

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

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Value Based Insurance
3 Design for Better Care Act of 2014” or the “VBID for
4 Better Care Act of 2014”.

5 **SEC. 2. FINDINGS.**

6 Congress makes the following findings:

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

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

24 (3) Financial barriers to prescription medica-
25 tions and clinical services that are deemed to be

1 high-value should be reduced or eliminated to in-
2 crease their use.

3 (4) Value-Based Insurance Design is a method-
4 ology that adjusts patient out-of-pocket costs for
5 prescription medications and clinical services accord-
6 ing to the clinical value—not exclusively the cost.
7 Value-Based Insurance Design is based on the con-
8 cept of clinical nuance that recognizes—

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

12 (B) the clinical benefit derived from a spe-
13 cific prescription medication or clinical service
14 depends on the clinical situation, the provider,
15 and where the care is delivered.

16 (5) The current “one-size-fits-all” copayment or
17 coinsurance design for prescription medications and
18 clinical services provided under the Medicare pro-
19 gram does not recognize the well-established value
20 differences in health outcomes produced by various
21 medical interventions.

22 (6) The establishment by Medicare of copay-
23 ment and coinsurance requirements using Value-
24 Based Insurance Design methodologies will improve
25 patient-centered health outcomes, enhance personal

1 responsibility, and afford a more efficient use of tax-
2 payer dollars.

3 **SEC. 3. DEMONSTRATION PROGRAM.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the “Sec-
6 retary”) shall establish a 3-year demonstration program
7 to test the use of value-based insurance design methodolo-
8 gies (as defined in subsection (c)(1)) under eligible Medi-
9 care Advantage plans offered by Medicare Advantage or-
10 ganizations under part C of title XVIII of the Social Secu-
11 rity Act (42 U.S.C. 1395w–21 et seq.).

12 (b) DEMONSTRATION PROGRAM DESIGN.—

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

16 (A) select at least two MA regions (as de-
17 fined in section 1858(a)(2) of the Social Secu-
18 rity Act (42 U.S.C. 1395w–27a(a)(2))) with re-
19 spect to which to conduct the demonstration
20 program under this section; and

21 (B) approve eligible Medicare Advantage
22 plans to participate in such demonstration pro-
23 gram.

24 (2) START OF DEMONSTRATION.—The dem-
25 onstration program shall begin with respect to the

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

5 (3) ELIGIBLE MEDICARE ADVANTAGE PLANS.—

6 For purposes of this section, the term “eligible
7 Medicare Advantage plan” means a Medicare Ad-
8 vantage plan under part C of title XVIII of the So-
9 cial Security Act (42 U.S.C. 1395w–21 et seq.) that
10 meets the following requirements:

11 (A) The plan is an MA regional plan (as
12 defined in paragraph (4) of section 1859(b) of
13 such Act (42 U.S.C. 1395w–28(b))) or MA
14 local plan (as defined in paragraph (5) of such
15 section) offered in the MA region selected under
16 paragraph (1)(A).

17 (B) The plan has—

18 (i) a quality rating under section
19 1853(n)(4) of such Act (42 U.S.C. 1395w–
20 23(n)(4)) of 4 stars or higher based on the
21 most recent data available for such year;

22 (ii) in the case of a specialized MA
23 plan for special needs individuals, as de-
24 fined in subsection (b)(6)(A) of section
25 1859(b)(6)(A) of such Act (42 U.S.C.

1 1395w–28(b)(6)(A)), received a multi-year
 2 approval by the National Committee for
 3 Quality Assurance under subsection (f)(7)
 4 of such section; or

5 (iii) at least 20 percent of the popu-
 6 lation to whom the plan is offered consists
 7 of subsidy eligible individuals (as defined
 8 in section 1860D–14(a)(3)(A) of the Social
 9 Security Act (42 U.S.C. 1395w–
 10 114(a)(3)(A))).

