



COMMITTEE ON
WAYS & MEANS
REPUBLICANS

the **WAY FORWARD** *on* HEALTH CARE

The upcoming election is a referendum on health care like this country has not before seen. Democrats are promising the radical elimination of Americans' choice of private coverage and ending Medicare as we know it. And as part of their fearmongering, they are accusing Republicans of lacking ideas to expand access to affordable, quality health coverage for all.

This is wrong.

Republicans have a long track record of creating successful, popular coverage options— like Medicare Advantage and the Medicare Prescription Drug plan— and empowering Americans with tools to get in the driver's seat of their health care decisions.

That experience means we know we need to build on what works rather than double-down on flawed one-size-fits all solutions. With a constructive approach, we will create an even brighter, more optimistic path forward that puts patients and families in control of their own health. In our new series, "The Way Forward," Ways and Means GOP will outline proposals to lower costs, modernize services, expand access, and improve quality. This series will highlight both new ideas to accomplish these goals as well as provide reminders of creative policy solutions we have supported in the past.

Our work is rooted in a single principle: Every American deserves health care that works for them.

Everyone's needs are different: Health care is important— and incredibly personal— for every American. An eighty-year-old woman on Medicare has different health care needs than a thirty-year-old single mom. A forty-year-old business executive with health insurance at her job has different health care needs than a man who is unemployed.

Everyone deserves choice and control: Thirty million people under the age of 65 are still uninsured. How do we offer them lower cost, high quality, modern health care options?

Everyone deserves an abundant, effective, and innovative health care system. American innovation must continue to produce treatments and cures to help us and our loved ones stay healthy and live longer.



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With these questions in mind, here is a common-sense framework for a modernized, personalized health care plan for people at every stage of life:

- 1. Protect people with pre-existing conditions**, regardless of whether they get their health care from their employer, an individual insurance plan, or a government program like Medicare or Medicaid. Everyone will have access to affordable coverage regardless of a pre-existing condition. While this is the law of the land already, Congressional Republicans are prepared to work in a bipartisan way to restore those critical provisions should they be struck because the Supreme Court finds Democrats wrote a law that tramples on Americans' constitutional rights. [Here's what we've already done.](#)
- 2. Provide certainty and fairness for people by ending surprise medical bills and increasing transparency.** When people's health is uncertain, they deserve predictability from their care. Under our plan, no one will get an unexpected bill from an insurance company or medical provider. [Here's how we'd do it.](#)
- 3. Improve coverage and lower costs for those who have job-based health insurance.** These people deserve greater access to health savings accounts to purchase medicines and pay other out-of-pocket costs. And they deserve more options for portability, so when they lose their job, they don't lose their coverage. [Here's how we'd do both.](#)
- 4. Save and Strengthen Medicare.** This critical entitlement program is careening toward insolvency. [Here's how](#) our plan preserves the Medicare guarantee, [here's how](#) it modernizes the drug benefit and [here's how](#) it harnesses technology to deliver care through telehealth.
- 5. Incentivize innovation and cures.** Private-sector research will continue to pave the way for new therapies and life-saving cures. Our plan increases research and development as well as invests in vaccines and therapies for infectious diseases like COVID-19. [Here's how.](#)
- 6. More affordable options to expand coverage to those without insurance.** Every American should be able to access more options for insurance. [Here's how we'd create those options.](#)

Over the coming weeks, we will continue to share more on these items— their history and future—and other policies as part of “The Way Forward,” a project by the Ways and Means GOP.



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EXPANDING ACCESS TO MORE AFFORDABLE OPTIONS

What's the problem?

The Affordable Care Act is not perfect, which is why we must continue our work to address its most harmful policies and lower costs and improve access. Republicans in Congress have already fixed the law's most onerous provision: the tax on those Americans who did not want to buy an inflexible, one-size-fits-all Washington-centric product. Other changes followed: replacing its broken physician payment system with the bipartisan Medicare Access and CHIP Reauthorization Act of 2015; hundreds of billions of dollars of tax repeals to lower costs throughout the health-care system; fixes for Americans working abroad; removing a program targeted at the elderly a Democrat senator called "a Ponzi scheme of the first order, the kind of thing Bernie Madoff would be proud of"; ensuring a board of unelected, unaccountable bureaucrats could not de-facto ration Medicare; and further empowering governors and state legislatures to reduce health insurance premiums through federally-approved waivers that reflected each state's unique situation.

