115TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 115–832
Part 1

IMPROVING SENIORS ACCESS TO QUALITY BENEFITS ACT

JULY 17, 2018.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 4952]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4952) to direct the Secretary of Health and Human Services to conduct a study and submit a report on the effects of the inclusion of quality increases in the determination of blended benchmark amounts under part C of the Medicare program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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79–006

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Seniors Access to Quality Benefits Act".

SEC. 2. DETERMINATION OF BLENDED BENCHMARK AMOUNT STUDY.

(a) SENSE OF CONGRESS.—It is the sense of Congress that the inclusion of quality increases in the determination of blended benchmark amounts under section 1853(n)(4) of the Social Security Act (42 U.S.C. 1395w–23(n)(4)) undermines the goal of delivering high-quality care under the Medicare program under title XVIII of such Act.

(b) STUDY AND REPORT.—Not later than one year after the date of enactment of this section, the Secretary of Health and Human Services, in consultation with relevant stakeholders, shall conduct a study and submit to Congress a report on the effects of the inclusion of quality percentage increases under section 1853(n)(5) of such Act in the determination of blended benchmark amounts under section 1853(n)(4) of such Act. Such study and report shall include an analysis of the following:

(1) The authority of the Secretary to remove such increases from the determination of such amounts.

(2) The effects of including such increases in the determination of such amounts on Medicare Advantage organizations (including the effects on any contracts entered into by such organizations).

(3) The financial impact of including such increases in the determination of such amounts by county.

(4) The effects of including such increases in the determination of such amounts on individuals enrolled in a plan under part C of title XVIII of such Act.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 4952, the "Improving Seniors Access to Quality Benefits Act," as ordered reported by the Committee on Ways and Means on June 21, 2018, requires the Secretary to study and report to Congress on the effects of including quality bonus payments under the benchmark cap on Medicare Advantage (MA) plans and enrollees, among other things.

B. BACKGROUND AND NEED FOR LEGISLATION

The MA program relies on private insurance companies to deliver Medicare benefits. Under MA plans, beneficiaries may receive supplemental services that are not provided under FFS.

MA plans are reimbursed at a capitated payment rate, one payment per month per beneficiary to encompass all of a patient's care, as opposed to Medicare Parts A and B (also referred to as fee-for-service), which rely on a variety of mechanisms for payment depending on the type and site of service. MA capitated payments are based on a county benchmark. The benchmark is the maximum the federal government will pay an MA plan for providing Part A and B services in a particular county. As required under the Affordable Care Act (ACA), the benchmark is set by taking the average per county fee-for-service spending for all fee-for-service beneficiaries enrolled in either Part A or Part B, or both. The ACA also in-

creases the benchmark based on plan quality, with higher increases for qualifying areas.

MA plans submit a bid reflecting the plan's estimated costs of offering Medicare beneficiaries' Part A and Part B benefits. The bid is presented as the total cost to Medicare to cover an average or standard beneficiary. The bid includes plan administrative cost and profit.

The Secretary of the Department of Health and Human Services (HHS) must review each plan bid. If the bid meets the statutory and actuarial requirements, the plan is paid the difference between the bid and the statutorily defined payment benchmark. The difference can be used to reduce consumer costs and offer supplemental benefits. The agreed upon capitated rate is then risk adjusted based on the beneficiary's health status.

Plans with higher quality ratings receive bonus amounts, commonly referred to as quality bonus payments. The ACA subjects these bonus payments to the benchmark, effectively capping the amount of bonus payments high performing plans are able to receive in certain counties. The Centers for Medicare and Medicaid Services (CMS) does not believe the Secretary has the authority to exclude the quality bonus payments from the cap calculation. The current Administration's policy on this issue remains consistent with the previous Administration's policy. Therefore, high quality plans are capped at the benchmark rate and may not receive the same quality payment as a similar high quality plan in a higher benchmark area. By counting the quality payment toward the benchmark cap, plans have less flexibility to offer additional services or lower cost-sharing.

C. LEGISLATIVE HISTORY

Background

H.R. 4952 was introduced on February 6, 2018, and was referred to the Committee on Ways and Means and additionally the Committee on Energy and Commerce.

Committee hearings

On May 8, 2018, the Committee held a hearing on the Medicare Advantage Program, in which the challenges of including quality bonus payments under the benchmark was discussed.

On June 8, 2017, the Committee held a hearing on the Department of Health and Human Services' Fiscal Year 2018 Budget Request, in which the benchmark cap was discussed.

On July 24, 2014, the Subcommittee on Health held a hearing on The Future of Medicare Advantage Plans.

Committee action

The Committee on Ways and Means marked up H.R. 4952, the "Improving Seniors Access to Quality Benefits Act," on June 21, 2018, and ordered the bill, as amended, favorably reported by voice vote (with a quorum being present).

II. EXPLANATION OF THE BILL

A. THE "IMPROVING SENIORS ACCESS TO QUALITY BENEFITS ACT"

PRESENT LAW

Under the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services (CMS) counts quality bonus payments to Medicare Advantage plans under the benchmark.

REASONS FOR CHANGE

Since quality bonus payments are counted under the benchmark, high performing plans in certain counties often have diminished quality bonus payments. This leads to less flexibility to offer additional services or lower cost sharing.

