead some to reduce their Medicaid programs. We recommend an increase of an additional 7.8 percent to both boost the economy and stave off hospital and provider closure.

3. **Appropriate \$500 billion for state and local funding.** States and localities, [including jobs in education](#), are significantly shedding positions as these entities have no other place to turn than the federal government to bridge the significant gaps in tax revenue they are experiencing. Boosting this sector will ensure governments are able to continue to manage the public health crisis while also supporting families and regional economies.
4. **Establish another round of the Payroll Protection Program (PPP).** It is now clear that our economy and our public health situation are inextricably linked. That is why it is necessary for the government to again step in and establish a second round of the PPP which will support businesses during necessary stay at home orders to stem the spread of the virus. This assistance should be effectively targeted to small businesses and be implemented with specific oversight controls and responsibilities.

Telehealth/Virtual Care During & After the Pandemic

The COVID-19 pandemic has made it more difficult for people to access health care due to quarantine and stay-at-home measures. In response, health care providers have identified alternative methods for people to get the care they need. Virtual care - including telehealth, remote monitoring, and other remote forms of communication - is one approach that has been significantly expanded as part of the COVID-19 response. The increased need for virtual care across all populations due to COVID-19 has demonstrated just a baseline of its potential capabilities to help achieve better care and address long-standing inequities in access. While emergency virtual care legislation and administrative action to close immediate gaps in accessing care were enacted during the first stages of the pandemic, state and federal policymakers now face decisions on whether to turn these short-term fixes into long-term policy solutions.

As policymakers evaluate next steps for virtual care and consider making permanent existing emergency action, it is critical that policies - whether legislative, administrative, or via executive order - are evaluated against criteria that place the needs of patients at the center. Specifically, permanent virtual care policies should address barriers people experience in accessing virtual care, including:

1. Proper provider reimbursement levels for in-person vs. video vs. phone appointments;
2. New definition of the geographic locations where providers can deliver care and where patients are able to receive care; and
3. Coverage of tele-mental health services, in addition to primary care.

When clinically appropriate, patients must have the flexibility to choose how they would like to receive care whether it is in-person or through any of the multiple virtual modalities. The federal government should ensure providers are not incentivized to steer patients to certain methods of



care based on reimbursement. By putting the patient first, these policy measures have the potential to close gaps in virtual care access.

While CMS has proposed to expand a limited number of telehealth flexibilities on a permanent basis, these changes are not sufficient. Without more robust permanent telehealth expansion, the delivery of these services would still be greatly limited in scope to more rural areas and would continue to impose unnecessary barriers to care, such as the requirement of dual audio-visual communication.

Telehealth/Virtual Care for Mental and Behavioral Health

We support continued Medicare payment for a broad range of mental and behavioral health services furnished through audio-only telephones. Older adults and younger individuals with disabilities who rely on Medicare for essential behavioral health care will lose access to critically needed services if they are limited to using devices with both audio and visual communication technology. Some services can easily be provided through telehealth and should be among the first services to be covered.¹

Medicare's originating and geographic site restrictions should not prevent patients from receiving essential behavioral health services regardless where they are located, including at home. Although the pandemic has so clearly demonstrated the tremendous value of providing telehealth to individuals and families in their homes during this crisis, the benefits transcend the goal of reducing the spread of COVID-19. Allowing telehealth from homes is enabling millions of people to receive care who, due to barriers to care such as transportation and scheduling difficulties, previously were unable to access services.

Virtual care is a priority policy area for USofCare, and we have [launched an initiative](#) to look at the extent to which virtual care is closing gaps in access to care for people. We are holding a national listening tour with people, providers, and other key stakeholders to learn about their diverse experiences with virtual care. We will pair what we learn with what the research evidence and the experts know so we can see what we're missing and what more we can do to ensure an equitable approach. As we move forward in our work, we will continue to evaluate the extent to which [current policies](#) and future legislation are meeting the needs of people, and we will make recommendations in the coming months regarding necessary changes that reflect people's priorities and close gaps in access.

