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

by Medicare Advantage plans participating under such program.

(B) An analysis of whether reducing or eliminating the copayment or coinsurance for each medication and clinical service identified pursuant to subsection (c)(2)(A) resulted in increased adherence to medication regimens, increased service utilization, improvement in quality metrics, better health outcomes, and enhanced beneficiary experience.

(C) An analysis of the extent to which costs to Medicare Advantage plans under part C of title XVIII of the Social Security Act participating in the demonstration program is less than costs to Medicare Advantage plans under such part that are not participating in the demonstration program.

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

(E) An analysis, for each provider so identified, the extent to which costs to Medicare Advantage plans under part C of title XVIII of the Social Security Act participating in the demonstration program is less than costs to Medicare Advantage plans under such part that are not participating in the demonstration program.

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

(2) REPORT.—The contract or agreement entered into under paragraph (1) shall require such entity to submit to the Secretary a report on the review and assessment conducted by the entity under such paragraph in time for the inclusion of the results of such report in the report required by paragraph (3). Such report shall include a description, in clear language, of the manner in which the entity conducted the review and assessment.

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

(A) A description of the results of the review and assessment included in the report submitted pursuant to paragraph (2).

(B) Such recommendations as the Secretary considers appropriate for enhancing the utilization of the methodologies applied under the demonstration program to all Medicare Advantage plans under part C of title XVIII of the Social Security Act so as to reduce copayments and coinsurance under such plans paid by Medicare beneficiaries for high-value prescription medications and clinical services for which coverage is provided under such plans and to otherwise improve the quality of health care provided under such plans.

(4) OVERSIGHT REPORT.—Not later than three years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the demonstration program that includes an assessment, with respect to individuals enrolled under Medicare Advantage plans approved to participate under the demonstration program, of the impact that the age, co-morbidities, and geographic regions of such individuals had upon the implementation of the demonstration program by the plans with respect to such individuals.

(f) SAVINGS.—In no case may any reduction in beneficiary copayments or coinsurance resulting from the implementation of the demonstration program under this section result in expenditures under parts A, B, and D of the title XVIII of the Social Security Act that are greater than such expenditures without application of this section.

(g) EXPANSION OF DEMONSTRATION PROGRAM.—Taking into account the review and assessment conducted under subsection (e), the Secretary may, through notice and comment rulemaking, expand (including implementation on a nationwide basis) the duration and scope of the demonstration program under title XVIII of the Social Security Act, other than under the original medicare fee-for-service program under parts A and B of such title, to the extent determined appropriate by the Secretary, if the requirements of paragraphs (1), (2) and (3) of subsection (c) of section 1115A of the Social Security Act (42 U.S.C. 1315a), as applied to the testing of a model under subsection (b) of such section, applied to the demonstration under this section.

(h) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this section.

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

SEC. 4. TREATMENT OF INFUSION DRUGS FURNISHED THROUGH DURABLE MEDICAL EQUIPMENT.

Section 1842(o)(1) of the Social Security Act (42 U.S.C. 1395u(o)(1)) is amended—

(1) in subparagraph (C), by inserting ''(and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017)'' after ''2005''; and

(2) in subparagraph (D)—

(A) by striking ''infusion drugs'' and inserting ''infusion drugs or biologicals'' each place it appears; and

(B) in clause (i)—

(i) by striking ''2004'' and inserting ''2004, and before January 1, 2017''; and

(ii) by striking ''for such drug''.

SEC. 5. SENSE OF CONGRESS REGARDING THE IMPLEMENTATION AND DISTRIBUTION OF QUALITY INCENTIVE PAYMENTS TO MEDICARE ADVANTAGE PLANS.

It is the sense of Congress that—

(1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of section 1853 of the Social Security Act (42 U.S.C. 1395w–23) as prohibiting the provision of any Medicare quality incentive payments under subsection (o) of such section with respect to Medicare Advantage plans that exceed the payment benchmark cap under such subsection (n) for the area served by such plans; and

(2) the Secretary should immediately apply quality incentive payments under such subsection (o) with respect to such Medicare Advantage plans without regard to the limits set forth in such subsection (n).

