to create a more stable and sustainable health care system that will achieve billions in savings through:

Implementing proposals in all sectors of the health care system, focusing on administrative simplification, standardization, and transparency that supports effective markets;

Reducing over-use and under-use of health care by aligning quality and efficiency incentives among providers across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together towards the highest standards of quality and efficiency;

Encouraging coordinated care, both in the public and private sectors, and adherence to evidence-based best practices and therapies that reduce hospitalization, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies; and,

Reducing the cost of doing business by addressing cost drivers in each sector and through common sense improvements in care delivery models, health information technology, workforce deployment and development, and regulatory reforms.

These and other reforms will make our health care system stronger and more sustainable. However, there are many important factors driving health care costs that are beyond the control of the delivery system alone. Billions in savings can be achieved through a large-scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which leads to unnecessary sickness and higher health costs. Reform should include a specific focus on obesity prevention commensurate with the scale of the problem. These initiatives are crucial to transform health care in America and to achieve our goal of reducing the rate of growth in health costs.

We, as stakeholder representatives, are committed to doing our part to make reform a reality in order to make the system more affordable and effective for patients and purchasers. We stand ready to work with you to accomplish this goal.

Sincerely,

STEPHEN J. UBL,
President and CEO, Advanced Medical Technology Association.

KAREN IGNAGNI,
President and CEO, America's Health Insurance Plans.

RICH UMBDENSTOCK,
President and CEO, American Hospital Association.

J. JAMES ROHACK, MD,
President-elect American Medical Association.

BILLY TAUZIN,
President and CEO, Pharmaceutical Research and Manufacturers of America.

DENNIS RIVERA,
Chair, SEIU Healthcare, Service Employees International Union.

Mr. LEVIN. I yield back the balance of my time.

Mr. PAULSEN. Mr. Speaker, I yield myself the balance of my time.

I have a couple of points right off the bat. My friend from Michigan claims that the tax hasn't necessarily impacted jobs, that there are only certain stories. I would just point out that, in his home State, there is a company named Stryker—now, it is a larger company—that laid off 1,000 employees back in November of 2011 to provide efficiencies and realign resources in advance of the new medical device excise tax.

As to a lot of data that was mentioned earlier, those figures that are talking about how well the industry is doing and as to the growth and the sales numbers are global data. These are companies that have global awareness and a global presence. Those are not U.S. jobs. We want those jobs in the United States. If we can repeal this tax, we can make sure that job growth is here in the U.S. instead of outside of the United States.

Mr. Speaker, this is not smart tax policy. It is hurting our innovators, and it is costing us jobs. This industry is an American success story. We all know the names of the larger companies because some of those were mentioned here in debate on the floor today, but there are thousands of these companies—the vast majority—because, again, 98 percent have fewer than 500 employees, and over 80 percent have fewer than 50 employees.

These are companies you have never heard of, but there is a doctor or an engineer or an entrepreneur who has started or who has come up with an idea to create a company in the backyard or in the garage to help improve lives or to save lives. That is what we are trying to protect here, Mr. Speaker.

These are not technicians in some white lab coats who are trying to improve widgets or to build a widget faster. These are, literally, small businesses that are on missions to save lives. If you think about it, what could be more entrepreneurially worthwhile than that?

We in Congress have a responsibility to give America's innovators the best shot, the best opportunity possible, by removing any obstructions to those inventions that are going to bring us all a better quality of life. We have the ability to help create a new age of American innovation, and we can help kick-start that process this week—today, tomorrow, with a vote—by repealing the destructive medical device tax.

It was mentioned as a part of the debate also that the industry came forward and that there was vast support for the Affordable Care Act, and they agreed to the tax. Mr. Speaker, there are no letters from the industry whatsoever that support their buy-in for a 2.3 percent excise tax—a tax on revenue, not on profit.

It is true that there were letters that were put out that said they were committed to healthcare reform and that they wanted to see that process move forward, but then they were very vocal when this excise tax idea was floated as a part of the new healthcare law and even after the law passed. It has been continuous, this awareness about their opposition in their knowing of the detrimental effects that it would have.

Mr. Speaker, this is also not about the Affordable Care Act because we have had many votes on that—to repeal it, to change it, to move in a different direction. This is about a tax that is going into the general fund, that is not going into some special account to fund ObamaCare. That is not what this tax is doing. This is going into the general fund.

That Affordable Care Act discussion will come up at another time with the Court case coming up in the near future. This is more of an opportunity to stand up with a bipartisan voice to declare our support for American manufacturing, for American jobs, and for protecting our patients, including our seniors.

I just want to remind my friends that the President has said that he has been open to any ideas that will improve accessibility, that will improve affordability, and the quality of health care. That is exactly what this bill does. It is about protecting access to those devices.

It is also important to point out the 281 cosponsors. The bipartisan support is deep, and it is broad. If you think back to the sustainable growth rate debate we had just a little over a month ago, that is important to bring up. Why? It is because there was broad, bipartisan support and a belief that the policy was harming patient care and innovation.

This is good policy now if we can repeal this tax. It is about doing the right thing for our constituents, which outweighs the concerns of the offsets.

Mr. Speaker, I urge support for this legislation, and I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 319, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. LEVIN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

STRENGTHENING MEDICARE ADVANTAGE THROUGH INNOVATION AND TRANSPARENCY FOR SENIORS ACT OF 2015

Mr. BRADY of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (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, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2570

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015''.

SEC. 2. TREATMENT OF PATIENT ENCOUNTERS IN AMBULATORY SURGICAL CENTERS IN DETERMINING MEANINGFUL EHR USE.

