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

fully with access to this data. As we continue to work on, process, and pass legislation to improve the Medicare program, getting this enrollment snapshot will provide very necessary transparency and openness.

I want to thank the gentleman from Pennsylvania (Mr. KELLY), Mr. KIND, and Mr. BILIRAKIS for their hard work in getting this legislation through the committee and to the House floor.

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

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, June 12, 2015.

Hon. PAUL RYAN,
Chairman, Committee on Ways and Means, Washington, DC.

DEAR CHAIRMAN RYAN: I write in regard to H.R. 2505, Medicare Advantage Coverage Transparency Act of 2015, which was ordered reported by the Committee on Ways and Means on June 2, 2015. As you are aware, the bill also was referred to the Committee on Energy and Commerce. I wanted to notify you that the Committee on Energy and Commerce will forgo action on H.R. 2505 so that it may proceed expeditiously to the House floor for consideration.

This is done with the understanding that the Committee on Energy and Commerce's jurisdictional interests over this and similar legislation are in no way diminished or altered. In addition, the Committee reserves the right to seek conferees on H.R. 2505 and requests your support when such a request is made.

I would appreciate your response confirming this understanding with respect to H.R. 2505 and ask that a copy of our exchange of letters on this matter be included in the CONGRESSIONAL RECORD during consideration of the bill on the House floor.

Sincerely,

FRED UPTON,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 9, 2015.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for your letter regarding the Committee's jurisdictional interest in H.R. 2505, the Medicare Advantage Coverage Transparency Act of 2015, and your willingness to forego consideration by your committee.

I agree that the Committee on Energy and Commerce has a valid jurisdictional interest in certain provisions of the bill and that the Committee's jurisdiction will not be adversely affected by your decision to forego consideration. As you have requested, I will support your request for an appropriate appointment of outside conferees from your committee in the event of a House-Senate conference on this or similar legislation should such a conference be convened.

Finally, I will include a copy of your letter and this response in the Congressional Record during the floor consideration of H.R. 2505. Thank you again for your cooperation.

Sincerely,

PAUL RYAN,
Chairman.

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

I concur with the gentleman from Texas. My dear friend MIKE KELLY and Congressman RON KIND have worked together in trying to get more information for the Congress from our congressional districts to see exactly what the enrollments are in Medicare. It makes us better legislators so we can improve the bill.

I think these bills are worthy of the support of the House of Representatives, and I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I am proud to yield 4 minutes to the gentleman from Pennsylvania (Mr. KELLY), a new member of the Ways and Means Committee and a businessperson who understands the openness and transparency required to improve Medicare.

Mr. KELLY of Pennsylvania. I thank the gentleman for yielding.

Mr. Speaker, Thomas Jefferson once opined:

> The cornerstone of democracy rests on the foundation of an educated electorate. Whenever the people are well-informed, they can be trusted with their own government.

Jefferson's vision for our democracy was premised on the notion that individuals are intelligent enough to determine the best choices for their lives, their families, and their communities, and not some monolithic, paternalistic government.

A prerequisite to being well-informed, however, is to ensure that the American people have adequate information about how Federal policies and decisions made in Washington will or are impacting their lives. That is why transparency is so vital to our system of government: it provides the necessary information to educate or our on which our democracy depends.

Laws and their impacts should not be shrouded in secrecy. Congress and the administration need to be fostering a culture of openness and transparency when legislating and making decisions here in Washington. That is what this legislation is all about: providing more transparency to the American people about their health care, specifically Medicare Advantage coverage.

H.R. 2505, the Medicare Advantage Coverage Transparency Act, is a bill to do just that. With passage of H.R. 2505, CMS will be required to provide additional information on Medicare Advantage enrollment based on ZIP Code, congressional district, and State.

This data will be available for both Medicare Advantage Prescription Drug Plans as well as regular Medicare Advantage. Enrollment data under part A, part B, enrollment under an MA plan under part C, and enrollment under part D would also be covered.

The purpose of this additional data is to provide greater information to the public, policymakers, and the healthcare community so that they have the benefit of more and better information when making decisions.

CMS should provide a more transparent accounting of Medicare enrollment data to Congress, other government offices, and the American people so committees of jurisdiction can better understand how Medicare is serving the healthcare needs of the Nation as well as individual congressional districts.

H.R. 2505 would require an annual report on Medicare enrollment data so that Members of Congress have more accurate information regarding the constituents' use of Medicare programs. Such transparency will allow Americans and Members of Congress to better know and understand the scope of Medicare enrollment on a local level as well as the specific population affected.