Now, we need to fix the gaps that remain from the law's original design and what the courts had to fix when they found the parts of the law to be **unconstitutional**:

- 1.** Our health care system provides limitless subsidies to those who get coverage at work, including the richest Americans, and nothing for some of our most vulnerable Americans who are living with incomes below the poverty line. That is unconscionable. Fixing this gross inequity should be a bipartisan priority for Congress.
- 2.** Innovative plan offerings are limited while others are constantly submitted to litigation, which results in disruptions and uncertainty for American families looking for a coverage lifeline.

Here's how we'd fix it:

- 1.** Restructure Federal Support for Health Coverage Away from the Rich and Toward Low-Income Americans
- 2.** Enshrine in Law Access to Short-Term Health Plans
- 3.** Protect Association Health Plans (AHPs) from Elimination in the Courts
- 4.** Allow More Americans to Enroll in Catastrophic Health Care Plans Under Current Law
- 5.** Consider Options for Targeted Benefit Plans
- 6.** Expand States' Ability to Customize their Health Coverage Systems



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EXPANDING ACCESS TO MORE AFFORDABLE OPTIONS

The Details:

1. Restructure Federal Support for Health Coverage Away from the Rich and Toward Low-Income Americans

Millions of Americans get health insurance through their employer, which comes with one of the most generous tax benefits available: individuals do not pay income and payroll taxes on the value of their job-based coverage. This makes job-based health coverage unique; take-home pay, for instance, doesn't get the same treatment. The tax benefit of job-based health insurance is endless, unlimited, and uncapped.

The non-partisan CBO projects this job-based subsidy lowers federal revenues by \$288 billion in fiscal year 2020 alone and \$3.86 trillion over the next decade, making it the third largest component of government spending on health, after Medicare and Medicaid.

This subsidy has been found to increase the cost of coverage, and, most critically, benefit the rich more than those with lower incomes. Because it excludes dollars from taxable income, those who pay the highest rates—the wealthiest Americans—receive the biggest benefit.

Meanwhile, as a result of the Supreme Court finding the ACA's Medicaid policies were unconstitutional, many low income Americans—who do not have job-based coverage—have fallen into a coverage “gap”: they make too much money to be on Medicaid, but not enough to get help to buy health insurance on the individual market.

So, to sum up: our health care system provides limitless subsidies to those who get coverage at work, including the richest Americans, and nothing for some of our most vulnerable Americans who are living with incomes below the poverty line. That is unconscionable. Fixing this gross inequity should be a bipartisan priority for Congress.

Here's how we do it. First, we would put a cap on the size of the tax break the wealthiest Americans get on their job-based insurance. This would be not only a more equitable approach but would also help put downward pressure on ever-increasing health care costs. Then, we would redirect those government savings to provide tax credits to those in the Medicaid coverage gap so they can buy the private health insurance of their choosing.



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EXPANDING ACCESS TO MORE AFFORDABLE OPTIONS

The Details:

2. Enshrine in Law Access to Short-Term Health Plans

President Trump's actions on short-term health plans reversed an Obama-era regulation designed to eliminate options outside of the Affordable Care Act (ACA). Reverting back to the rules that governed these plans for nearly 20 years restores a health care option for people that might not want or be able to afford an ACA plan.

According to eHealth, the lowest cost short-term plan that offers coverage for 12 months can be more than 60 percent cheaper than the lowest cost ACA plan in an area. This option is incredibly valuable for families that don't qualify for the ACA's subsidies but still need or want health coverage. In 2019, it is estimated that about 3 million people enrolled in short-term health plans.

Some might warn that expanding short-term plan damages the ACA exchanges by taking healthy enrollees out of the risk pool. However, states that fully allowed short-term plans in 2019 did not seem to have experienced greater declines in unsubsidized ACA enrollment relative to other states.

There is no definition of short-term, limited-duration (STLD or "short-term") health plans in law except to say that these plans are exempt from federal rules that apply to the individual insurance market. This type of insurance was defined by regulations in 1997 that were implementing the Health Insurance Portability and Accountability Act. The 1997 definition applied until October 2016, when the Obama administration changed it to specify that the plans could not provide coverage for longer than three months, including any renewal period. They did this because short-term plans were being used as a source of primary coverage for healthier individuals, reducing coverage in the individual market, and therefore lessening enrollment in the ACA's exchanges.

