Responding to the COVID-19 Emergency

Expand the availability of HSAs to everyone

Under current law, only individuals with high deductible health plans (HDHPs) can contribute to tax-advantaged health savings accounts (HSAs). Individuals with health plans that do not meet IRS definitions for HDHPs, or who are uninsured, cannot contribute to HSAs. Given the COVID-19 crisis and the resulting out-of-pocket costs that may result from treating the condition, all individuals should be allowed to make tax-advantaged payments to HSAs to help cover out-of-pocket expenses.

Recommendation: Expand availability of HSAs to all tax filers for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow HSAs to be used to pay for other health care related expenses

Currently, taxpayers can only use HSA funds to pay for certain IRS-defined medical expenses. The IRS does not currently consider expenses related to certain types of arrangements, including direct health care arrangements and health care sharing ministries, eligible expenses. Executive Order 13877 directed the Treasury Department to revise its regulations to allow such costs to be paid from HSAs. Many of these subscription-based arrangements include innovative telehealth services that help promote social distancing during the COVID-19 crisis while ensuring individuals can receive the medical care they need.

Recommendation: Codify Executive Order 13877 and allow direct health care arrangements, health care sharing ministries, and other subscription-based services to count as eligible medical expenses for HSA purposes.

Increase limits on HSA contributions

Those eligible to contribute to HSAs can only contribute $3,550 per year for individuals and $7,100 per year for families. However, the out-of-pocket maximum for non-group coverage is up to $8,150 per year for individuals and $16,300 per year for families. During the COVID-19 crisis, individuals are likely to experience high out-of-pocket costs, especially for those hospitalized for the condition.

Recommendation: Increase limits on HSA contributions to match the out-of-pocket spending maximums for non-group coverage. At a minimum, these contributions should be increased for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Expand whose medical expenses can be paid for with HSAs

Currently, individuals can use HSA funds to pay for qualified medical expenses for themselves, their spouses, or their dependents. They cannot use HSA funds to cover medical costs for those

outside of their tax-filing unit. Individuals positive for COVID-19 who need hospitalization and treatment may find themselves with medical bills they cannot afford. Allowing individuals to use their HSA funds to cover qualified medical expenses for others outside of their tax unit—such as their elderly parents or grandparents, siblings, nieces and nephews, neighbors, friends, church members, and others—reduces the risk of patients forgoing treatment because they cannot afford it.

Recommendation: Allow individuals to use HSA funds to pay qualified medical expenses for individuals outside of their tax units. At a minimum, these expenses should be allowable for treatment delivered in any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow individuals to make charitable contributions to others' HSAs

In times of crisis, Americans come together as families, neighbors, and communities to rally together and defeat our most significant challenges. Millions of Americans are in positions to assist those less fortunate than themselves, including those suffering from high medical bills related to COVID-19, by contributing to their medical costs.

Recommendation: Allow individuals to make charitable contributions to others' HSAs. At a minimum, these expenses should be allowable for treatment delivered in any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow rollover of Health FSAs

Health flexible spending arrangements (FSAs) can serve as great tools to help working families cover out-of-pocket medical costs. These funds can be used for eligible medical expenses throughout the year. However, unused FSA funds cannot be rolled over to the following year and are instead forfeited—making them "use it or lose it" accounts. In the case of COVID-19 or another public health emergency, many families may be unable to use the entirety of these funds during the calendar year.

Recommendation: Allow FSAs to rollover any amount of unused funds to the following year for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Increase limits on Health FSAs

Those eligible to contribute to Health FSAs can only contribute $2,750 per year. However, out-of-pocket expenses can often exceed this amount. During the COVID-19 crisis, in particular, individuals are likely to experience high out-of-pocket costs, especially for those hospitalized for the condition.

Recommendation: Double the maximum contribution to Health FSAs for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active. This will give instant relief to families who need extra child care to recover from the disaster.

