



MEMORANDUM

July 9, 2019

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Subcommittee Markup

On **Thursday, July 11, 2019, at 10 a.m. in the John D. Dingell Room, 2123 of the Rayburn House Office Building**, the Subcommittee on Health will hold a markup of the following 10 bills: **H.R. 2781**, the “Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness for Health (EMPOWER for Health) Act of 2019”; **H.R. 728**, the “Title VIII Nursing Workforce Reauthorization Act of 2019”; **H.R. 1058**, the “Autism Collaboration, Accountability, Research, Education, and Support (Autism CARES) Act of 2019”; **H.R. 2507**, the “Newborn Screening Saves Lives Reauthorization Act of 2019”; **H.R. 776**, the “Emergency Medical Services for Children Program Reauthorization Act of 2019”; **H.R. 2035**, the “Lifespan Respite Care Reauthorization Act of 2019”; **H.R. 2296**, the “Fair Accountability and Innovative Research Drug Pricing (FAIR Drug Pricing) Act of 2019”; **H.R. 2328**, the “Community Health Investment, Modernization, and Excellence Act of 2019”; **H.R. 3631**, the “Territories Health Care Improvement Act”; and **H.R. 3630** the “No Surprises Act”.

For additional information, please refer to the Subcommittee on Health hearing memoranda dated June 25, 2019 (“Reauthorizing Vital Health Programs for American Families”); June 17, 2019 (“Strengthening Health Care in the U.S. Territories for Today and Into the Future”); June 12, 2019 (“No More Surprises: Protecting Patients From Surprise Medical Bills”); June 4, 2019 (“Investing in America’s Health Care”); and May 21, 2019 (“Improving Drug Pricing Transparency and Lowering Prices for American Consumers”).

I. H.R. 2781, THE “EMPOWER FOR HEALTH ACT OF 2019”

H.R. 2781, the “Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness for Health Act (EMPOWER for Health Act) of 2019”, introduced by Reps. Schakowsky (D-IL) and Burgess (R-TX), would provide a five-year reauthorization for the Public Health Service Act Title VII health care workforce development grant programs, including Area Health Education Centers and Health Professions Training for Diversity. The bill also updates language authorizing the Geriatrics Workforce Enhancement program and the Geriatric Academic Career Awards program in order to align that language with how the Health Resources and Services Administration (HRSA) currently administers the programs. Finally, the

legislation would reauthorize and update the Investment in Tomorrow’s Pediatric Health Care Workforce program, which provides loan repayment for certain qualifying pediatric specialists and subspecialists.

The House passed similar legislation in the 115th Congress with broad bipartisan support, but it was not considered in the Senate.

II. H.R. 728, THE “TITLE VIII NURSING WORKFORCE REAUTHORIZATION ACT OF 2019”

H.R. 728, the “Title VIII Nursing Workforce Reauthorization Act of 2019”, introduced by Reps. Joyce (R-OH), Matsui (D-CA), McKinley (R-WV), Castor (D-FL), Davis (R-IL), Gabbard (D-HI), Bonamici (D-OR), and Underwood (D-IL), would reauthorize federal nursing workforce development grant programs administered by HRSA for five years. These programs include traineeships, loan repayment, and scholarships for nurses to attain advance practice status and become nursing faculty. Continued investment in these programs is necessary to ensure the United States has an adequate supply of nurses.

The House passed similar legislation in the 115th Congress with broad bipartisan support, but it was not considered in the Senate.

III. H.R. 1058, THE “AUTISM COLLABORATION, ACCOUNTABILITY, RESEARCH, EDUCATION, AND SUPPORT ACT OF 2019” (THE “AUTISM CARES ACT OF 2019”)

H.R. 1058, the “Autism CARES Act of 2019”, introduced by Reps. Smith (R-NJ) and Doyle (D-PA), would reauthorize funding for programs at the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and HRSA through fiscal year (FY) 2024. The legislation expands efforts to conduct research, surveillance, education, detection, and intervention for all individuals with autism spectrum disorder (ASD) across their lifespan, regardless of age. The bill also aims to reduce disparities among individuals from diverse racial, ethnic, geographic, or linguistic backgrounds, and directs additional care to rural and underserved areas. The five-year reauthorization includes annual authorizations of \$23.1 million for developmental disabilities surveillance and research, \$50.599 million for autism education, early detection, and intervention, and such sums as may be necessary to carry out the work of the Interagency Autism Coordinating Committee (IACC) and other programs at the NIH.

