

114TH CONGRESS
1ST SESSION

H. R. 2570

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

IN THE HOUSE OF REPRESENTATIVES

MAY 22, 2015

Mrs. BLACK (for herself, Mr. BLUMENAUER, and Mrs. McMORRIS RODGERS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Value Based Insurance
3 Design for Better Care Act of 2015” or the “VBID for
4 Better Care Act of 2015”.

5 **SEC. 2. FINDINGS.**

6 Congress makes the following findings:

7 (1) A growing body of evidence demonstrates
8 that increases in patient-level financial barriers (in-
9 cluding deductibles, copayments, and coinsurance)
10 for high-value medical services (such as prescription
11 medications, clinician visits, diagnostic tests, and
12 procedures) systematically reduce their use. Savings
13 attributable to cost-related decreased utilization of
14 specific services may lead to an increase in total
15 medical expenditures due to increased use of other
16 related clinical services, such as hospitalizations and
17 emergency room visits.

18 (2) Empirical research studies demonstrate that
19 reductions in beneficiary out-of-pocket expenses for
20 high-value prescription medications and clinical serv-
21 ices can mitigate the adverse health and financial
22 consequences attributable to cost-related decreased
23 utilization of high-value services.

24 (3) Financial barriers to prescription medica-
25 tions and clinical services that are deemed to be

1 high-value should be reduced or eliminated to in-
2 crease their use.

3 (4) Value-Based Insurance Design is a method-
4 ology that adjusts patient out-of-pocket costs for
5 prescription medications and clinical services accord-
6 ing to the clinical value—not exclusively the cost.
7 Value-Based Insurance Design is based on the con-
8 cept of clinical nuance that recognizes—

9 (A) prescription medications and clinical
10 services differ in the clinical benefit provided;
11 and

12 (B) the clinical benefit derived from a spe-
13 cific prescription medication or clinical service
14 depends on the clinical situation, the provider,
15 and where the care is delivered.

16 (5) The current “one-size-fits-all” copayment or
17 coinsurance design for prescription medications and
18 clinical services provided under the Medicare pro-
19 gram does not recognize the well-established value
20 differences in health outcomes produced by various
21 medical interventions.

22 (6) The establishment by Medicare of copay-
23 ment and coinsurance requirements using Value-
24 Based Insurance Design methodologies will improve
25 patient-centered health outcomes, enhance personal

1 responsibility, and afford a more efficient use of tax-
2 payer dollars.

3 **SEC. 3. DEMONSTRATION PROGRAM.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the “Sec-
6 retary”) shall establish a 3-year demonstration program
7 to test the use of value-based insurance design methodolo-
8 gies (as defined in subsection (c)(1)) under eligible Medi-
9 care Advantage plans offered by Medicare Advantage or-
10 ganizations under part C of title XVIII of the Social Secu-
11 rity Act (42 U.S.C. 1395w–21 et seq.).

12 (b) DEMONSTRATION PROGRAM DESIGN.—

13 (1) SELECTION OF MEDICARE ADVANTAGE
14 SITES AND ELIGIBLE MEDICARE ADVANTAGE
15 PLANS.—Not later than two years after the date of
16 the enactment of this Act, the Secretary shall—

17 (A) select at least two Medicare Advantage
18 sites with respect to which to conduct the dem-
19 onstration program under this section; and

20 (B) approve eligible Medicare Advantage
21 plans to participate in such demonstration pro-
22 gram.

23 In selecting Medicare Advantage sites under sub-
24 paragraph (A), the Secretary shall take into account
25 area differences as well as the availability of health

1 maintenance organization plans and preferred pro-
2 vider organization plans offered in such sites.

3 (2) START OF DEMONSTRATION.—The dem-
4 onstration program shall begin not later than the
5 third plan year beginning after the date of the en-
6 actment of this Act.

7 (3) ELIGIBLE MEDICARE ADVANTAGE PLANS.—
8 For purposes of this section, the term “eligible
9 Medicare Advantage plan” means a Medicare Ad-
10 vantage plan under part C of title XVIII of the So-
11 cial Security Act (42 U.S.C. 1395w–21 et seq.) that
12 meets the following requirements:

13 (A) The plan is an Medicare Advantage re-
14 gional plan (as defined in paragraph (4) of sec-
15 tion 1859(b) of such Act (42 U.S.C. 1395w–
16 28(b))) or Medicare Advantage local plan (as
17 defined in paragraph (5) of such section) of-
18 fered in the Medicare Advantage region selected
19 under paragraph (1)(A).

20 (B) The plan has—

21 (i)(I) a quality rating under section
22 1853(n)(4) of such Act (42 U.S.C. 1395w–
23 23(n)(4)) of 4 stars or higher based on the
24 most recent data available for such year,
25 or

(II) in the case of a specialized Medicare Advantage plan for special needs individuals, as defined in section 1859(b)(6)(A) of such Act (42 U.S.C. 1395w–28(b)(6)(A)), a quality rating under 1853(n)(4) of such Act (42 U.S.C. 1395w–23(n)(4)) equal to or higher than the national average for special needs plans (excluding Institutional-Special needs plans) based on the most recent data available for such year; and

(ii) at least 20 percent of the population to whom the plan is offered consists of subsidy eligible individuals (as defined in section 1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(A))).