In August 2018, the Trump administration released a final rule to change the definition for short-term plans back to the previous definition--coverage lasting for less than 12 months, allowing plan contracts to be offered for up to 364 days. In addition, considering renewals or extensions, the contract can only have a duration of no longer than 36 months in total. In effect, someone could have a short-term plan with the same issuer for up to three years.

The rule does not preempt state regulation of short-term plans, so long as the maximum duration is the federally set amount. Thus, within those bounds, states are responsible for the regulation of these plans.

Short-term plans are much more affordable than ACA-compliant plans because they are not subject to the ACA's rules which means their level of coverage varies considerably based on the plan, coverage could be denied to applicants, and premiums can vary based on health and other factors.



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EXPANDING ACCESS TO MORE AFFORDABLE OPTIONS

The Details:

3. Protect Association Health Plans (AHPs) from Elimination by the Courts

The Trump administration changed existing regulations to allow more employers and the self-employed to form association health plans (AHPs), giving small businesses and sole proprietors the opportunity to join together to spread the risk and administrative costs of providing health insurance across a greater number of people.

Unfortunately for the millions of Americans in need of a lower-cost health care option, 12 Democratic attorneys general filed a lawsuit challenging the Trump administration's rule to expand access to AHPs and it is still held up in court, halting this option.

House and Senate Republicans have introduced the Association Health Plan Act of 2019 (H.R. 2294 and S. 1170) to codify definitions used in the Trump administration's final rule to ensure continued access to coverage offered by AHPs under the rule.

The rule, should it be allowed to take effect, would increase access to these plans by broadening who can form and join an AHP by allowing them to be based on common geography or industry. An AHP could cover different kinds of businesses in a state or metropolitan area, or all businesses in a particular industry could join up nationwide. In addition, it would allow working owners without other employees to join an AHP.

These changes would allow more AHPs to be regulated by the large group market. If an AHP has enough employees to qualify as a large group plan, it can avoid several expensive regulations that apply to the individual and small group markets.

The rule would also apply nondiscrimination rules to AHPs, including a prohibition on charging premiums or denying coverage based on health issues.

Should the rule be allowed to take effect, it has the potential to impact millions of Americans. The CBO has estimated that on average, 3.7 million people would be enrolled in an AHP annually under the new rules. Of those, they estimated that 400,000 people would have been previously uninsured. In addition, when the rule was proposed, the consulting firm Avalere estimated that, "Premiums in the new AHPs are projected to be between \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered."



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The Details:

4. Allow More Americans to Enroll in Catastrophic Health Care Plans Under Current Law

Current law allows some Americans— those under 30 years of age and anyone of any age who finds individual market or job-based insurance to be unaffordable— to enroll in catastrophic health-insurance plans. These plans typically have lower premiums, relative to other types of coverage. Uniquely, catastrophic plans cover the same essential health benefits as other individual market plans and allow for at least three primary care visits per year without out-of-pocket costs for the patient.

These plans can be a great option for some— that’s why they exist in the first place. But two policy changes will make them even more valuable. First, all age and affordability restrictions should be removed. Second, subsidies should be allowed to flow to these plans to put them on a level playing field as other plans on the individual market.

5. Consider Options for Targeted Benefit Plans

Recognizing the unique medical needs of some seniors, the current Medicare program allows for “Special Needs Plans” (SNPs). This type of coverage allows certain types of beneficiaries the chance to enroll in a private health plan with tailored benefits. For instance, a chronic-care SNP for a senior with cancer covers all the same benefits as Medicare, but also allows for additional benefits specific to that beneficiary’s health care issues. Congress should test if such plans, with appropriate risk adjustment, results in higher quality, more affordable care for the most vulnerable.

