ERIC "*Phase 4*" COVID Response Health Legislative Priorities

(1) Protect patients who need testing and treatment

- **Ensure access to treatments and care**
  - ***i. Permanently codify fix to HSA pandemic glitch*.** Broaden IRS definition of "preventive" to include testing and treatment of COVID, infectious diseases, and pandemics (broaden and codify IRS Notice 2020-15)
  - ***ii. Speed access to treatments approved in other markets.*** Pass the *ADAPT Act* (S. 658), to speed approval of drugs already approved in developed countries.

- **Implement transparency for patients and plan sponsors, including:**
  - ***i.*** Require all prices related to COVID testing and treatment to be posted online (amend *CARES Act* section 3202(b) to cover all COVID treatments and add "*negotiated rates*";
  - ***ii.*** Codify Administration's hospital and insurer transparency rules;
  - ***iii.*** Enact transparency provisions from *Lower Health Care Costs Act* (S. 1895), including provision to eliminate "*gag clauses*" on health claims data (section 301);
  - ***iv.*** Require transparency in the drug supply chain by enacting *PBM Transparency in Prescription Drug Costs Act* (H.R. 4304)

- **Any mandated coverage must be paired with provisions to control costs, including:**
  - ***i.*** Limit prices related to COVID testing and treatment: **EITHER** ensure that mandatory "cash prices" are reasonable and based on market rates, **OR** replace "cash price" mandate for testing with a requirement that reimbursement be based on the lowest negotiated rate a provider has agreed to, or Medicare
  - ***ii.*** In addition to creating a reinsurance program for fully-insured plans, consider a federal program to allow self-insured plans to submit COVID-related claims for reimbursement
  - ***iii.*** Provide full federal financial assistance to help separated workers afford COBRA enrollment; however, those subsidies must be sufficient to prevent adverse selection

- **Ban surprise billing of COVID patients**. Options include:
  - ***i.*** Enact the *Lower Health Care Costs Act / No Surprises Act*, the bipartisan, bicameral compromise agreed to in December of 2019 to completely ban surprise billing;
  - ***ii.*** Require hospitals accepting COVID payment increases to enact "network match" agreements with providers and firms operating within
  - ***iii.*** Implement a time-limited ban on surprise bills for the duration of the COVID crisis (modeled after H.R. 861, *End Surprise Billing Act*)

(2) Streamline access to telehealth

- Make telehealth HDHP exemption (*Telehealth Expansion Act, S. 3539*) permanent

- Direct agencies to clarify that telehealth benefits are not an ACA "plan" and thus can be offered standalone to part-time, seasonal, non-enrolled dependents, and others

- Institute national reciprocity for providers practicing within their license to practice via telehealth in any state. Model after the *TELE-MED Act (S. 1778 and H.R. 3081, 114th)*

- Implement a national set of standards for telehealth, override state barriers such as "video-only" requirements, mandatory pre-existing relationships, originating sites, etc.

(3) Eliminate administrative red tape and waste, improve flexibility

- Give Treasury and PBGC same flexibility as DOL to provide deadline relief (mirror *CARES Act* section 3607's addition of "*public health emergency*" in 26 USC 7508A).

- Codify HDHP improvements to preventive care (*Chronic Disease Management Act, S. 3200*)

- Clarify that plan changes to address pandemics can include retroactive modifications, delayed SMMs and notices, etc.

- Allow employers to voluntarily offer enrollment opportunities during a public health emergency to employees and dependents who may not be enrolled, or wish to switch plans

- Allow employees to change certain elections and withholding in Section 125 cafeteria plans during a public health emergency, including allowing them to stop contributing to a dependent care FSA

- Clarify that definitions pertaining to the "employee retention credit" align with ACA definitions to streamline implementation

- Eliminate "snail mail" notices, disclosure, and other requirements, moving to e-delivery for all plan administrative and related documents, EOBs, medical bills, etc.

(4) Protect employers under rapid transition

- Provide temporary relief from the ACA's "shared responsibility" mandate for employers undergoing rapid transition – including surges, layoffs, RIFs, etc. – to ensure they do not accrue penalties due to COVID

(5) Improve readiness for the next pandemic

- Create a MedPAC-like national preparedness council primarily comprised of payer, patient, and supply chain representatives. This council should evaluate reporting from relevant providers and facilities, and advise HHS on funding decisions based on readiness quality metrics – which should be made publicly available.

- Ensure that COVID funding for providers and facilities includes obligations to report on infection control and prevention readiness.