Helping a Distressed Health Care System Work Better for People in the Future

The fee-for-service paradigm our health care system has rested upon for decades has proven untenable during the pandemic for small and single health care provider practices. We need to transform how our health care providers are paid by establishing a COVID-19 [Health Care Resilience Program](#). In particular, primary care physicians have experienced [significant reductions](#) in the number of patients coming into their offices; these providers are critical to the

¹ CMS should permanently add Psychological and Neuropsychological Testing evaluation services (CPT codes 96130-96133 and 96135-96139) to Medicare's telehealth list, and Psychological and Neuropsychological Testing administration services (CPT codes 96136-96139); and CMS should add to the interim telehealth list Developmental Testing (CPT codes 96112 & 96113) and the Adaptive Behavior & Treatment Codes (CPT codes 97151, 97152, 0362T, 97153, 97154, 97155, 97156, 97157, 97158 and 0373T) to the interim telehealth list.

health of the nation and to fighting COVID-19 since they are often the first point of contact for anyone who may be sick and can also help patients find the right care they need at a given time, whether it is, for instance, pandemic related, a mental health concern or something else. Congress can seize this moment by improving access and care now, keeping providers in business and reducing costs in the future all while accelerating the long necessary transition to Value Based Payment (VBP) arrangements. Upfront payments would immediately allow providers to invest in the resources they need to respond to COVID-19, including:

1. Testing supplies (e.g., personal protective equipment) and staff for screening, testing, and contact tracing;
2. Infrastructure to facilitate COVID-19 data sharing with public health authorities; and
3. Telehealth and remote monitoring tools to support the implementation or expansion of home-based models of care.

These shifts will make providers, and the entire health care system, increasingly resilient when confronted by future public health crises.

Strengthening Our Public Health Workforce for the Long-Term

The pandemic is proving long-term investment in public health infrastructure is essential at the federal, state, and local levels. It is a matter of national security that the United States commit to prioritizing long-term public health efforts ranging from combating infectious diseases to addressing disparities in access to care. For all these reasons, the creation and funding of a new [public health ready reserve](#) would be valuable. State and local health departments had fewer than [2,000 contact tracers](#) prior to COVID-19 and, in the short term, such a program will be useful for these efforts. In the long term, these workers will be essential in connecting vulnerable communities to care, particularly if they are recruited from the communities in which they will work; [the nation stands to benefit](#) if public health education and navigation services can be offered in relevant languages and delivered by those with trusted local relationships, such as community health workers.

It may also be useful to direct HHS to research the gaps in our public health system and report to Congress on their recommendations to address the most critical needs, both in the context of pandemic response as well as for ongoing public health infrastructure, education, and safety recommendations outside of periods of crises. For instance, at a minimum, when a national contagion occurs within our borders, all workers should immediately have access to paid sick leave.

Legislative and Regulatory Policy to Help Incarcerated People

Individuals incarcerated in prisons, jails, and detention facilities have experienced significantly higher risks and poorer outcomes during the COVID-19 pandemic. 90 of the 100 [largest cluster outbreaks](#) have occurred in prisons and jails. Yet standards and supports for prison health and prevention remain seriously underfunded, and no standards for health care quality are routinely enforced. We recommend specific attention to health care for incarcerated people including:

1. Prevention, testing, and treatment for COVID-19.

2. Adopting the [recommendations](#) of the National Academy of Medicine regarding decarceration as a mitigation strategy during the pandemic.
3. Instituting immediate, mandatory biennial accreditation for all health care systems in prisons, jails, and detention facilities, during the pandemic and thereafter.

Protecting & Expanding Health Care Coverage

Our national health care debate has seemingly been stuck in neutral for the past decade. As the Affordable Care Act (ACA) brought about significant expansions in coverage for millions of Americans, the COVID-19 pandemic has demonstrated just how [fragile](#) our health security system remains. Below are recommendations which can strengthen our system and increase health security for people and families as life changes.