(4) DISCLOSURE TO BENEFICIARIES.—The Secretary shall provide to each individual eligible to enroll under a Medicare Advantage plan approved to participate under the demonstration program during a plan year for which the plan is so selected—

(A) notification that the plan is participating in such demonstration program;

1 (B) background information on the dem-
2 onstration program;

3 (C) clinical data derived from the studies
4 resulting from the demonstration program; and

5 (D) notification of the potential benefits
6 that the individual will receive, and of the other
7 potential impacts that the individual will experi-
8 ence, on account of the participation of the plan
9 in the demonstration program.

10 (c) VALUE-BASED INSURANCE DESIGN METHODOLO-
11 GIES.—

12 (1) DEFINITION.—For purposes of this section,
13 the term “value-based insurance design method-
14 ology” means a methodology for identifying specific
15 prescription medications, and clinical services that
16 are payable under title XVIII of the Social Security
17 Act, for which copayments, coinsurance, or both,
18 would improve the management of specific chronic
19 clinical conditions because of the high value and ef-
20 fectiveness of such medications and services for such
21 specific chronic clinical conditions, as approved by
22 the Secretary.

23 (2) USE OF METHODOLOGIES TO REDUCE CO-
24 PAYMENTS AND COINSURANCE.—A Medicare Advan-
25 tage organization offering an eligible Medicare Ad-

1 vantage plan approved to participate under the dem-
2 onstration program, for each plan year for which the
3 plan is so selected and using value-based insurance
4 design methodologies—

5 (A) shall identify each prescription medica-
6 tion and clinical service covered under such
7 plan for which the plan proposes to reduce or
8 eliminate the copayment or coinsurance, with
9 respect to the management of specific chronic
10 clinical conditions (as specified by the Sec-
11 retary) of Medicare Advantage eligible individ-
12 uals (as defined in section 1851(a)(3) of the
13 Social Security Act (42 U.S.C. 1395w-
14 21(a)(3))) enrolled under such plans, for such
15 plan year;

16 (B) may, for such plan year, reduce or
17 eliminate copayments, coinsurance, or both for
18 such prescription medication and clinical serv-
19 ices so identified with respect to the manage-
20 ment of such conditions of such individuals—

21 (i) if such reduction or elimination is
22 evidence-based and for the purpose of en-
23 couraging such individuals in such plan to
24 use such prescription medications and clin-
25 ical services (such as preventive care, pri-

1 mary care, specialty visits, diagnostic tests,
2 procedures, and durable medical equip-
3 ment) with respect to such conditions; and

4 (ii) for the purpose of encouraging
5 such individuals in such plan to use health
6 care providers that such organization has
7 identified with respect to such plan year as
8 being high value providers; and

9 (C) if a reduction or elimination is applied
10 pursuant to subparagraph (B), with respect to
11 such medication and clinical services, shall, for
12 such plan year, count toward the deductible ap-
13 plicable to such individual under such plan
14 amounts that would have been payable by the
15 individual as copayment or coinsurance for such
16 medication and services if the reduction or
17 elimination had not been applied.

18 (3) PROHIBITION OF INCREASES OF COPAY-
19 MENTS AND COINSURANCE.—In no case may any
20 Medicare Advantage plan participating in the dem-
21 onstration program increase, for any plan year for
22 which the plan is so participating, the amount of co-
23 payments or coinsurance for any item or service cov-
24 ered under such plan for purposes of discouraging
25 the use of such item or service.

1 (d) REPORT ON IMPLEMENTATION.—

2 (1) IN GENERAL.—Not later than 1 year after
3 the date on which the demonstration program under
4 this section begins under subsection (b)(2), the Sec-
5 retary shall submit to Congress a report on the sta-
6 tus of the implementation of the demonstration pro-
7 gram.

8 (2) ELEMENTS.—The report required by para-
9 graph (1) shall, with respect to eligible Medicare Ad-
10 vantage plans participating in the demonstration
11 program for the first plan year of such program, in-
12 clude the following:

13 (A) A list of each medication and service
14 identified pursuant to subsection (c)(2)(A) for
15 such plan with respect to such plan year.

16 (B) For each such medication or service so
17 identified, the amount of the copayment or co-
18 insurance required under such plan with respect
19 to such plan year for such medication or service
20 and the amount of the reduction of such copay-
21 ment or coinsurance from a previous plan year.

22 (C) For each provider identified pursuant
23 to subsection (c)(2)(B)(ii) for such plan with
24 respect to such plan year, a statement of the
25 amount of the copayment or coinsurance re-

1 quired under such plan with respect to such
2 plan year and the amount of the reduction of
3 such copayment or coinsurance from the pre-
4 vious plan year.

5 (e) REVIEW AND ASSESSMENT OF UTILIZATION OF
6 VALUE-BASED INSURANCE DESIGN METHODOLOGIES.—

7 (1) IN GENERAL.—The Secretary shall enter
8 into a contract or agreement with an independent
9 entity to review and assess the implementation of
10 the demonstration program under this section. The
11 review and assessment shall include the following:

12 (A) An assessment of the utilization of
13 value-based insurance design methodologies by
14 Medicare Advantage plans participating under
15 such program.

