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-

quality care they receive under the program, the Centers for Medicare and Medicaid Services, known as CMS, is expected to pay about $156 billion to more than 3,600 Medicare Advantage plans just this year. That is nearly 30 percent of all Medicare spending, by the way.

Typically, every year CMS sends out what is called the rate notice to plans and Medicare Advantage companies that details the various payment rates and benefit changes the agency plans to make for the following year. This notice follows the standard rulemaking process of other payment systems. That is, a draft notice is published, the public has a certain amount of time to submit comments and questions, and then the agency publishes a final notice based on that feedback.

Right now, this current process takes about 45 days. Do you know how many days are currently allotted for public comment? The answer: A mere 15 days—15 days for thousands of plans and millions of stakeholders to submit comments on proposed changes to a program that amounts to one-third of all Medicare spending.

I could almost understand this if the rate notice were a short and concise document, easy to understand, and simple to implement, but of course it is not. The rate notice has grown from around 16 pages in 2006 to nearly 150 pages this year. That is over a ninefold increase. All the while, the time for the public comment period has remained the same. This means less and less time for plans and Congress to conduct the necessary review so we can provide CMS with the kind of feedback that would better help the agency assess the impact of their proposed changes. This is important because without accurate feedback, CMS could inadvertently move forward with a proposed change to the Medicare Advantage program that might negatively impact these seniors who depend on these plans for access to essential medical care.

The legislation before us is simple and straightforward. All it proposes to do is extend the public notice period from 45 days to 60 days, which would mean an extension of the comment period from 15 to 30 days. This is a commonsense, good government fix we can make that will give plans more time to understand the changes that Medicare proposes, offer constructive feedback, and make the Medicare Advantage program overall more responsive to senior needs.

I want to thank Mr. THOMPSON of California, who is a key member of our Committee on Ways and Means, and Mr. PITTS, the chairman of the Health Subcommittee on Energy and Commerce, for their thoughtful and very helpful work on this legislation.

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

Mr. THOMPSON of California. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to thank Mr. BRADY. It was a pleasure working with him on this piece of legislation.

I rise in support of H.R. 2507. Every year, as was pointed out, the Centers for Medicare and Medicaid Services publishes its Medicare Advantage call letter and rate notice that outlines all the payment rates and the changes for nearly 2,000 plans that serve our most vulnerable population.

About 10 years ago the call letter and rate notice were less than 20 pages long. Since then, enrollment in Medicare Advantage has nearly tripled. Medicare Advantage policies have become more complex, and the call letter and the rate notice has grown nearly tenfold. They run about 150 to 200 pages.

The same time, the time between the publishing of the draft notice and the final notice, which is currently 45 days, has remained unchanged. During this 45-day period, in which there are only 15 days to comment on the proposed changes in the program, the plans, Members of this body and our staff are expected to review 150 pages of regulatory changes and understand the impacts of the proposed policy changes on those programs that provide essential medical care to over one-third of Medicare beneficiaries.

As we all know, and as we have all experienced every February and March, this does not lend itself to an efficient, effective, nor transparent process. Moreover, it deprives CMS of thoughtful, constructive feedback that is necessary to improve a program that our seniors love and rely on. This bill is a simple, straightforward measure that will improve the current process by expanding the current cycle from 45 to 60 days, which will give plans, stakeholders, Members, and our staff 30 full days—double the current time allowed—to analyze and provide feedback on the draft call letter and rate notices.

This is a no-cost, good government, bipartisan bill that will make the process more transparent, more fair, and more advantageous for the beneficiaries whom we serve. Therefore, I strongly urge my colleagues to join me in supporting this important piece of legislation.

I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER), a key new member of the House of Representatives who understands the importance of Medicare Advantage.

Mr. CARTER of Georgia. Mr. Speaker, one of the things I always strive for in my personal and professional life is always trying to do things better. As I tell my staff, there is no such thing as standing still. If you are not moving forward, then you are moving backward. We can all continue to get better at what we do.

That is the goal of H.R. 2507, the Increasing Regulatory Fairness Act of 2015. As part of an annual rulemaking process, the Centers for Medicare and Medicaid Services update payments to the Medicare Advantage program. With the current structure of this annual process, health insurers are given little time to submit comments to the new payment rates or even determine whether the payment adjustment is beneficial to Medicare Advantage enrollees.