6. Expand States’ Ability to Customize their Health Coverage Systems

There has been continued bipartisan approval of waivers that allow the states to continue apply for help to lower premiums in their communities. Current law’s Section 1332 State Innovation Waivers allow states to try different approaches to deliver high quality, lower cost coverage. Most states have used this for “reinsurance,” that is, using federal dollars and state-based assessments to provide insurance to health insurance companies against high medical claims. Mitigating this risk allows health insurance companies to offer plans to enrollees at lower costs, which is especially beneficial to enrollees that do not qualify for the ACA’s subsidies. This system— allowable under current law— provides for marketplace stabilization without increasing the federal deficit. It should be easier for states to get a 1332 waiver and to combine it with their 1115 Medicaid waiver.



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SAVING MEDICARE BY BUILDING ON MEDICARE ADVANTAGE'S SUCCESS

What's the problem?

The current Medicare program has very serious financing challenges. The part of Medicare that pays for care at hospitals is expected to be exhausted just six years from now. At that point, the government will only have enough money to pay for 90 percent of benefits. To shore up that part of Medicare for the long-term, benefits would need to be cut immediately by 16 percent, or the payroll tax would need to be increased to 3.66 percent from 2.90 percent.

It is irresponsible for Congress to ignore the financial issues that are currently jeopardizing health care security for current and future seniors. A top priority for Congress should be to work to make sure we can keep our promises to those in or near retirement.

Here's how we'd fix it:

The Medicare Advantage program (MA) has proven that private insurers can provide the Medicare benefit to seniors better than the government can. In MA, where private insurers provide Medicare's benefit to 36 percent of all Medicare beneficiaries, 89 percent of enrollees were enrolled in a plan that included drug coverage and 60 percent of them got that coverage premium free in 2020.

On top of that bonus drug coverage, 79 percent of MA enrollees had some type of vision benefit, 74 percent had a dental benefit, and 72 percent had a hearing aid benefit in 2020. All of these valuable extra benefits are in combination with the out-of-pocket maximum required by law in MA plans to protect seniors from catastrophic costs. No such protection exists for seniors in the government-run traditional Medicare program. For that, seniors in traditional Medicare have to buy a separate, supplemental plan.

Private insurers have shown us that they can provide better health coverage to seniors more efficiently than the government can, with extra benefits, and with near-universal satisfaction among enrollees. A [May 2020 poll](#) found that 99 percent of seniors on Medicare Advantage are satisfied with their health care coverage, with 64 percent saying they are very satisfied.

With traditional Medicare quickly approaching insolvency and Medicare Advantage's popularity and enrollment consistency rising, Congress should start to develop and test new ideas to lower costs and guarantee the Medicare benefit is stable for current and future seniors based on this success. In particular, Congress should test the bipartisan idea of setting payments in Medicare based on a competitive bidding system. This system would adjust the amount of money paid to a plan on a beneficiary's behalf based on how that plan's cost estimates for coverage compare to other plans in the same geographic area. This new system would replace the antiquated MA payment system used today that links MA payment to the costs of traditional Medicare. Private plans would compete against each other to attract seniors, just as they do today, but their payment would be more directly tied to how they compare against other private plans. This reform has the power to put Medicare on stable financial footing and deliver better, more generous Medicare benefits to seniors.



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LOWERING OUT-OF-POCKET DRUG COSTS FOR SENIORS

What's the problem?

The current Medicare fee-for-service program was enacted in 1965. Arguably, its greatest modernization came when President George W. Bush and Congressional Republicans passed the Medicare Part D Prescription Drug Program in 2003.

Part D has been a tremendous accomplishment:

- 1.** It is **popular**: 92 percent of seniors report that their plans are convenient to use. 88 percent report they are satisfied with their coverage choices on their individual plan.
- 2.** It is also nearly 50 percent **under budget** for taxpayers and has offered consistently low premiums for seniors since the program's inception.

Yet despite its successes, it has a significant short-coming: there is no dollar limit to what a senior can pay for their drugs in a year. This annual uncertainty is a burden on our seniors.

Here's how we'd fix it:

Across four introduced bills, it is clear there is **bipartisan, bicameral agreement — supported by the President** — to reform the structure of Part D:

- **Create an out-of-pocket cap for seniors** so once they've spent a certain amount of money, they're covered 100 percent for the rest of the year.
- **Enable seniors** who hit the cap early on in the year to divide the financial burden over the course of the plan year instead of absorbing the full cost in the first quarter, further easing financial challenges for seniors.
- **Reversing the perverse incentives** in the current design by lowering the government's financial liability and giving insurers and manufacturers a greater incentive to manage costs.