Expand whose medical expenses can be paid for with Health FSAs

Currently, individuals can use Health FSA funds to pay for qualified medical expenses for themselves, their spouses, or their dependents. They cannot use Health FSA funds to cover medical costs for those outside of their tax-filing unit. Individuals positive for COVID-19 who need hospitalization and treatment may find themselves with medical bills they cannot afford. Allowing individuals to use their Health FSA funds to cover qualified medical expenses for others outside of their tax unit—such as their elderly parents or grandparents, siblings, nieces and nephews, neighbors, friends, church members, and others—reduces the risk of patients forgoing treatment because they cannot afford it.

Recommendation: Allow individuals to use Health FSA funds to pay qualified medical expenses for individuals outside of their tax units. At a minimum, these expenses should be allowable for treatment delivered in any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow individuals to make charitable contributions to others' Health FSAs

In times of crisis, Americans come together as families, neighbors, and communities to rally together and defeat our most significant challenges. Millions of Americans are in positions to assist those less fortunate than themselves, including those suffering from high medical bills related to COVID-19, by contributing to their medical costs.

Recommendation: Allow individuals to make charitable contributions to others' Health FSAs. At a minimum, these expenses should be allowable for treatment delivered in any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow rollover of DCFSAs

Dependent care flexible spending arrangements (DCFSAs) can serve as great tools to help working parents afford child care for their families by allowing them to exclude or deduct dependent care benefits of up to $5,000. These funds can be used for eligible child care expenses throughout the year. However, unused DCFSA funds cannot be rolled over to the following year and are instead forfeited – making them "use it or lose it" accounts. This requires the year to be predictable to maximize the benefit of the accounts. In the case of COVID-19 or another public health emergency, many families are losing weeks in which they would use these funds to pay for child care.

Recommendation: Allow DCFSAs to rollover any amount of unused funds to the following year for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Increase limits on DCFSAs

As families dig out from the aftermath of the COVID-19 emergency, many families with children will undoubtedly need to work increased hours to regain their economic footing. Likewise, businesses will need workers to pick up extra shifts to bring their operations back into full engagement. Many families rely on DCFSAs to help stretch the funds they use to pay for child care expenses, which are often substantial out-of-pocket costs for working families. Currently, pre-tax contributions to DCFSAs cap out at $5,000.

Recommendation: Double the maximum contribution to DCFSAs for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active. This will give instant relief to families who need extra child care to recover from the disaster.

Expand whose child care expenses can be paid for with DCFSAs

Currently, individuals can use DCFSA funds to pay for qualified child care expenses for their eligible dependents. They cannot use DCFSA funds to cover child care expenses for others' dependents. Allowing individuals to use their DCFSA funds to cover qualified child care expenses for others' dependents—such as their nieces and nephews or children of neighbors, friends, or church members—can help working families return to work once the COVID-19 public health emergency ends.

Recommendation: Allow individuals to use DCFSA funds to pay qualified child care expenses for others' dependents. At a minimum, these expenses should be allowable for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Allow individuals to make charitable contributions to others' DCFSAs

In times of crisis, Americans come together as families, neighbors, and communities to rally together and defeat our most significant challenges. Millions of Americans are in positions to assist those less fortunate than themselves, including those suffering from the economic fallout of COVID-19, by contributing to their dependent care costs.

Recommendation: Allow individuals to make charitable contributions to others' DCFSAs. At a minimum, these expenses should be allowable for treatment delivered in any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active.

Codify price transparency for patients

The U.S. Department of Health and Human Services (HHS) has finalized new transparency rules for hospitals and insurers. This new transparency could be a game-changer for patients as they face costly COVID-19 treatment. Unfortunately, these rules are being challenged under procedural grounds by special interests. Congress should codify these rules to ensure those undergoing COVID-19 treatment have access to the information needed to make health care decisions and share savings for finding high-value providers. Providers and insurers should

automatically provide patients with real cost estimates when appointments are scheduled or inquiries made.