With H.R. 2507, health insurers will have additional time to analyze whether the payment adjustments for Medicare Advantage plans are justified and overall beneficial. I believe we must always try to get better every day. This includes our work as civil servants. H.R. 2507 will provide a better environment for CMS and health insurers to create the best payment rate agreement regarding Medicare Advantage plans. By providing more time for comments and the finalizing of rates, Medicare Advantage enrollees will receive a better calculated benefit for their plans.

I urge my colleagues to support this bill.

Mr. THOMPSON of California. Mr. Speaker, I concur with the statements previously made by my colleagues and thank both Mr. BRADY and Mr. PITTS for working with me on this legislation. As I have stated before, this is a simple, no-cost bill that will improve the current process and the Medicare Advantage program for our seniors. I urge my colleagues to support H.R. 2507.

I yield back the balance of my time.

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

Mr. Speaker, I join with Congressman THOMPSON. I appreciate so much his work in this area in a bipartisan way on a bill that not only bridges both parties but a number of committees in this Congress and really just provides a commonsense way to make sure the public, Congress, and others can comment, and to make sure these rules really benefit the seniors who are receiving Medicare Advantage. I urge strong support for this bill.

I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, the bill before us today expands an annual regulatory schedule for Medicare Advantage (MA) payment rates so that stakeholders have the necessary time to review and provide feedback to ensure seniors continue to have access to quality, low-cost plans of their choosing.

H.R. 2507, the Increasing Regulatory Fairness Act of 2015, was introduced by my colleague, Representative KEVIN BRADY (TX), Chairman of the Health Subcommittee of Ways and Means, and I cosponsored along with MIKE THOMPSON (CA), PETE SESSIONS (TX), and KYRSTEN SINEMA (AZ). This bipartisan, commonsense legislation will facilitate greater understanding and collaboration between industry stakeholders and regulators, and will offer a greater opportunity for public input in the establishment of policies affecting the MA and Part D plans.

Since 2006, when the Medicare Modernization Act's official implementation, and the Medicare Advantage/Part D call letter and rate

notice were around 16 pages long, a two-week comment period may have been adequate. Today, however, that document has grown to nearly 150 pages—and the comment period—still just 15 days—is simply not enough time for plans that now serve one-third of the Medicare population to analyze and gather substantive comments on increasingly complex policy changes. This bill would increase that comment period to 30 days, a strong step towards regulatory fairness for the successful Medicare Advantage/Part D programs.

Expanding this comment period allows for a fair amount of time in which both stakeholders, as well as Members of Congress and Committees, have sufficient time to understand the policy implications and formulate comments, if they so choose. More time equals better, more thoughtful policies.

Mr. Speaker, by approving this legislation, we will be giving seniors, insurance plan providers and other interested stakeholders adequate time to comprehend and provide comments on proposed changes to Medicare Advantage plans.

This is an important and necessary legislative change and I urge all of my colleagues to support H.R. 2507.

Mr. ENGEL. Mr. Speaker, I rise in opposition to, specifically, the provision of H.R. 2570 that pays for the Value Based Insurance Design for Better Care Act. If this bill passes with its current pay-for in place, it will do so at the detriment of Americans who rely on home infusion therapies.

''Infusion therapy'' refers to the administration of medication directly into the bloodstream through a needle or catheter. A patient will undergo infusion therapy when his or her disease or infection cannot be adequately treated by oral medications. Infusion therapy is used to treat cancers, congestive heart failure, immune deficiencies, multiple sclerosis, rheumatoid arthritis, gastrointestinal diseases, and other conditions.

The administration of infusion therapies is significantly more involved than that of oral medications. Infusion therapy entails specialized equipment, supplies, and professional services, including sterile drug compounding, care coordination, and patient education and monitoring.

Currently, Medicare fully covers infusion therapy when it is administered in a hospital, doctor's office or nursing home. However, Medicare's coverage of infusion therapy in the home is fractured and does not adequately cover the services needed to provide infusions in the home.

