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113TH CONGRESS
2D SESSION

H. R. 5183

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

IN THE HOUSE OF REPRESENTATIVES

JULY 23, 2014

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

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A BILL

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

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 ''Value Based Insurance Design for Better Care Act of 2014'' or the ''VBID for Better Care Act of 2014''.

SEC. 2. FINDINGS.

Congress makes the following findings:

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

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

(3) Financial barriers to prescription medications and clinical services that are deemed to be

high-value should be reduced or eliminated to increase their use.

(4) Value-Based Insurance Design is a methodology that adjusts patient out-of-pocket costs for prescription medications and clinical services according to the clinical value—not exclusively the cost. Value-Based Insurance Design is based on the concept of clinical nuance that recognizes—

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

(B) the clinical benefit derived from a specific prescription medication or clinical service depends on the clinical situation, the provider, and where the care is delivered.

(5) The current ''one-size-fits-all'' copayment or coinsurance design for prescription medications and clinical services provided under the Medicare program does not recognize the well-established value differences in health outcomes produced by various medical interventions.

(6) The establishment by Medicare of copayment and coinsurance requirements using Value-Based Insurance Design methodologies will improve patient-centered health outcomes, enhance personal

responsibility, and afford a more efficient use of taxpayer dollars.

SEC. 3. 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.).

(b) DEMONSTRATION PROGRAM DESIGN.—

(1) SELECTION OF MA REGION AND ELIGIBLE MEDICARE ADVANTAGE PLANS.—The Secretary shall—

(A) select at least two MA regions (as defined in section 1858(a)(2) of the Social Security Act (42 U.S.C. 1395w–27a(a)(2))) 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.

(2) START OF DEMONSTRATION.—The demonstration program shall begin with respect to the

first plan year beginning after the date on which at least two eligible Medicare Advantage plans have been approved by the Secretary in at least one MA region selected under paragraph (1).

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

(B) The plan has—

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

(ii) in the case of a specialized MA plan for special needs individuals, as defined in subsection (b)(6)(A) of section 1859(b)(6)(A) of such Act (42 U.S.C.

1395w–28(b)(6)(A)), received a multi-year approval by the National Committee for Quality Assurance under subsection (f)(7) of such section; or

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

(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 reimbursable under title XVIII of the Social Security Act, for which copayments, coinsurance, or both should be reduced or eliminated because of the high-value and effectiveness of such medications and services for 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 Ad-

vantage plan selected 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 amount of the copayment or coinsurance should be reduced or eliminated, with respect to the management of specific chronic clinical conditions (as specified by the Secretary) of MA 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; and

(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, 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, pro-

cedures, 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.

(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 the 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, non-biased entity having expertise in value-based in-

surance design methodologies 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).

(3) REPORT TO CONGRESS.—Not later than 3 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.

(f) EXPANSION OF DEMONSTRATION PROGRAM.—The Secretary shall expand the demonstration program, pursuant to notice and comment rulemaking, to implement, on a permanent basis, the components of the demonstration program that are beneficial to Medicare beneficiaries and the Medicare program, unless the report under subsection (d) or (e)(3) contains an evaluation that the demonstration program—

(1) increases expenditures under title XVIII with respect to Medicare beneficiaries participating in the demonstration program; or

(2) decreases the quality of health care services furnished to such Medicare beneficiaries participating in the demonstration program.

(g) 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.

(h) 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.

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