This will **lower patients' costs at the pharmacy counter** by directly cutting what they owe when they pick up their medicines and **lower the actual price of drugs** by lowering the government's financial liability and giving insurers and manufacturers a greater incentive to manage costs.



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Reforming the structure of Part D keeps **drug companies on the hook** for their fair share of costs without picking winners and losers in the industry. And it **reduces the influence of middlemen** by simplifying the program.

Together, Republicans and Democrats can build a set of incentives to **lower seniors' spending** on medicines, **keep Part D premiums stable**, and ensure continued **investment in innovative, life-saving therapies**.

But this means Democrats cannot continue to try to force through Congress their cures-killing agenda. The House spent months drafting and considering Speaker Pelosi's H.R. 3, a bill Republicans continue to oppose and has no chance of becoming law. The Congressional Budget Office found that H.R. 3 could result in up to eight fewer drugs being brought to market over the next 10 years, and 30 fewer drugs in the subsequent decade. Other studies have shown that H.R. 3 could result in up to 100 fewer drugs over the next decade and result in an 88 percent reduction in new drugs manufactured by small biopharmaceutical firms in California.

H.R. 3 will not become law. There are bipartisan policies that can – Congress should focus on those solutions.

Let's abandon partisan messaging bills and work together to deliver real relief to seniors.



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EXPANDING TELEHEALTH TO MORE AMERICANS

What's the problem?

Health disparities experienced by some racial and ethnic minority groups in underserved communities are often very similar to health disparities experienced in rural populations [Obesity, hypertension](#), and diabetes are all major contributors to health disparities in these communities. Plus, racial and ethnic minorities in rural communities often experience a compounding effect resulting in the [poorest health outcomes](#).

Barriers to accessing care contribute to these disparities.

Here's how we'd fix it:

One way to improve access to care in these communities is continuing to expand and invest in telehealth. CMS has issued a bevy of temporary flexibilities and financial investments to make telehealth more accessible for patients across the country during the public health emergency. [Congress should build on this progress](#) and take steps to ensure these technologies are breaking through to the communities in dire need, both for the remainder of our COVID-19 response and into the future.

That's why Ways and Means Health Subcommittee Republican Leader Devin Nunes, together with the GOP members of the Committee, [released a discussion draft](#) to chart a new course in the delivery of health care.

Here's what the proposal includes:

Make permanent the removal of originating site and geographic restrictions and add the beneficiary's home as an originating site.

Traditionally, in order to receive a telehealth service in Medicare, a beneficiary must be in a rural area and must travel to a healthcare facility. By removing geographic and originating site restrictions, Medicare beneficiaries across the country will have the option of utilizing telehealth services from the convenience of their home.

Permanently allow reimbursement to FQHCs and RHCs for telehealth services.

Prior to the Public Health Emergency waivers, FQHCs and RHCs were restricted in their ability to provide telehealth services to Medicare beneficiaries. Permanently removing these restrictions is critical to improving access for patients in rural and underserved areas.



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Permanently include physical therapists, occupational therapists, and speech language pathologists as authorized practitioners of telehealth services and give the HHS Secretary authority to waive limitations on other types of clinical practitioners that can furnish Medicare telehealth services.

Before waiver expansions during the Public Health Emergency, the list of providers that were eligible to furnish telehealth was narrow, limiting opportunities for Medicare beneficiaries to access telehealth services. Breaking down these limitations on which practitioners can provide telehealth services in Medicare will provide new opportunities for patients.

Permanently allow for telehealth services to be provided by audio-only telephone, if the patient does not have the ability to use audio-visual technologies and if the patient already has an established relationship with the provider.

Not all Americans have access to Zoom or Facetime. The use of audio-only telehealth – like a landline telephone – during the Public Health Emergency has been critical for reaching many patients that otherwise might not be able to receive care. In rural and underserved areas, a lack of technological infrastructure can limit patients' video-conferencing capabilities. Additionally, digital literacy can also keep patients from accessing telehealth resources via videoconferencing. While more examination is needed to determine how to best incorporate audio-only telehealth, it is clear this option has a role to play moving forward.

Permanently allow coverage for telehealth services under the deductible for high deductible health plans with a health savings account.