In 2014, the majority of the 54 million people on Medicare are in the traditional Medicare program, with 30 percent enrolled in a Medicare Advantage plan. Since 2004, the number of beneficiaries enrolled in private plans has almost tripled—from 5.3 million to 15.7 million in 2014.

In Pennsylvania, 18 percent of the total population in the Commonwealth is enrolled in some form of Medicare. Of the 18 percent, 39 percent of those Medicare beneficiaries are enrolled in Medicare Advantage plans. That means that 7 percent of Pennsylvanians are enrolled in the Medicare Advantage plan.

This legislation will give me and my constituents more information about how changes to Medicare Advantage plans in Washington will impact my constituents at home in the Third Congressional District of Pennsylvania and every Member and their constituents around this great country.

I want to thank Chairman RYAN for bringing up this bill. I also want to thank Leader MCCARTHY for bringing this bill to the floor.

Mr. RANGEL. Mr. Speaker, I have no further requests for time, and I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I am pleased to yield 2 minutes the gentleman from Florida (Mr. BILIRAKIS), one of the key authors of the legislation and one of the leaders of health care on the Energy and Commerce Committee.

Mr. BILIRAKIS. Mr. Speaker, I rise today in support of a bill I am proud to sponsor with my friends—Representative KELLY, who is the lead sponsor, and Representative KIND—H.R. 2505, the Medicare Advantage Coverage Transparency Act.

Fifteen million Americans choose Medicare Advantage. By all accounts, Medicare Advantage has been successful for its enrollees, including those I represent. Similarly, approximately 37 million seniors chose part D as of 2014. Over 1,000 Medicare part D plans are offered nationwide, and the program has continued to grow in popularity and be well under its initial budget projections. I think Medicare part D is one of the greatest programs in the history of the Congress.

The Center for Medicare and Medicaid Services' Office of Legislation used to issue reports on the Medicare Advantage and part D enrollment data for each congressional district; however, in 2012, they stopped issuing these

reports. Why? It is now 2015, and they have still not provided this data.

Information is valuable to legislators and health researchers. The more information we have about how a program is working, the better decisions we can make. Currently, enrollment data for Medicare Advantage and part D come from third-party sources; however, it is time for CMS to continue to do its job and provide this information.

As I said earlier, by all accounts from third parties, both Medicare Advantage and part D are successful programs and, of course, as is traditional Medicare. These programs are used by so many seniors, Mr. Speaker. They are keeping our seniors healthier and saving them money.

This is a good government bill, and I am hopeful for a strong, bipartisan vote.

Mr. RANGEL. Mr. Speaker, I concur with the objectives of this bill. I advocate a ''yes'' vote, and I yield back the balance of my time.

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

I appreciate the leadership of Mr. KELLY, Mr. BILIRAKIS, and Mr. KIND from Wisconsin, who together, Republicans and Democrats, crossed committees and recognized the need for openness.

Knowledge is power. Knowledge of Medicare Advantage and who is receiving it in whose district we think is very important to strengthening Medicare as an entire program going forward.

I urge support for this legislation, and 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. 2505, 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.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF THE SENATE AMENDMENT TO H.R. 2146, DEFENDING PUBLIC SAFETY EMPLOYEES' RETIREMENT ACT

Mr. SESSIONS (during consideration of H.R. 2505) from the Committee on Rules, submitted a privileged report (Rept. No. 114–167) on the resolution (H. Res. 321) providing for consideration of the Senate amendment to the bill (H.R. 2146) to amend the Internal Revenue Code of 1986 to allow Federal law enforcement officers, firefighters, and air traffic controllers to make penalty-free withdrawals from governmental plans after age 50, and for other purposes, which was referred to the House Calendar and ordered to be printed.

SENIORS' HEALTH CARE PLAN PROTECTION ACT OF 2015

Mr. BRADY of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2582) to amend title XVIII of the Social Security Act to improve the risk adjustment under the Medicare Advantage program, to delay the authority to terminate Medicare Advantage contracts for MA plans failing to achieve minimum quality ratings, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2582

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 ''Seniors' Health Care Plan Protection Act of 2015''.

SEC. 2. DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.

(a) FINDINGS.—Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113–185), it is the intent of Congress—

(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

(2) pending the results of such studies and input, to provide for a temporary delay in authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system.