Recommendation: Codify price transparency rules, paired with shared savings options, making real cost estimates automatically available when appointments are scheduled.

Protect access to high-value providers, even when out-of-network

In many markets, independent providers are being pushed out of insurer networks, even when they provide high-quality care for lower costs. Significant provider consolidation has increased prices, leading insurers to narrow their networks even further to contain costs. This can hurt patient access to the highest value providers for services related to COVID-19, as patients must pay up to 100 percent of the costs of these lower-cost, out-of-network options, which often do not count toward deductibles or out-of-pocket maximums.

Recommendation: Allow spending at lower cost out-of-network providers to count toward any in-network out-of-pocket responsibility and allow such out-of-network expenditures to be included in the numerator for medical loss ratio calculations by insurers.

Protect patients with substantial medical bills who are in payment plans before their finances are ruined

Individuals who are hospitalized for COVID-19 are likely to experience high out-of-pocket medical costs. Medical debt can lead to credit impairment, which has long-term financial ramifications that could ultimately hurt economic recovery. Unfortunately, many of these debts go into collection without the knowledge of the medical provider, without regard to the reasonableness of the charges, and even when the patient has negotiated a payment plan with the provider.

Recommendation: Health care providers should be prohibited from impairing patients' credit if they are negotiating or have negotiated a payment plan and should not be able to report medical debt if the debt is purely balance bills. Consumers should also be provided an avenue to challenge the reasonableness of the charges before their credit is impaired. Additionally, debt collectors should be prohibited from impairing individuals' credit for medical debt without the express written consent of the health care provider. Finally, credit reporting agencies should be required to remove credit impairment within 30 days for consumers who settle the underlying medical debt.

Codify AHP options for small businesses

Association Health Plans (AHPs) are comprehensive plans that help small businesses join together to purchase health insurance for their employees, putting them on the same playing field as large employers. The Department of Labor (DOL) has expanded this option for more small businesses and entrepreneurs, but the rules are currently tied up in litigation. As the economic fallout from the COVID-19 public health emergency sets in, small businesses will need every tool available to offer affordable coverage to their employees.

Recommendation: Codify AHP regulations to help small businesses and self-employed workers access AHP coverage.

Extend new nationwide AHP options for impacted industries

Under current rules, self-insured AHPs seeking to operate nationwide must satisfy a patchwork of regulations in each state, including state insurance laws that conflict with other large group requirements or that limit or prohibit AHPs entirely. This patchwork of laws significantly limits industries from forming multi-state and nationwide AHPs. Developing a "class exemption" would create uniformity for AHPs seeking to operate in multiple states, creating more options for small businesses. As the economic fallout from the COVID-19 public health emergency sets in, small businesses will need every tool available to offer affordable coverage to their employees.

Recommendation: Create a class exemption to allow for nationwide AHPs in impacted industries.

Extend availability of Copper plans

Under current law, Copper (or "catastrophic") plans are only available to individuals who are under the age of 30 or who otherwise qualify for a hardship exemption. These plans have lower premiums and higher cost-sharing requirements than other individual market coverage. Unfortunately, many individuals who do not qualify for Copper plans under current rules have been priced out of the individual market altogether. Many others who may be affected by the economic ramifications of the COVID-19 public health emergency may lose current coverage and need affordable options like Copper plans to be made available. Extending the availability of these plans to more Americans would give impacted individuals the ability to select plans that fit their budgets and circumstances.

Recommendation: Remove Copper plan enrollment restrictions that prohibit enrollment for individuals over the age of 30 who do not meet hardship exemptions.

Preempt state-level CON laws

Certificate of Need (CON) laws require hospitals and other facilities to seek permission to build new facilities, expand facilities, add modern technology, or offer certain services. Although the federal government repealed its CON mandate in 1986 after the requirements failed to meet their objectives, many states still require providers to obtain CON approval before making capital expenditures. This severely limits hospitals' ability to rapidly react to public health emergencies such as the COVID-19 emergency, as they cannot quickly build isolated treatment facilities, mobile testing facilities, or otherwise expand capacity to meet new demand during a pandemic.