11 (c) VALUE-BASED INSURANCE DESIGN METHODOLO-
 12 GIES.—

13 (1) DEFINITION.—For purposes of this section,
 14 the term “value-based insurance design method-
 15 ology” means a methodology for identifying specific
 16 prescription medications, and clinical services that
 17 are reimbursable under title XVIII of the Social Se-
 18 curity Act, for which copayments, coinsurance, or
 19 both should be reduced or eliminated because of the
 20 high-value and effectiveness of such medications and
 21 services for specific chronic clinical conditions (as
 22 approved by the Secretary).

23 (2) USE OF METHODOLOGIES TO REDUCE CO-
 24 PAYMENTS AND COINSURANCE.—A Medicare Advan-
 25 tage organization offering an eligible Medicare Ad-

1 vantage plan selected to participate under the dem-
2 onstration program, for each plan year for which the
3 plan is so selected and using value-based insurance
4 design methodologies—

5 (A) shall identify each prescription medica-
6 tion and clinical service covered under such
7 plan for which the amount of the copayment or
8 coinsurance should be reduced or eliminated,
9 with respect to the management of specific
10 chronic clinical conditions (as specified by the
11 Secretary) of MA eligible individuals (as defined
12 in section 1851(a)(3) of the Social Security Act
13 (42 U.S.C. 1395w–21(a)(3))) enrolled under
14 such plans, for such plan year; and

15 (B) may, for such plan year, reduce or
16 eliminate copayments, coinsurance, or both for
17 such prescription medication and clinical serv-
18 ices so identified with respect to the manage-
19 ment of such conditions of such individuals—

20 (i) if such reduction or elimination is
21 evidence-based, for the purpose of encour-
22 aging such individuals in such plan to use
23 such prescription medications and clinical
24 services (such as preventive care, primary
25 care, specialty visits, diagnostic tests, pro-

1 cedures, and durable medical equipment)
 2 with respect to such conditions; and
 3 (ii) for the purpose of encouraging
 4 such individuals in such plan to use health
 5 care providers that such organization has
 6 identified with respect to such plan year.

7 (3) PROHIBITION OF INCREASES OF COPAY-
 8 MENTS AND COINSURANCE.—In no case may any
 9 Medicare Advantage plan participating in the dem-
 10 onstration program increase, for any plan year for
 11 which the plan is so participating, the amount of co-
 12 payments or coinsurance for any item or service cov-
 13 ered under such plan for purposes of discouraging
 14 the use of such item or service.

15 (d) REPORT ON IMPLEMENTATION.—

16 (1) IN GENERAL.—Not later than 1 year after
 17 the date on which the demonstration program under
 18 this section begins under subsection (b)(2), the Sec-
 19 retary shall submit to Congress a report on the sta-
 20 tus of the implementation of the demonstration pro-
 21 gram.

22 (2) ELEMENTS.—The report required by para-
 23 graph (1) shall, with respect to eligible Medicare Ad-
 24 vantage plans participating in the demonstration

1 program for the first plan year of such program, in-
2 clude the following:

3 (A) A list of each medication and service
4 identified pursuant to subsection (c)(2)(A) for
5 such plan with respect to such plan year.

6 (B) For each such medication or service so
7 identified, the amount of the copayment or co-
8 insurance required under such plan with respect
9 to such plan year for such medication or service
10 and the amount of the reduction of such copay-
11 ment or coinsurance from the previous plan
12 year.

13 (C) For each provider identified pursuant
14 to subsection (c)(2)(B)(ii) for such plan with
15 respect to such plan year, a statement of the
16 amount of the copayment or coinsurance re-
17 quired under such plan with respect to such
18 plan year and the amount of the reduction of
19 such copayment or coinsurance from the pre-
20 vious plan year.

21 (e) REVIEW AND ASSESSMENT OF UTILIZATION OF
22 VALUE-BASED INSURANCE DESIGN METHODOLOGIES.—

23 (1) IN GENERAL.—The Secretary shall enter
24 into a contract or agreement with an independent,
25 non-biased entity having expertise in value-based in-

1 insurance design methodologies to review and assess
2 the implementation of the demonstration program
3 under this section. The review and assessment shall
4 include the following:

5 (A) An assessment of the utilization of
6 value-based insurance design methodologies by
7 Medicare Advantage plans participating under
8 such program.