Section 1848(o)(2) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended by adding at the end of the following new subparagraph:

''(D) TREATMENT OF PATIENT ENCOUNTERS AT AMBULATORY SURGICAL CENTERS.—

''(i) IN GENERAL.—Subject to clause (ii), for a payment year after 2015 any patient encounter of an eligible professional occurring at an ambulatory surgical center (described in section 1833(i)(1)(A)) shall not be treated as a patient encounter in determining whether an eligible professional qualifies as a meaningful EHR user. Notwithstanding any other provision of law, the Secretary may implement this clause by program instruction or otherwise.

''(ii) SUNSET.—Clause (i) shall no longer apply as of the first payment year that begins more than 3 years after the date the Secretary determines, through notice and comment rulemaking, that certified EHR technology is applicable to the ambulatory surgical center setting.''.

SEC. 3. VALUE-BASED INSURANCE DESIGN DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a 3-year demonstration program to test the use of value-based insurance design methodologies (as defined in subsection (c)(1)) under eligible Medicare Advantage plans offered by Medicare Advantage organizations under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.). The Secretary may extend the program to a duration of 4 or 5 years, as determined necessary by the Secretary in coordination with the Centers for Medicare and Medicaid Innovation.

(b) DEMONSTRATION PROGRAM DESIGN.—

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

(A) select at least two Medicare Advantage sites with respect to which to conduct the demonstration program under this section; and

(B) approve eligible Medicare Advantage plans to participate in such demonstration program.

In selecting Medicare Advantage sites under subparagraph (A), the Secretary shall take into account area differences as well as the availability of health maintenance organization plans and preferred provider organization plans offered in such sites.

(2) START OF DEMONSTRATION.—The demonstration program shall begin not later than the third plan year beginning after the date of the enactment of this Act.

(3) ELIGIBLE MEDICARE ADVANTAGE PLANS.—For purposes of this section, the term ''eligible Medicare Advantage plan'' means a Medicare Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) that meets the following requirements:

(A) The plan is an Medicare Advantage regional plan (as defined in paragraph (4) of section 1859(b) of such Act (42 U.S.C. 1395w–28(b))) or Medicare Advantage local plan (as defined in paragraph (5) of such section) offered in the Medicare Advantage region selected under paragraph (1)(A).

(B) The plan has—

(i)(I) a quality rating under section 1853(o) of such Act (42 U.S.C. 1395w–23(o)) of 4 stars or higher based on the most recent data available for such year, 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 section 1853(o) of such Act (42 U.S.C. 1395w–23(o)) 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 in a service area 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;

(B) background information on the demonstration program;

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

(D) notification of the potential benefits that the individual will receive, and of the other potential impacts that the individual will experience, on account of the participation of the plan in the demonstration program.

(c) VALUE-BASED INSURANCE DESIGN METHODOLOGIES.—

(1) DEFINITION.—For purposes of this section, the term ''value-based insurance design methodology'' means a methodology for identifying specific prescription medications, and clinical services that are payable under title XVIII of the Social Security Act, for which the reduction of copayments, coinsurance, or both, would improve the management of specific chronic clinical conditions because of the high value and effectiveness of such medications and services for such specific chronic clinical conditions, as approved by the Secretary.

(2) USE OF METHODOLOGIES TO REDUCE COPAYMENTS AND COINSURANCE.—A Medicare Advantage organization offering an eligible Medicare Advantage plan approved to participate under the demonstration program, for each plan year for which the plan is so selected and using value-based insurance design methodologies—

(A) shall identify each prescription medication and clinical service covered under such plan for which the plan proposes to reduce or eliminate the copayment or coinsurance, with respect to the management of specific chronic clinical conditions (as specified by the Secretary) of Medicare Advantage eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))) enrolled under such plans, for such plan year;

(B) may, for such plan year, reduce or eliminate copayments, coinsurance, or both for such prescription medication and clinical services so identified with respect to the management of such conditions of such individuals—

(i) if such reduction or elimination is evidence-based and for the purpose of encouraging such individuals in such plan to use such prescription medications and clinical services (such as preventive care, primary care, specialty visits, diagnostic tests, procedures, and durable medical equipment) with respect to such conditions; and

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

(C) if a reduction or elimination is applied pursuant to subparagraph (B), with respect to such medication and clinical services, shall, for such plan year, count toward the deductible applicable to such individual under such plan amounts that would have been payable by the individual as copayment or coinsurance for such medication and services if the reduction or elimination had not been applied.

(3) PROHIBITION OF INCREASES OF COPAYMENTS AND COINSURANCE.—In no case may any Medicare Advantage plan participating in the demonstration program increase, for any plan year for which the plan is so participating, the amount of copayments or coinsurance for any item or service covered under such plan for purposes of discouraging the use of such item or service.

(d) REPORT ON IMPLEMENTATION.—

(1) IN GENERAL.—Not later than 1 year after the date on which the demonstration program under this section begins under subsection (b)(2), the Secretary shall submit to Congress a report on the status of the implementation of the demonstration program.

(2) ELEMENTS.—The report required by paragraph (1) shall, with respect to eligible Medicare Advantage plans participating in the demonstration program for the first plan year of such program, include the following:

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

(B) For each such medication or service so identified, the amount of the copayment or coinsurance required under such plan with respect to such plan year for such medication or service and the amount of the reduction of such copayment or coinsurance from a previous plan year.

(C) For each provider identified pursuant to subsection (c)(2)(B)(ii) for such plan with respect to such plan year, a statement of the amount of the copayment or coinsurance required under such plan with respect to such plan year and the amount of the reduction of such copayment or coinsurance from the previous plan year.

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

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

(A) An assessment of the utilization of value-based insurance design methodologies