EXPLANATION OF PROVISIONS

Section 1: Short Title: Improving Seniors Access to Quality Benefits Act of 2018.

Section 2: Determination of Blended Benchmark Amount Study.

Sense of Congress: Expresses it is the sense of Congress that the inclusion of quality increases in the determination of the blended benchmark amounts undermines the goal of delivering high-quality care under the Medicare Advantage (MA) program.

Study and Report: Not later than one year after the date of enactment, the Secretary of Health and Human Services, in consultation with relevant stakeholders, is required to conduct a study and submit to Congress a report on the effects of removing quality bonus payments from the MA benchmark. The study is required to include an analysis of the following: (1) the authority of the Secretary to remove quality bonus payments from the MA benchmark; (2) the effects of including quality bonus payments in the MA benchmark; (3) the financial impact of including quality bonus payments in the determination of the MA benchmark by county; and (4) the effects of including quality bonus payments in the MA benchmark on plan enrollees.

EFFECTIVE DATE

Section 2: Not later than one year after the date of enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 4952, the "Improving Seniors Access to Quality Benefits Act", on June 21, 2018.

The bill, H.R. 4952, was ordered favorably reported as amended by voice vote (with a quorum being present).

The vote on the amendment offered by Mr. Higgins to the amendment in the nature of a substitute to H.R. 4952, which would require a study on creating a Medicare buy-in for individuals aged 50–64, was not agreed to by a roll call vote of 14 yeas to 23 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson		X		Mr. Levin	X		
Mr. Nunes				Mr. Lewis	X		
Mr. Reichert		X		Mr. Doggett	X		
Mr. Roskam		X		Mr. Thompson	X		
Mr. Buchanan		X		Mr. Larson	X		
Mr. Smith (NE)		X		Mr. Blumenauer	X		
Ms. Jenkins		X		Mr. Kind	X		
Mr. Paulsen		X		Mr. Pascrell	X		
Mr. Marchant		X		Mr. Crowley			
Ms. Black		X		Mr. Davis	X		
Mr. Reed		X		Ms. Sanchez	X		
Mr. Kelly		X		Mr. Higgins	X		
Mr. Renacci		X		Ms. Sewell			
Ms. Noem		X		Ms. DelBene	X		
Mr. Holding		X		Ms. Chu	X		
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					
Mr. LaHood		X					
Mr. Wenstrup		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 4952, as reported. The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below.

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee states further that the bill involves no new or increased tax expenditures.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 9, 2018.

Hon. Kevin Brady,
Chairman Committee on Ways and Means,
U.S. House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4952, the Improving Seniors Access to Quality Benefits Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lori Housman.

Sincerely,

MARK P. HADLEY
(For Keith Hall, Director).

Enclosure.

H.R. 4952—Improving Seniors Access to Quality Benefits Act

H.R. 4952 would direct the Secretary of Health and Human Services to study and report to the Congress on how quality bonuses affect Medicare Advantage payment rates.

CBO estimates that the cost of this study would be less than $500,000; that spending would be subject to the availability of appropriated funds. Enacting H.R. 4952 would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply. CBO estimates that enacting H.R. 4952 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

H.R. 4952 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The CEO staff contact for this estimate is Lori Housman. The estimate was reviewed by Leo Lex, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of H.R. 4952 that the Committee concluded it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined the bill does not contain Federal mandates on the private sector. The Committee has determined the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95–220, as amended by Pub. L. No. 98–169).

VI. CORRESPONDENCE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

July 13, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden,

I write to you regarding H.R. 4952, the "Improving Seniors Access to Quality Benefits Act" the Committee on Ways and Means ordered favorably reported that was also referred to the Committee on Energy and Commerce.

I ask that the Committee on Energy and Commerce waive formal consideration of the bill so that it may proceed expeditiously to the House Floor

I acknowledge that by waiving formal consideration of the bill, the Committee on Energy and Commerce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bills that fall within your Rule X jurisdiction. I would support your effort to seek appointment of an appropriate number of conferees on any House-Senate conference involving this legislation.

I will include a copy of our letters in the *Congressional Record* during consideration of this legislation on the House floor.

Sincerely,

Kevin Brady

Kevin Brady
Chairman

cc: The Honorable Paul Ryan, Speaker
The Honorable Richard E. Neal
The Honorable Frank Pallone
Thomas J. Wickham, Jr., Parliamentarian

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

July 16, 2018

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

Thank you for your letters regarding H.R. 4952, the "Improving Seniors Access to Quality Benefits Act," H.R. 6138, the "Ambulatory Surgical Center (ACS) Payment Transparency Act of 2018," and H.R. 6311, the "To amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copper plan."

The Committee on Energy and Commerce will forgo consideration of both bills so that they may proceed expeditiously to the House Floor.

I appreciate your assurance that by forgoing action on these bills, the Committee is in no way waiving its jurisdiction over the subject matter contained in the bills. I also appreciate your offer of support for the appointment of conferees from the Committee to any House-Senate conference involving this legislation.

Sincerely,

Greg Walden
Chairman

VII. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, the bill, as reported, makes no changes to existing law.

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