Administrative and Regulatory Measures

Administrative Improvements to Enrollment

It is critical for the incoming Administration to restore funding to help people understand their coverage options. Increasing outreach and advertising funding will augment awareness of coverage options, particularly among eligible yet unenrolled populations. Providing outreach and consumer assistance has proven to be [critical](#), and is likely even more so as people churn on and off coverage. Similarly, increasing funding for enrollment assistance will ensure people enroll in plans that best meet their health care and budgetary needs, which can be increasingly complex and uncertain as the pandemic continues.

Encouraging State Innovation to Expand State-Based Coverage Options

A handful of states are exploring public options as a viable way to help people access affordable insurance coverage. The incoming Administration has an opportunity to provide states with needed federal support to advance public options through federal 1332 and 1115 waivers.

1. A recent national [poll](#) shows 67 percent of Americans support a public health insurance option, and this finding is consistent with research that USofCare has conducted in Colorado, Connecticut, and New Mexico.
2. Between 2018-2019, 15 states introduced legislation to explore state-based approaches, but the economic recession will hinder states' ability to pass innovative policy without federal policy and financial support.
3. USofCare is monitoring activities across the country, and working with on-the-ground partners in these states to provide policy technical assistance, strategic counsel, stakeholder engagement and coalition development.

Legislative

Augmenting Affordability in the Marketplaces

Insurance sold on the individual market has a long history of being expensive for consumers. While the ACA created important protections and made it easier for people to shop for affordable coverage, more needs to be done. Given the increase in consumer cost-sharing, specifically extremely high deductibles, Congress should consider two ways to help middle-class consumers who purchase their own health coverage. These include:

1. Remove the income cap on Advanced Premium Tax Credits (APTCs). Extending this assistance to those earning more than 400 percent of the federal poverty level (FPL) would eliminate the “subsidy cliff” that causes dramatic increases in premiums when people’s income increases by only a small amount. This would particularly benefit middle-class older adults who purchase unsubsidized coverage on the marketplaces and who also [face](#) the highest premiums.
2. Fix the [Family Glitch](#) by amending the eligibility calculation for APTCs by attaching the affordability standard to the coverage cost of an entire family rather than just one individual’s coverage.

Enacting Auto-Enrollment for Health Care Coverage

Congress should enact legislation to allow for people to be automatically enrolled in coverage, including ACA plans. This will help millions of people who churn from one coverage source to another. For example, federal legislation currently requires states to cover people until the public health emergency ends. When that happens, millions of people will be disenrolled in Medicaid. Congress should ensure this does not happen.

Balanced Access to Medicaid Throughout the Nation

There are still 14 states that have not yet expanded their Medicaid programs as outlined in the Affordable Care Act. To encourage all states to expand Medicaid, Congress should incentivize these states to expand Medicaid by offering a 100 percent federal match for those enrolled in coverage through Medicaid expansion. The 100 percent match would be available to all states, regardless of whether they previously expanded Medicaid.

Protecting People from High Health Care Costs

Congress should take action to protect consumers from high out-of-pocket costs when seeking care and treatment for COVID-19 as well as other health care needs. While COVID-19 testing is free, people continue to struggle with high costs for the care and treatment they receive related to this disease. In addition, while surprise billing is largely federally banned for COVID-19 patients for the duration of the pandemic, Congress should extend these protections against surprise billing to all people by enacting permanent legislation.

Access to Care and Protections for People with Disabilities

To ensure the safety and best care for people with disabilities, we recommend increasing funding for Medicaid Home and Community Based Services (HCBS) including on-going funding for the Money Follows the Person (MFP) program. This funding will help transition seniors and people with disabilities out of nursing homes and other institutions and into the community, which is a critical response to the COVID-19 crisis in long-term care (LTC) facilities this country is experiencing. Investments in HCBS and MFP should target racial and ethnic populations to ameliorate [existing racial disparities](#) throughout our nation’s HCBS systems which lead to, among many negative outcomes, expensive and unnecessary institutionalization.