SEC. 6. MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''during and after fiscal year 2020, $0'' and inserting ''after fiscal year 2020, $220,000,000''.

SEC. 7. NON-INCLUSION OF DME INFUSION DRUGS UNDER DME COMPETITIVE ACQUISITION PROGRAMS.

(a) IN GENERAL.—Section 1847(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)(A)) is amended—

(1) by striking ''and excluding'' and inserting '', excluding''; and

(2) by inserting before the period at the end the following: '', and excluding drugs and biologicals described in section 1842(o)(1)(D)''.

(b) CONFORMING AMENDMENT.—Section 1842(o)(1)(D)(ii) of the Social Security Act (42 U.S.C. 1395u(o)(1)(D)(ii)) is amended by striking ''2007'' and inserting ''2007, and before the date of the enactment of the Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015''.

The SPEAKER pro tempore (Mr. HARDY). Pursuant to the rule, the gentleman from Texas (Mr. BRADY) and the gentleman from New York (Mr. RANGEL) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BRADY of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on H.R. 2570, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

I stand in strong support of H.R. 2570, the Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act.

This package is comprised of two policies, and I will let the sponsors, who have worked so hard, speak to them in more depth.

The Electronic Health Fairness Act of 2015, as marked up by the committee back in February, brings fairness to physicians who are practicing in the ASC setting by reducing meaningful use burdens for sites of service that were left out of the EHR technology requirements. This exemption only lasts until the ASCs are able to catch up, and then everybody will be on an equal footing regarding meaningful use requirements.

The bill then establishes a new demonstration program based on value-based insurance design. This proposal would give plans the ability to adjust benefits based on their enrollees' needs. The one-size-fits-all policies in Medicare Advantage create the need for different types of plans that wouldn't be necessary if regular Medicare Advantage plans could adjust their benefit structures to better serve our seniors.

Reducing copays or cost sharing for beneficiaries for the sake of better healthcare outcomes is right in line with the principles that I support as all seniors are different and should be served as such, so that all have an opportunity for positive health outcomes.

The bill also includes a policy that changes the way Medicare pays for drugs that doctors prescribe that are infused through durable medical equipment items. This change means that Medicare payments will be more market based.

The policy does take away the potential that these rates could change significantly in the future by exempting the drugs from DME competitive bidding. I am committed to ensuring that beneficiaries who need these drugs are able to continue to get them in their homes, and I will certainly monitor the impact.

I want to thank Ways and Means members Mrs. BLACK of Tennessee and Mr. BLUMENAUER of Oregon for their continued leadership in improving Medicare Advantage. Their very hard work will ensure that seniors, for years to come, will enjoy better healthcare choices and more options at that.

Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

I join with the gentleman from Texas in supporting H.R. 2570. Representative DIANE BLACK and Representative EARL BLUMENAUER have worked hard on this issue.

This legislation will allow the Secretary of HHS to conduct a demonstration, giving managed care organizations the ability to offer plans with a variety of benefit structures that would lower the cost sharing for high-value service. We think it makes a lot of sense, and I concur.

I reserve the balance of my time.

□ 1730

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACK), a key member of the Committee on Ways and Means and a healthcare professional herself.

Mrs. BLACK. Mr. Speaker, as a nurse for over 40 years, I understand the challenge of helping Americans find affordable healthcare coverage, but the sad truth is, even for those who do have health coverage, high deductibles and out-of-pocket costs can leave too many Americans functionally uninsured.

When families are forced to choose between buying groceries and filling a prescription, their health is sidelined, and they risk facing even higher medical costs down the road. That is why I authored H.R. 2570, the Strengthening Medicare Advantage Through Innovation and Transparency for Seniors Act. Our bill directs CMS to set up a pilot project for what is known as Value-Based Insurance Design, or otherwise known as VBID.