IV. H.R. 2507, THE “NEWBORN SCREENING SAVES LIVES REAUTHORIZATION ACT OF 2019”

H.R. 2507, the “Newborn Screening Saves Lives Reauthorization Act of 2019”, introduced by Reps. Roybal-Allard (D-CA), Simpson (R-ID), Clark (D-MA), and Herrera Beutler (R-WA), would reauthorize newborn screening programs for five years. The bill includes reforms to ensure that the activities of the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) are transparent, including requiring the creation of a publicly accessible website which details the uniform screening panel nomination process. The

bill also requires CDC to standardize data collection and reporting to track and monitor newborn screening in real time. Additionally, the bill orders a study on the modernization of newborn screening. The bill authorizes appropriations of \$60.65 million per year through FY 2024.

V. H.R. 776, THE “EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM REAUTHORIZATION ACT OF 2019”

H.R. 776, the “Emergency Medical Services for Children Program Reauthorization Act of 2019”, introduced by Reps. King (R-NY), Castor (D-FL), Butterfield (D-NC), and Stewart (R-UT), would reauthorize the Emergency Medical Services for Children program at \$22.334 million each year through FY 2024.

VI. H.R. 2035, THE “LIFESPAN RESPITE CARE REAUTHORIZATION ACT OF 2019”

H.R. 2035, the “Lifespan Respite Care Reauthorization Act of 2019”, introduced by Reps. Langevin (D-RI) and McMorris Rodgers (R-WA), would reauthorize the Lifespan Respite Care program at \$20 million in FY 2020, and increase the funding level by \$10 million each year thereafter through FY 2024. It would also add new reporting requirements for program grantees.

VII. H.R. 2296, THE “FAIR DRUG PRICING ACT OF 2019”

H.R. 2296, the “Fair Accountability and Innovative Research Drug Pricing (FAIR Drug Pricing) Act of 2019”, introduced by Reps. Schakowsky (D-IL) and Rooney (R-FL), would require certain drug manufacturers to submit documentation to the Secretary of the Department of Health and Human Services (HHS) 30 days before increasing the price of a qualifying drug. The bill requires manufacturers to report their justification for an increase in the wholesale acquisition cost (WAC) of a qualifying drug should the manufacturer decide to increase the price by 10 percent or more over a 12-month period, or by 25 percent or more over a 36-month period. A manufacturer of a qualifying drug would be required to report the total expenditures for manufacturing the qualifying drug, the research and development expenditures for the drug, and total revenue and net profit generated by the drug, as well as other documentation as applicable.

An amendment in the nature of a substitute (AINS) is expected to be offered to H.R. 2296 that will make some changes to the underlying legislation, including changes to the qualifying drug provisions, the HHS reporting requirements, and reporting timeline for manufacturers of qualifying drugs in calendar year 2019. The AINS will also include provisions from the following bills: H.R. 2115, the “Public Disclosures of Drug Discounts Act”, introduced by Reps. Spanberger (D-VA) and Arrington (R-TX); H.R. 2376, the “Prescription Pricing for the People Act”, introduced by Reps. Collins (R-GA) and Nadler (D-NY); H.R. 2064, the “Sunshine for Samples Act”, introduced by Reps. Chu (D-CA) and Nunes (R-CA); H.R. 2087, the “Drug Price Transparency Act”, introduced by Reps. Doggett (D-TX) and Buchanan (R-FL).

VIII. H.R. 2328, THE “COMMUNITY HEALTH INVESTMENT, MODERNIZATION, AND EXCELLENCE ACT OF 2019”

H.R. 2328, the “Community Health Investment, Modernization, and Excellence Act of 2019”, introduced by Reps. O’Halloran (D-AZ) and Stefanik (R-NY), would reauthorize and extend funding for community health centers through the Community Health Center Fund as well as for the National Health Service Corps.

A. Public Health Provisions

An AINS is expected to be offered to H.R. 2328, which, in addition to four-year extensions of the Community Health Center Fund at \$4 billion annually and National Health Service Corps at \$310 million annually, includes four-year extensions of the following programs: \$126.5 million annually in funding for the Teaching Health Center Graduate Medical Education program, \$150 million annually each for the Special Diabetes Program and the Special Diabetes Program for Indians, \$6 million annually for Family-to-Family Health Information Centers, \$75 million annually for the Personal Responsibility Education Program, and \$75 million annually for the Sexual Risk Avoidance Program.