The unknown chronic, long-term, and potentially disabling effects of COVID-19 make it more important than ever to ensure people with disabilities receive the Social Security Disability Insurance (SSDI) benefits to which they are entitled. We recommend the Administration move to reverse and not finalize policies that would make it more difficult for people with disabilities to receive, and keep, the SSDI benefits they deserve and have earned.²

Meeting Mental Health Demand

People living with behavioral health conditions need timely and safe access to mental health and Substance Use Disorder (SUD) services now more than ever. Research indicates the pandemic is greatly exacerbating existing behavioral health issues and leading to substantial increases in anxiety, depression, and SUDs. A recent [study](#) found approximately 27 percent of people in the United States are suffering from symptoms of depression, representing a three-fold increase in the prevalence of depression before the pandemic began.

Administrative Measures

Mental Health Parity Regulation & Enforcement

There are several ways in which CMS can strengthen mental health parity laws. They include:

1. Require states to include requirements in Medicaid MCO contracts that health plans must conduct detailed parity compliance analyses on their non-quantitative treatment limitations (NQTLs) using a standardized stepwise approach.
2. Require states to include requirements in Medicaid MCO contracts that plans have robust parity compliance programs.
3. Direct the Center for Consumer Information and Insurance Oversight (CCIIO) to exercise its authority under the parity law to regulate insurers in states that fail to “substantially enforce” the law by relying solely on consumer complaints to check for parity compliance.

² Actions include not finalizing, implementing, or providing funding for the proposed regulation entitled [Rules Regarding the Frequency and Notice of Continuing Reviews](#) (84 Fed. Reg. 63588 et seq.) and reversing the notice of proposed rulemaking entitled [Hearings Held by Administrative Appeals Judges of the Appeals Council](#) (84 Fed. Reg. 70080 et seq.).

4. Have CCIIO require non-ERISA commercial insurance plans to follow generally accepted standards of care and use utilization review criteria that are fully consistent with these standards. CCIIO should utilize the same parity oversight practices for non-ERISA commercial plans as the Department of Labor (DOL) does for ERISA plans.
5. Require states to use performance standards for mental health and addiction coverage that, if not met, would trigger parity investigations.

Legislative Measures

Building a Mental Health Workforce Equal to the Task of Our Time

Graduate Medical Education is critical to ensuring there are enough clinical providers to meet the nation's mental health care needs. Our specialized mental health workforce was insufficient to meet demand prior to COVID-19, and is not large enough to meet the augmented need resulting from the pandemic. As an example, [33 percent](#) of those seeking care wait more than one week to access a mental health clinician, 50 percent drive more than one-hour round trip to mental health treatment locations, and 50 percent of counties in the United States lack any psychiatrist. Additionally, approximately 60 percent of psychiatrists are 55 or older, meaning that retirement of the current workforce is likely to exacerbate existing shortages.

We must increase the pipeline of mental health providers by not only expanding Graduate Medical Education (GME) slots, but providing incentives for would-be providers to concentrate in mental health professions. This might include:

1. Better financing for those in school, as well as expanding loan repayment programs.
2. Boosting diversity in the [mental health workforce](#) - only 6.2 percent of psychologists, 5.6 percent of advanced-practice psychiatric nurses, 12.6 percent of social workers, and 21.3 percent of psychiatrists are members of minority groups.
3. Expanding existing investments in mental health workforce development programs, such as Graduate Medical Education (GME), Graduate Psychology Education (GPE), Behavioral Health Workforce Education and Training (BHWET), and the Minority Fellowship Program.
4. Providing incentives, such as loan repayment, for graduating residents to take Medicaid and Medicare patients.
5. Eliminating the barrier for child and adolescent psychiatrists to receive Health Resources and Services Administration (HRSA) loan repayment.
6. Expanding fellowship and college programs to encourage more diversity in all mental health professions.

Confronting Our Suicide Epidemic

Suicide is the [tenth leading cause](#) of death in the United States and rates have [increased 33 percent](#) since 1999. This epidemic impacts all ages and ethnic groups, although certain populations are affected disproportionately. For example, suicide is the [second leading](#) cause of

death in adolescents, increasing [87 percent](#) between 2007 and 2017, and as many as [one in four youth](#) seriously considered suicide this past summer. Several pieces of legislation have been introduced in Congress that would take meaningful action to prevent these outcomes.³ In addition, there have been calls for action around suicide prevention from both the [public and private sector](#).