(b) DELAY IN MA CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.—Section 1857(h) of the Social Security Act (42 U.S.C. 1395w–27(h)) is amended by adding at the end the following new paragraph:

''(3) DELAY IN CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATING.—The Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system established under section 1853(o) during the period beginning on the date of the enactment of this paragraph and through the end of plan year 2018.''.

SEC. 3. IMPROVEMENTS TO MA RISK ADJUSTMENT SYSTEM.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clauses:

''(iv) EVALUATION AND SUBSEQUENT REVISION OF THE RISK ADJUSTMENT SYSTEM TO ACCOUNT FOR CHRONIC CONDITIONS AND OTHER FACTORS FOR THE PURPOSE OF MAKING THE RISK ADJUSTMENT SYSTEM MORE ACCURATE, TRANSPARENT, AND REGULARLY UPDATED.—

''(I) REVISION BASED ON NUMBER OF CHRONIC CONDITIONS.—The Secretary shall revise for 2017 and periodically thereafter, the risk adjustment system under this subparagraph so that a risk score under such system, with respect to an individual, takes into account the number of chronic conditions with which the individual has been diagnosed.

''(II) EVALUATION OF DIFFERENT RISK ADJUSTMENT MODELS.—The Secretary shall evaluate the impact of including two years of data to compare the models used to determine risk scores for 2013 and 2014 under such system.

''(III) EVALUATION AND ANALYSIS ON CHRONIC KIDNEY DISEASE (CKD) CODES.—The Secretary shall evaluate the impact of removing the diagnosis codes related to chronic kidney disease in the 2014 risk adjustment model and conduct an analysis of best practices of MA plans to slow disease progression related to chronic kidney disease.

''(IV) EVALUATION AND RECOMMENDATIONS ON USE OF ENCOUNTER DATA.—The Secretary shall evaluate the impact of including 10 percent of encounter data in computing payment for 2016 and the readiness of the Centers for Medicare & Medicaid Services to incorporate encounter data in risk scores. In conducting such evaluation, the Secretary shall use data collected as encounter data on or after January 1, 2012, shall analyze such data for accuracy and completeness and issue recommendations for improving such accuracy and completeness, and shall not increase the percentage of such encounter data used unless the Secretary releases the data publicly, indicates how such data will be weighted in computing the risk scores, and ensures that the data reflects the degree and cost of care coordination under MA plans.

''(V) CONDUCT OF EVALUATIONS.—Evaluations and analyses under subclause (II) through (IV) shall include an actuarial opinion from the Chief Actuary of the Centers for Medicare & Medicaid Services about the reasonableness of the methods, assumptions, and conclusions of such evaluations and analyses. The Secretary shall consult with the Medicare Payment Advisory Commission and accept and consider comments of stakeholders, such as managed care organizations and beneficiary groups, on such evaluation and analyses. The Secretary shall complete such evaluations and analyses in a manner that permits the results to be applied for plan years beginning with the second plan year that begins after the date of the enactment of this clause.

''(VI) IMPLEMENTATION OF REVISIONS BASED ON EVALUATIONS.—If the Secretary determines, based on such an evaluation or analysis, that revisions to the risk adjustment system to address the matters described in any of subclauses (II) through (IV) would make the risk adjustment system under this subparagraph better reflect and appropriately weight for the population that is served by the plan, the Secretary shall, beginning with 2017, and periodically thereafter, make such revisions.

''(VII) PERIODIC REPORTING TO CONGRESS.—With respect to plan years beginning with 2017 and every third year thereafter, the Secretary shall submit to Congress a report on the most recent revisions (if any) made under this clause, including the evaluations conducted under subclauses (II) through (IV).

''(v) NO CHANGES TO ADJUSTMENT FACTORS THAT PREVENT ACTIVITIES CONSISTENT WITH NATIONAL HEALTH POLICY GOALS.—In making any changes to the adjustment factors, including adjustment for health status under paragraph (3), the Secretary shall ensure that the changes do not prevent Medicare Advantage organizations from performing or undertaking activities that are consistent with national health policy goals, including activities to promote early detection and better care coordination, the use of health risk assessments, care plans, and programs to slow the progression of chronic diseases.

''(vi) OPPORTUNITY FOR REVIEW AND PUBLIC COMMENT REGARDING CHANGES TO ADJUSTMENT FACTORS.—For changes to adjustment factors effective for 2017 and subsequent years, in addition to providing notice of such changes in the announcement under subsection (b)(2), the Secretary shall provide an opportunity for review of proposed changes of not less than 60 days and a public comment period of