B. Medicare Provisions

The AINS will also include three-year extensions of certain expiring Medicare programs including: \$30 million annually for the contract with a consensus-based entity, such as the National Quality Forum, to support activities related to quality measurement and performance improvement; \$50 million annually in funding for low-income Medicare beneficiary outreach, enrollment, and education activities through State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach and Enrollment; extension of the Geographic Practice Cost Index (GPCI) floor; extension of the Patient-Centered Outcomes Research Institute (PCORI); extension of the Independence at Home Medical Practice Demonstration Program; and extension of the Limited-Income Newly Eligible Transition Program (LINET).

Additionally, the AINS will include two bills that passed the House in the 115th Congress. H.R. 2371, the “Hearts Act”, introduced by Reps. Thompson (D-CA) and Ferguson (R-GA), would allow military disability retirees under the age of 65 to decline to enroll in Medicare Part B in situations where their Social Security Disability Insurance Payments have been terminated because they are gainfully employed, as well as allow them to continue to access their TRICARE benefits. H.R. 2293, the “Protecting Access to Wheelchairs Act”, introduced by Reps. Larson (D-CA) and Zeldin (R-NY), would exclude complex rehabilitative manual wheelchairs from the Medicare durable medical equipment competitive bidding program.

C. Medicaid Provisions

An amendment to the AINS is expected to be offered that would eliminate the allotment reductions for Medicaid disproportionate share hospitals for FY 2020 and 2021 and lower the reduction from \$8 billion to \$4 billion in FY 2022. This amendment would also require the

Comptroller General to issue a report on the Medicaid disproportionate share hospital (DSH) formula, and it would implement the Medicaid and CHIP Payment and Access Commission recommendation to make Medicaid upper payment limit (UPL) demonstrations public, effective FY 2021.

IX. H.R. 3631, THE “TERRITORIES HEALTH CARE IMPROVEMENT ACT”

H.R. 3631, introduced by Reps. Soto (D-FL) and Bilirakis (R-FL), would increase Puerto Rico’s Medicaid funding to approximately \$3 billion annually for four years, increase the federal medical assistance percentage (FMAP) for four years, and make important program integrity improvements to Puerto Rico’s Medicaid program. It would require Puerto Rico to have an asset verification program in place by the end of the third year, and a payment error rate measurement program in place by the end of the fourth year. It would also provide six years of increased federal funding and increased FMAP for the U.S. Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands. By the end of year four, the legislation would require all of the territories to have established a Transformed Medicaid Statistical Information System (T-MSIS) and a Medicaid Fraud Control Unit (MFCU).

X. H.R. 3630, THE “NO SURPRISES ACT”

H.R. 3630, the “No Surprises Act”, was introduced by Chairman Pallone and Ranking Member Walden on July 9, 2019, after releasing a discussion draft for comment in May. The bill would prohibit balance billing and limit patient cost-sharing to the in-network amount for emergency services. Additionally, the legislation would prohibit surprise medical bills from facility-based providers that patients cannot reasonably choose, whether arising from emergency care or scheduled care. For all other scheduled care at an in-network facility, the legislation would require that patients receive notice and provide their consent to out-of-network care. Such consent must include information about the network status of any and all providers who will be treating the patient, and an estimate of the out of network provider’s charges for each item or service that will be provided. If a patient did not receive adequate notice and consent to the services, the provider could not balance bill the patient.

The “No Surprises Act” establishes a payment benchmark to resolve out-of-network payment disputes between providers and insurers. H.R. 3630 would require that the insurer pay, at minimum, the median contracted rate (in-network rate) for the services in the geographic area where the services were delivered. That rate may also account for differences in sites of care. It also preserves a state’s ability to determine its own solution to resolve out-of-network payment between insurers and providers for plans regulated by the state.

The legislation includes several changes to the discussion draft, including: tying the median in-network rate to a base year (2019) and inflating the rate forward by CPI-U; requiring the Secretary of HHS to establish a process to audit the accuracy of the median contracted rate; prohibiting balance billing for services that may occur post-stabilization (after emergency care) but before a patient is able to travel without emergency transport to a facility or provider in their network; clarifying that patients are protected from all out-of-network services that occur during the course of a medical visit that they did not explicitly consent to including: the use of

equipment, devices, telemedicine services, imaging services, laboratory services, and other treatments or services, regardless of whether the provider furnishing the services is at the facility; prohibiting balance billing for unforeseen medical services that arise during the course of treatment or when there is no in-network provider available to deliver the service at the in-network facility; increasing the amount of time prior to the patient receiving the service that a provider or facility must obtain written consent for scheduled out-of-network care to 72 hours (from 24 hours); and requiring insurers to maintain more accurate provider directories.