Making this policy permanent will give patients easier access to this effective and convenient type of care, potentially lowering health care costs overall.



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Permanently allow the remote authorization of dialysis care through telehealth technologies instead of requiring an in-person visit (so long as patients receive mandatory in-person training for the first three months when starting home dialysis), and give the HHS Secretary the authority to waive other in-person visit requirements as long as the Secretary can certify safety.

The Public Health Emergency has demonstrated the ability to better integrate telehealth into a variety of home health settings. Moving forward, patients should have the choice to continue to use telehealth to receive care such as home dialysis. Additionally, the Secretary of HHS should have the ability to expand similar flexibilities to other cases, where clinically appropriate.

Ensure rigorous stewardship of taxpayer dollars in three ways: require OIG to conduct a survey of telehealth claims to study potential improper payments one year after the end of the Public Health Emergency; increase funding to the HHS Office of Audit Services and Office of Investigations to ensure they have the resources necessary to handle oversight of the increase in telehealth claims since the start of the public health emergency; and require CMS to offer education and training sessions to practitioners on Medicare telehealth requirements and related resources.

These provisions serve as a starting point towards ensuring that increasing patients' opportunity to utilize telehealth does not mean increasing our tolerance for waste, fraud, and abuse. Any steps Congress takes to expand telehealth must also include appropriate program integrity safeguards.

Together, these provisions serve as a way to launch a discussion as to how to best secure patients' access to care through technology and ensure that patients in rural and underserved areas are not left behind.



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EMPOWER CONSUMERS

What's the problem?

Health care costs are too high. Americans are too often in the back seat of their health care decisions. And with the current system's morass of regulations and bureaucrats, there are often too few opportunities for families to control their health care dollar.

Here's how we'd fix it:

While Democrats have tried to sideline consumer-directed health care, Republicans believe we should eliminate the roadblocks that currently exist and institute several commonsense expansions:

- Allow spouses near retirement to make catch-up contributions to the same HSA account.
- Allow qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days.
- Increase contribution limits to HSAs so families can better prepare for future health care expenses.
- Remove the unique out-of-pocket maximum that applies to HDHPs because it causes a lot of plans in the individual market to be ineligible for HSAs.
- Expand accessibility for HSAs to certain groups, like those who get services through the Indian Health Service.

We should also complete the bipartisan work started in 2016 and further encourage the use health reimbursement arrangements. These tools allow employers of all sizes to give pre-tax dollars to employees to help them purchase a health plan in the individual market or get reimbursed for health expenses. That way, the plan belongs to the individual, but they still get financial support from their work.



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CREATING MORE MADE-IN-AMERICA DRUGS & CURES

What's the problem?

In our quest to find a cure to COVID-19, we are learning the normal rules of supply and demand aren't working. Americans—and the world—are desperate for a cure to this virus. And in order for that to happen, we need to develop a resilient medical supply chain here in the U.S. that can be the global leader for new therapies and medical cures—one that reduces our reliance on products manufactured in China.

That requires more private investment and a nimbler manufacturing system than we have today.

Here's how we'd fix it:

First, **we must attract private capital investment in critical therapeutic areas** to give the global population a head-start on the next outbreak. [GOP members of the Ways and Means Committee](#) have developed three steps to expand our capacity to develop cutting-edge cures and medicines:

- Direct investment toward innovative, smaller firms.
- Eliminate roadblocks for investors to finance these biotech companies.
- Make it easier for there to be greater and earlier investment in these life-saving cures.

Our country's smallest biotech firms are some of the biggest innovators. These small research firms are on the frontlines of this battle, engaging in the most innovative aspects of infectious disease drug development without any previously FDA-approved products.

We need to do more to help them raise the funds they need to make these discoveries. Our legislation will direct investment towards these smaller firms, helping them raise the funds needed to continue doing this life-saving work.

Further, because small firms have no revenues, they cannot benefit from the normal tax incentives companies use to reduce their taxable income – like tax credits or expensing research and development (R&D) costs. They also have a harder time attracting outside investors who do not see a substantial upside to an investment in a firm that may never generate profits. Congress needs to make it easier for these innovators to raise money and bring these cures to market.



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We also need to allow greater and earlier investment toward cures. Our tax system should make it easier to unite those developing these cures and those looking to invest in these medicines. Our legislation provides greater flexibility so that financial support for certain drug development firms isn't discouraged by risk.