Not only does this coverage gap force patients into expensive institutional settings, but it also puts patients at risk of developing additional infections in these environments. What's more, this coverage gap prevents patients from receiving the treatment they need in the most comfortable setting possible: their homes.

Although Medicare does not presently pay for the services that are essential for a patient to receive infusion therapies at home, providers have been able to offer a limited set of home infusion drugs to Medicare beneficiaries via Medicare Part B DME coverage, as the reimbursement they receive for home infusion drugs is substantial enough to cover the services necessary to administer those drugs.

If H.R. 2570 passes in its current form, this will no longer be the case.

The demonstration program that this legislation creates is financed by modifying the reimbursement structure for infusion drugs under the Medicare Part B durable medical equipment benefit. This change will perpetuate the coverage gap that prevents Medicare from covering the indispensable service component of home infusion therapy.

In addition, the drug reimbursement that providers receive will no longer be significant enough to capture home infusion services as it does currently. As a result, it will become exceedingly difficult for providers to offer Medicare beneficiaries infusion therapy in their homes.

I want to emphasize that I do not oppose changing the manner in which home infusion drugs are paid for. On the contrary, I have introduced H.R. 605, the Medicare Home Infusion Site of Care Act, with Congressman PAT TIBERI. Our bill, which has garnered cosponsors from both sides of the aisle, would explicitly cover the services that must be provided to administer infusion drugs at home.

I ask that my colleagues think about the patients who depend on home infusion therapies. If we allow H.R. 2570 to pass in its current form, we simultaneously deny patients the ability to receive life-saving therapies in their homes, forcing them into institutional settings that will come at a cost to the Medicare program and, most importantly, to patients' quality of life.

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. 2507, as amended.

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

A motion to reconsider was laid on the table.

□ 1745

MEDICARE ADVANTAGE COVERAGE TRANSPARENCY ACT OF 2015

Mr. BRADY of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2505) to amend title XVIII of the Social Security Act to require the annual reporting of data on enrollment in Medicare Advantage plans, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2505

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 ''Medicare Advantage Coverage Transparency Act of 2015''.

SEC. 2. REQUIREMENT FOR ENROLLMENT DATA REPORTING FOR MEDICARE.

Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(g) REQUIREMENT FOR ENROLLMENT DATA REPORTING.—

''(1) IN GENERAL.—Not later than May 1 of each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) for the plan year or, in the case of part A and part B, for the fiscal year or year (as applicable) ending before January 1 of such plan year, fiscal year, or year. Such enrollment data shall be presented—

''(A) by zip code, congressional district, and State;

''(B) in a manner that provides for such data based on enrollment (including receipt of benefits other than through enrollment) under part A, enrollment under part B, enrollment under an MA plan under part C, and enrollment under part D; and

''(C) in the case of enrollment data described in subparagraph (B) relating to MA plans, presented in a manner that provides for such data for each MA–PD plan and for each MA plan that is not an MA–PD plan.

''(2) DELAY OF DEADLINE.—If the Secretary is unable to submit a report under paragraph (1) by May 1 of a year for data of the plan year, fiscal year, or year (as applicable) ending before January 1 of such year, the Secretary shall, not later than April 30 of such year, notify the committees described in such paragraph of—

''(A) such inability, including an explanation for such inability; and

''(B) the date by which the Secretary will provide such report, which shall be not later than June 1 of such year.''.

The SPEAKER pro tempore. 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 in which to revise and extend their remarks and include extraneous material on H.R. 2505 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, after my remarks, I will include in the RECORD an exchange of letters between the committees of jurisdiction.

I stand in strong support of H.R. 2505, the Medicare Advantage Coverage Transparency Act of 2015. This is commonsense legislation. It is truly about transparency in healthcare data.

Medicare Advantage currently makes up close to one-third of the Medicare program's enrollees. The Congressional Budget Office projects that Medicare enrollment numbers will swell over the next decade and that Medicare Advantage will grow to over 40 percent of Medicare.

It will be beneficial for Members of Congress to fully understand what the makeup of health enrollment is in their district, whether it is Medicare Advantage; part D, the prescription drug plan; or fee-for-service. Members and their staff will be able to serve their constituents better and more