Treating Mental Health in the Time of COVID-19

Standard of care for follow-up for those diagnosed with COVID-19 should include mental health screening and, when necessary, treatment. Because these mental health needs are tied to a COVID-19 diagnosis, insurers should be required to cover mental health services as the same level they would physical health needs, and necessary mental health care for those who are uninsured should be covered under the Provider Relief Fund in supplemental emergency funding packages, as are physical health impacts from the infection. Efforts to minimize cost sharing for COVID-19 treatment should include mental health services.

Strengthening and Enforcing Parity Laws Legislatively

Though the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008, it remains poorly understood or enforced, leaving many who are denied care or saddled with unexpected costs. Many of these problems are due to lack of transparency by health insurers and the government, both federal and state, and holding them accountable for meeting existing law. Action is necessary to achieve the intent of the MHPAEA, and should include:

1. Applying the MHPAEA to all current and future public and private payers (including Medicare, Medicaid Fee-for-Service, TRICARE and the Indian Health Service).
2. Increasing funding for parity enforcement of ERISA plans by the DOL, and providing authority to issue fines. Currently, the Department of Labor cannot issue civil monetary penalties (i.e. fines) for violations of the Federal Parity Law.
3. Eliminating caps that government payers place on mental health (e.g. eliminate Medicare 190-day lifetime psychiatric inpatient limit and Medicaid coverage limitations for certain facility-based care).

Embedding Equity Into Our Health Care System

The COVID-19 pandemic has highlighted and exacerbated existing inequities in our health care system. To address this crisis-level issue, we believe equity should be infused throughout the policymaking process. This requires having diverse perspectives and experiences at the table and in positions with decision-making power. Diversity includes, but is not limited to, race,

³ The following bills take important steps to address these issues: The STANDUP Act (H.R. 7293/ S.2492), Mental Health Services for Students Act (H.R.1109/S.1122), Effective Suicide Screening and Assessment in the Emergency Department Act (H.R.4861/S.3006), Pursuing Equity in Mental Health Act (H.R.5469/S.4388), Improving Mental Health Access from the Emergency Department Act (H.R.2519/S.1334), Suicide Prevention Act (H.R.5619/S.3198), Helping Emergency Responders Overcome (HERO) Act (H.R.1646/ S.3244), Suicide Prevention Lifeline Improvement Act (H.R.4564), and the Campaign to Prevent Suicide Act (H.R.4585). In a bipartisan effort, Congress passed legislation that would establish a three-digit number (988) for crisis response, which is to be in place by July 2022. While the creation of this service is a step in the right direction, there is much work remaining to ensure appropriate services are available at the local level when the number becomes operational e.g. robust investment in local infrastructure.



ethnicity, rural/urban classifications, veteran status, disability, gender, and sexual orientation. Quality affordable health care for all requires barriers to be removed, especially for those who have been underserved.

Administrative and Regulatory Measures

We believe the incoming Biden Administration has the responsibility to ensure equity throughout all the federal government's work and decision-making, which includes building a diverse, inclusive, and knowledgeable federal workforce. To do this we recommend:

1. Creating a mechanism to ensure equity impacts are evaluated and considered as a part of formal rulemaking, policy development and internal decision making.
2. Developing White House Councils to promote and expand diversity, equity, and inclusion and creating the position of Chief Equity Officer for the federal government.
3. Revoking the Executive Order restricting Diversity, Equity and Inclusion training for federal agencies and federal grant recipients.

Additionally, the Administration can utilize regulatory powers to ensure underserved communities have equitable access and affordability to health care. While these issues are attracting media and policy attention now, they are not new to the communities which are affected. In fact, these realities have led to an even larger trust deficit when it comes to public health. We recommend the federal government:

1. Declare, as the American Medical Association [has](#), that racism is a public health emergency.
2. Improve CMS risk adjustment to account for social determinants of health, and ensure that benchmarks and other payment provisions do not disadvantage rural providers or the people they serve.
3. Require the collection and reporting of race and ethnicity data across all payers and quality programs. This should include state compliance with [federal guidance](#) on data collection standards for race, ethnicity, sex, primary language, and disability status.
4. Data collection requirements should include provisions to increase understanding of the impact of disability on ethnic and minority populations in the United States.
5. Invest in state capacity to collect Medicaid data identifying populations at greatest risk of morbidity and mortality due to social determinants of health.
6. Issue CMS directives requiring Medicaid Managed Care Organizations (MCOs) to survey their populations and identify where trust deficits lie within the Medicaid population and measure steps which could be taken by MCOs and the government to increase these critical working relationships.