If these firms eventually lose money, investors in these firms would be able to use their share of the firm's losses or R&D tax credits to offset income from other investments. This makes supporting these innovators more attractive. This small tweak will make a big difference in attracting investment to these cures.

Second, we must shift to advanced manufacturing. Top scientists from the Food and Drug Administration said "advanced manufacturing" – which means to utilize new and emerging approaches to enhance the making of cures and treatments – will help increase the production and invention of new medical breakthroughs. Whether through 3D printing for medical devices or advancing new gene therapies, advanced manufacturing "enables innovation," boosts efficiency, and improves "supply chain resiliency for medical products that provide wide-ranging public health benefits," according to the FDA.

The FDA is right: There are tremendous benefits to advanced manufacturing for all Americans. That's why House Republicans are working to advance legislation that would help deploy these new medical throughs, benefiting patients, medical providers, and the economy.

Ways and Means Republicans, led by Rep. Brad Wenstrup (R-OH), introduced the Domestic Medical and Drug Manufacturing Tax Credit. This legislation lowers the tax rate on the income from the domestic manufacturing and sales of active pharmaceutical ingredients and medical countermeasures – giving manufacturers more immediate capital to invest in advanced manufacturing.

By providing a credit of 10.5 percent of the net income from the sale of these important medical products, this effectively cuts the corporate tax rate of 21 percent in half on these domestically manufactured products.

The bill also creates a 30 percent tax credit for new investments in advanced manufacturing equipment or machinery used in the U.S. to manufacture drugs, medical devices, or biological products. The credit phases down to 20 percent in 2028, 10 percent in 2029, and phases out in 2030.



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PUTTING AN END TO SURPRISE MEDICAL BILLING

What's the problem?

Emergencies happen. And when they do, families don't have time to pull up Google Maps and find out how close the nearest in-network emergency room is.

Because of this, many privately insured Americans who find themselves at an out-of-network emergency room or have to be treated unexpectedly by an out-of-network provider later receive significant medical bills.

These “surprises” occur for two reasons: first, because the insurance company and the provider are unable to come to an agreement on the provider's compensation for services; and second, the patient has no idea the cost or network status of their provider.

Here's how we'd fix it:

These provisions are all included in the bipartisan Consumer Protections Against Surprise Medical Bills Act of 2020.

End Surprise Medical Bills. Providers (including facilities) will be prohibited from balance billing patients for surprise services. Patients cannot be charged more than the in-network cost-sharing amount.

Create New Patient Protections. Patients will receive an Advance Explanation of Benefits — a true and honest cost estimate — that describes which providers will deliver their treatment, the cost of services, and provider network status. Patients will also see additional relief from surprise bills, and those undergoing treatment at the time their provider leaves their network will receive an up to 90-day period for transitioning care.



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the **WAY FORWARD** *on* **HEALTH CARE**

PUTTING AN END TO SURPRISE MEDICAL BILLING

Allow for a Mediated Dispute Resolution Process. In most cases, plans and providers will resolve payment issues without federal intervention. However, when the requested or proposed payment amount is unsatisfactory, a two-step process is available to resolve disputes. This process respects the rights of private parties to freely contract and negotiate. There is no minimum dollar threshold to bring disputes, and the Secretary of the Department of Health and Human Services (HHS) is permitted to develop a process that would allow batching of similar claims if it would promote efficiency. First, either party may initiate an open negotiation process – a 30-day period that allows the private parties to attempt resolution and requires the exchange of certain information. If the parties do not reach resolution, either can initiate the mediation process, administered by independent third parties without any affiliation to providers or payers. The independent third parties will be assigned or selected through an impartial process, subject to rules determined by the relevant Secretary. During mediation, the parties will present best and final offers along with any supporting information to the mediator, who will also consider the median contracted rate specific to the plan, and for similar providers, services, and geographic areas. Independent entities are prohibited from considering usual and customary charges or billed charges, and other guardrails ensure a fair and reasonable process.

Help the Uninsured or Those Paying Cash. For individuals without health insurance or electing to pay cash, providers will share cost estimates directly with patients before a procedure. If the final charge is significantly higher than the cost estimate, the final payment will be determined through mediation.