Instead of the current one-size-fits-all approach to cost sharing, VBID embraces the idea that by lowering a patient's out-of-pocket costs for essential prescription drugs and services, customers will then be motivated to stick with their regimen and stay healthier. This will, in turn, decrease the overall long-term costs to our healthcare system and provide a higher quality of care for our patients.

My bill also helps our providers by offering ambulatory surgical centers relief from the electronic health records' meaningful use mandate. While this recordkeeping system may make sense in a hospital setting, it doesn't always work for a small, outpatient surgical facility. Providers who practice medicine in these settings should not be penalized as a result.

I thank Congressman BLUMENAUER and Congresswoman CATHY MCMORRIS RODGERS for their strong commitment to VBID policy.

I urge a ''yes'' vote on H.R. 2570.

Mr. RANGEL. I yield myself the balance of my time to close.

Mr. Speaker, at this time I concur with the gentleman from Texas. Members have worked hard in perfecting these bills, and I support H.R. 2570.

I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

This is a very good bill. It is a good improvement to Medicare Advantage, and it is really a case of Republicans and Democrats finding common ground and doing it in a way that helps seniors with their choices and really tailoring health care to them.

I strongly urge support for this bill.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BRADY) that the House suspend the rules and pass the bill, H.R. 2570, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to amend title XVIII of the Social Security Act with respect to the treatment of patient encounters in ambulatory surgical centers in determining meaningful EHR use, 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, and for other purposes.''.

A motion to reconsider was laid on the table.

INCREASING REGULATORY FAIRNESS ACT OF 2015

Mr. BRADY of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2507) to amend title XVIII of the Social Security Act to establish an annual rulemaking schedule for payment rates under Medicare Advantage, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2507

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 ''Increasing Regulatory Fairness Act of 2015''.

SEC. 2. ESTABLISHING AN ANNUAL RULEMAKING SCHEDULE FOR PAYMENT RATES UNDER MEDICARE ADVANTAGE.

Section 1853(b) of the Social Security Act (42 U.S.C. 1395w–23(b)) is amended—

(1) in the subsection heading, by inserting '', ANNUAL RULEMAKING SCHEDULE FOR PAYMENT RATES FOR 2017 AND SUBSEQUENT YEARS'' after ''RATES'';

(2) in paragraph (1)—

(A) in subparagraph (B)—

(i) in the subparagraph heading, by inserting ''BEFORE 2017'' after ''YEARS''; and

(ii) in the matter preceding clause (i), by inserting ''and before 2017'' after ''2005''; and

(B) by adding at the end the following new subparagraph:

''(C) ANNUAL RULEMAKING SCHEDULE FOR PAYMENT RATES FOR 2017 AND SUBSEQUENT YEARS.—For 2017 and each subsequent year, before April 1 of the preceding year, the Secretary shall, by regulation and in accordance with the notice and public comment periods required under paragraph (2) for such a year, annually determine and announce the following:

''(i) The annual MA capitation rate for each MA payment area for such year.

''(ii) The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in such year.

''(iii) With respect to each MA region and each MA regional plan for which a bid was submitted under section 1854, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

''(iv) The major policy changes to the risk adjustment model, and the 5-star rating system established under subsection (o), that are determined to have an economic impact.''; and

(3) in paragraph (2)—

(A) by inserting ''(or, for 2017 and each subsequent year, at least 60 days)'' after ''45 days''; and

(B) by inserting ''(for 2017 and each subsequent year, of no less than 30 days)'' after ''opportunity''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BRADY) and the gentleman from California (Mr. THOMPSON) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BRADY of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 2507 currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I stand in support of H.R. 2507, the Increasing Regulatory Fairness Act. This is an important piece of legislation. Today, the Medicare Advantage program serves more than 16 million seniors throughout the country. Enrollment has increased more than threefold over the past decade, and it is expected to nearly double in the next.

To ensure that seniors are able to continue receiving the kind of high-