9 (B) An analysis of whether reducing or
10 eliminating the copayment or coinsurance for
11 each medication and clinical service identified
12 pursuant to subsection (c)(2)(A) resulted in in-
13 creased adherence to medication regimens, in-
14 creased service utilization, improvement in qual-
15 ity metrics, better health outcomes, and en-
16 hanced beneficiary experience.

17 (C) An analysis of the extent to which
18 costs to Medicare Advantage plans under part
19 C of title XVIII of the Social Security Act par-
20 ticipating in the demonstration program is less
21 than costs to Medicare Advantage plans under
22 such part that are not participating in the dem-
23 onstration program.

24 (D) An analysis of whether reducing or
25 eliminating the copayment or coinsurance for

1 providers identified pursuant to subsection
2 (c)(2)(B)(ii) resulted in improvement in quality
3 metrics, better health outcomes, and enhanced
4 beneficiary experience.

5 (E) An analysis, for each provider so iden-
6 tified, the extent to which costs to Medicare Ad-
7 vantage plans under part C of title XVIII of the
8 Social Security Act participating in the dem-
9 onstration program is less than costs to Medi-
10 care Advantage plans under such part that are
11 not participating in the demonstration program.

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

14 (2) REPORT.—The contract or agreement en-
15 tered into under paragraph (1) shall require such
16 entity to submit to the Secretary a report on the re-
17 view and assessment conducted by the entity under
18 such paragraph in time for the inclusion of the re-
19 sults of such report in the report required by para-
20 graph (3).

21 (3) REPORT TO CONGRESS.—Not later than 3
22 years after the date on which the demonstration pro-
23 gram begins under subsection (b)(2), the Secretary
24 shall submit to Congress a report on the review and
25 assessment of the demonstration program conducted

1 under this subsection. The report shall include the
2 following:

3 (A) A description of the results of the re-
4 view and assessment included in the report sub-
5 mitted pursuant to paragraph (2).

6 (B) Such recommendations as the Sec-
7 retary considers appropriate for enhancing the
8 utilization of the methodologies applied under
9 the demonstration program to all Medicare Ad-
10 vantage plans under part C of title XVIII of the
11 Social Security Act so as to reduce copayments
12 and coinsurance under such plans paid by
13 Medicare beneficiaries for high-value prescrip-
14 tion medications and clinical services for which
15 coverage is provided under such plans and to
16 otherwise improve the quality of health care
17 provided under such plans.

18 (f) EXPANSION OF DEMONSTRATION PROGRAM.—
19 The Secretary shall expand the demonstration program,
20 pursuant to notice and comment rulemaking, to imple-
21 ment, on a permanent basis, the components of the dem-
22 onstration program that are beneficial to Medicare bene-
23 ficiaries and the Medicare program, unless the report
24 under subsection (d) or (e)(3) contains an evaluation that
25 the demonstration program—

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

4 (2) decreases the quality of health care services
5 furnished to such Medicare beneficiaries partici-
6 pating in the demonstration program.

7 (g) WAIVER AUTHORITY.—The Secretary may waive
8 such provisions of titles XI and XVIII of the Social Secu-
9 rity Act as may be necessary to carry out the demonstra-
10 tion program under this section.

11 (h) IMPLEMENTATION FUNDING.—For purposes of
12 carrying out the demonstration program under this sec-
13 tion, the Secretary shall provide for the transfer from the
14 Federal Hospital Insurance Trust Fund under section
15 1817 of the Social Security Act (42 U.S.C. 1395i) and
16 the Federal Supplementary Insurance Trust Fund under
17 section 1841 of the Social Security Act (42 U.S.C. 1395t),
18 including the Medicare Prescription Drug Account in such
19 Trust Fund, in such proportion as determined appropriate
20 by the Secretary, of such sums as may be necessary.

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