16 (B) An analysis of whether reducing or
17 eliminating the copayment or coinsurance for
18 each medication and clinical service identified
19 pursuant to subsection (c)(2)(A) resulted in in-
20 creased adherence to medication regimens, in-
21 creased service utilization, improvement in qual-
22 ity metrics, better health outcomes, and en-
23 hanced beneficiary experience.

24 (C) An analysis of the extent to which
25 costs to Medicare Advantage plans under part

1 C of title XVIII of the Social Security Act par-
2 ticipating in the demonstration program is less
3 than costs to Medicare Advantage plans under
4 such part that are not participating in the dem-
5 onstration program.

6 (D) An analysis of whether reducing or
7 eliminating the copayment or coinsurance for
8 providers identified pursuant to subsection
9 (c)(2)(B)(ii) resulted in improvement in quality
10 metrics, better health outcomes, and enhanced
11 beneficiary experience.

12 (E) An analysis, for each provider so iden-
13 tified, the extent to which costs to Medicare Ad-
14 vantage plans under part C of title XVIII of the
15 Social Security Act participating in the dem-
16 onstration program is less than costs to Medi-
17 care Advantage plans under such part that are
18 not participating in the demonstration program.

19 (F) Such other matters as the Secretary
20 considers appropriate.

21 (2) REPORT.—The contract or agreement en-
22 tered into under paragraph (1) shall require such
23 entity to submit to the Secretary a report on the re-
24 view and assessment conducted by the entity under
25 such paragraph in time for the inclusion of the re-

1 sults of such report in the report required by para-
2 graph (3). Such report shall include a description, in
3 clear language, of the manner in which the entity
4 conducted the review and assessment.

5 (3) REPORT TO CONGRESS.—Not later than 4
6 years after the date on which the demonstration pro-
7 gram begins under subsection (b)(2), the Secretary
8 shall submit to Congress a report on the review and
9 assessment of the demonstration program conducted
10 under this subsection. The report shall include the
11 following:

12 (A) A description of the results of the re-
13 view and assessment included in the report sub-
14 mitted pursuant to paragraph (2).

15 (B) Such recommendations as the Sec-
16 retary considers appropriate for enhancing the
17 utilization of the methodologies applied under
18 the demonstration program to all Medicare Ad-
19 vantage plans under part C of title XVIII of the
20 Social Security Act so as to reduce copayments
21 and coinsurance under such plans paid by
22 Medicare beneficiaries for high-value prescrip-
23 tion medications and clinical services for which
24 coverage is provided under such plans and to

1 otherwise improve the quality of health care
2 provided under such plans.

3 (4) OVERSIGHT REPORT.—Not later than three
4 years after the date of the enactment of this Act, the
5 Comptroller General of the United States shall sub-
6 mit to Congress a report on the demonstration pro-
7 gram that includes an assessment, with respect to
8 individuals enrolled under Medicare Advantage plans
9 approved to participate under the demonstration
10 program, of the impact that the age, co-morbidities,
11 and geographic regions of such individuals had upon
12 the implementation of the demonstration program by
13 the plans with respect to such individuals.

14 (f) SAVINGS.—In no case may any reduction in bene-
15 ficiary copayments or coinsurance resulting from the im-
16 plementation of the demonstration program under this
17 section result in expenditures under parts A, B, and D
18 of the title XVIII of the Social Security Act that are great-
19 er than such expenditures without application of this sec-
20 tion.

21 (g) EXPANSION OF DEMONSTRATION PROGRAM.—
22 Taking into account the review and assessment conducted
23 under subsection (e), the Secretary may, through notice
24 and comment rulemaking, expand (including implementa-
25 tion on a nationwide basis) the duration and scope of the

1 demonstration program under title XVIII of the Social Se-
2 curity Act, other than under the original Medicare fee-for-
3 service program under parts A and B of such title, to the
4 extent determined appropriate by the Secretary, if the re-
5 quirements of paragraphs (1), (2) and (3) of subsection
6 (c) of section 1115A of the Social Security Act (42 U.S.C.
7 1315a), as applied to the testing of a model under sub-
8 section (b) of such section, applied to the demonstration
9 under this section.

10 (h) WAIVER AUTHORITY.—The Secretary may waive
11 such provisions of titles XI and XVIII of the Social Secu-
12 rity Act as may be necessary to carry out the demonstra-
13 tion program under this section.

14 (i) IMPLEMENTATION FUNDING.—For purposes of
15 carrying out the demonstration program under this sec-
16 tion, the Secretary shall provide for the transfer from the
17 Federal Hospital Insurance Trust Fund under section
18 1817 of the Social Security Act (42 U.S.C. 1395i) and
19 the Federal Supplementary Insurance Trust Fund under
20 section 1841 of the Social Security Act (42 U.S.C. 1395t),
21 including the Medicare Prescription Drug Account in such
22 Trust Fund, in such proportion as determined appropriate
23 by the Secretary, of such sums as may be necessary.

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