Recommendation: Preempt state-level CON laws to ensure hospitals and other providers can rapidly respond to public health emergencies. At a minimum, this preemption should

last for the duration of any period where a public health emergency declaration based on an outbreak of COVID-19 is active.

Suspend FDA regulations to allow hospitals to produce and use 3D-printed ventilator valves and other pandemic-related medical supplies

Hospitals may rapidly face medical supply shortages as the COVID-19 public health emergency begins to impact the nation's health care infrastructure, especially concerning supplies related to COVID-19 treatment. Hospitals and other facilities are largely unprepared for pandemic-level influxes of patients. In other countries, hospitals facing severe medical supply shortages have turned to engineers to 3D print COVID-19 related medical equipment, including ventilator valves and masks. The federal government should remove existing barriers for manufacturers and facilities to replicate this solution and fast-track the creation of much-needed medical supplies.

Recommendation: Waive FDA regulations and approval processes to allow hospitals and other medical facilities to 3D print vital medical supplies to cover emergency shortages for the duration of any period where a public health emergency declaration based on an outbreak of COVID-19 is active.

Remove barriers on third-party contractors in welfare eligibility process

As states begin to feel the economic ramifications of the COVID-19 public health emergency, they are likely to experience significant upswings in applications for welfare programs, such as Medicaid and food stamps. The Office of Personnel Management (OPM) has directed relevant agencies to clarify existing regulations and guidance to allow states to more widely use third-party contractors to assist with a broader array of responsibilities within the administration process in these programs. Unfortunately, these rule changes have not been finalized, and states have been unable to utilize this flexibility so far.

Recommendation: Codify OPM policy and allow states to contract with third-party contractors for all parts of the eligibility process in Medicaid, food stamps, and other welfare programs.

Codify flexible work rules to allow more individuals to work from home

Millions of Americans are self-employed and work as independent contractors. Many of these individuals do so because they need flexibility in their worksite, schedule, or other accommodations that typical on-site jobs cannot provide. Although federal law has a clear test to determine independent contractor status, states often use different tests that result in self-employed workers classified as independent contractors by the federal government and employees by state governments. These inconsistent laws make it difficult for these individuals to find work, hold back the economy, and place unemployment trust funds at risk.

Recommendation: Preempt states from adopting more stringent worker classification tests under the Federal Unemployment Tax Act (FUTA) and exempt workers from FUTA taxes if they fall outside the common law test to determine "employee."

Provide relief to employers on ACA mandate reporting

The employer mandate represents a significant administrative and financial burden on employers. Changes in employment status will be common in 2020 as employers struggle with the economic fallout from the COVID-19 public health emergency. This situation complicates preparation of 1095-C forms, as well as tracking and managing eligibility for group health plans.

Recommendation: Temporarily suspend 1095-C and 1094-C reporting requirements for all applicable large employers, as individuals no longer need 1095-C for tax filing purposes. At a minimum, this suspension should last for any tax year in which a public health emergency declaration based on an outbreak of COVID-19 is active. Additionally, the 1095-C statutory deadline should be permanently extended to March 15, consistent with annual administrative extensions. "Good faith effort" provisions for 1095-C and 1094-C preparation should also be made permanent to maintain reasonable accommodations for employers who make technical errors in the course of good faith efforts to comply with the reporting requirements. Additionally, the Treasury Department should be required to create a path for employers to report on and prove compliance with ACA affordability requirements by complying with the statutory rule, rather than employer-adverse safe harbors. Finally, Section 1411 certification should be provided to employers within 14 days of the date on which an employee is granted a tax credit or cost-sharing subsidy on the Exchange and employers should be given an adequate opportunity to dispute the penalty at that time.