Legislative Measures

It is critical to build a federal workforce which reaches and works with marginalized communities. This, in part, requires ensuring the health care providers caring for underserved communities receive adequate funding. Congress should:

1. Increase funding for community health workers and support payment parity for community health workers providing care outside of a practice or clinic, such as at a community center or at a patient's home.
2. Increase funding for public health programs in underserved and low-income communities including programs on health education, social determinants, and health literacy training.
3. Combat the significant [maternal health crisis](#) in the United States and allocate funds to increase the volume of freestanding birth centers across the country.
4. Update the 1991 Telephone Consumer Protection Act (TCPA). Due to limits the TCPA places on text messages from HIPAA covered entities, the law puts populations with limited internet connectivity at risk, especially as texting has become an acceptable form of communication for every aspect of life. Congress should update the TCPA to allow for payer and provider initiated SMS engagement (or engagement initiated on behalf of the consumer's payer or provider) without express consent or a prior opt-in. Engagement via SMS by payers and providers should be exempt from TCPA, provided consumers are given easy instructions for opting out, and messaging.

Conclusion

United States of Care is committed to listening to the voices of real people, bridging the partisan divide and relying on our expert leadership councils to inform our policy recommendations. We look forward to working with the President-Elect, the Vice President-Elect, their Cabinet, and all Members of Congress to ensure our health system emerges from the COVID-19 pandemic stronger, more affordable and more understandable than it was before. If you have any questions, please contact Andrew Schwab, our Director of Policy, Federal Affairs & Partnerships at aschwab@usofcare.org.

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- | | |
|---|--|
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| ★ Dr. Charles Grim, D.D.S. - Secretary of Health for the Chickasaw Nation and | |



- Former President of the American Nurses Association
- ★ Abner Mason - Founder & CEO of Consejosano and Member of President George W. Bush's Advisory Council on HIV/AIDS
- ★ Dr. Reagan McDonald-Mosley, MD - Chief Medical Officer, Planned Parenthood of Maryland
- ★ Ben Miller - Psy.D, Chief Strategy Office, Well Being Trust
- ★ Peter Morley - Patient Advocate
- ★ Ian Morrison - Health Care Futurist, Author and Consultant
- ★ Dr. Farzad Mostashari - CEO of Aledade
- ★ Mina Schultz - ACA Outreach and Enrollment Program Manager, Young Invincibles
- ★ Dr. Mark Smith, MD/MBA - Founding President and Former CEO of the California Health Care Foundation
- ★ Dr. Leana Wen, MD - Visiting Professor of Health Policy and Management, George Washington University Milken Institute School of Public Health
- ★ Cindy Zeldin, MA/MPH - Former Executive Director of Georgians for a Healthy Future

Additional USofCare Resources

November 18, 2020:

[November 18 Webinar: A SYSTEM UNDER STRESS: The State of Job-Connected Health Insurance](#)

September 9, 2020:

[COVID-19 Exposed the Fragility of Job-Connected Health Insurance For People and Employers](#)

June 25, 2020:

[USofCare's Response to U.S. Senate on Pandemic Preparedness](#)

September 9, 2020:

[A System Under Stress, Exacerbated: The Employer-Sponsored Health Insurance System at a Crossroads](#)

July 16, 2020:

[People Over Politics - Policy Recommendations for Next Federal Relief Package](#)

April 29, 2020:

[USofCare's Founder's Council Members Urge Congress to fund \\$46 billion for COVID-19 Contact Tracing](#)

Evergreen:

[At a Glance: Job-Connected Health Insurance](#)