

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

not less than 30 days before implementing such changes.”.

SEC. 4. SENSE OF CONGRESS RELATING TO MEDICARE ADVANTAGE STAR RATING SYSTEM.

It is the sense of Congress that—

(1) the Centers for Medicare & Medicaid Services has inadvertently created a star rating system under section 1853(o)(4) of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) for Medicare Advantage plans that lacks proper accounting for the socioeconomic status of enrollees in such plans and the extent to which such plans serve individuals who are also eligible for medical assistance under title XIX of such Act; and

(2) Congress will work with the Centers for Medicare & Medicaid Services and stakeholders, including beneficiary groups and managed care organizations, to ensure that such rating system properly accounts for the socioeconomic status of enrollees in such plans and the extent to which such plans serve such individuals described in paragraph (1).

SEC. 5. SENSE OF CONGRESS RELATING TO MEDICARE ADVANTAGE RISK ADJUSTMENT.

It is the sense of Congress that—

(1) the Secretary of Health and Human Services should periodically monitor and improve the Medicare Advantage risk adjustment model to ensure that it accurately accounts for beneficiary risk, including for those individuals with complex chronic comorbid conditions;

(2) the Secretary should closely examine the current Medicare Advantage risk adjustment methodology to ensure that plans enrolling beneficiaries with the greatest health care needs receive adequate reimbursement to deliver high-quality care and other services to help beneficiaries avoid costly complications and further progression of chronic conditions and to the extent data indicate this to be the case, the Secretary should make necessary adjustment to the risk adjustment methodology; and

(3) the Secretary should reconsider the implementation of changes in the Medicare Advantage risk adjustment methodology finalized for 2016 and to use to the extent appropriate the methodology finalized in 2015 for one additional 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. 2582, 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 strong support of H.R. 2582, the Securing Seniors' Health Care Act of 2015.

When Medicare began implementing the STARS ratings measurement system, they did so using the typical Washington approach of one size fits all. The STARS program uses the same

measures to evaluate plans with different benefit designs and different coverage mixes. Congress needs to work with stakeholders and Medicare to reform this system to make it work for all.

CMS should continue to study issues like the effect that socioeconomic conditions have on health care and the effect that coverage of duals has on various rating systems and thus properly serve their populations.

This legislation is common sense. Let's not restrict seniors from plans they have chosen and like just because they aren't performing well under CMS's poorly managed STARS standards.

Until we truly understand the effects of duals and low-income beneficiaries on the plan's STARS ratings, we shouldn't be terminating them. A 3-year delay will do just that: give CMS and Congress the time to address the STARS rating system and allow all seniors access to the plans they choose and that they like.

CMS has made some poor policy decisions in recent years through the regulatory process in Medicare Advantage and part D of the prescription drug plan, and this year's call letter and rate notice is no exception.

The changes to the risk adjustment system include masking coding intensity adjustments, while in press releases CMS touts not exceeding statutory levels of coding intensity adjustments.

In plain English, Medicare Advantage plans are managed care plans, and the changes in the recent regulations handcuff plans from properly managing some of our frailest seniors suffering from, for example, blood and kidney diseases.

This bill requires that CMS review the changes made in their most recent regulatory cycle and reverse those that negatively affect risk adjustments.

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This bill has CMS reviewing the use of encounter data as well. CMS has told Congress, the Government Accountability Office, and MedPAC that the data is not ready yet to show us; yet it is being used for risk adjustment in Medicare Advantage? That doesn't make sense. We need to see a stronger commitment by CMS to be transparent about their policies and their data in Medicare Advantage.

The changes made this year to MA just don't make sense, and I look forward to working with all my colleagues to reverse some of these changes and make continued improvements to the system as a whole.

I want to thank Mr. BUCHANAN, Mr. RANGEL, Mrs. BLACKBURN of Tennessee, Mr. GUTHRIE, and Mr. LOESACK for their hard work in getting this policy moving forward.

I want to, again, reiterate my thanks to Mrs. BLACK and Mr. BLUMENAUER on our committee for their leadership regarding these issues.

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

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

I want to thank the gentleman from Texas for bringing up this bill and also my colleague, Mr. BUCHANAN of Florida.

There was some comment that CMS was making some mistakes that have not been transparent. It has been my understanding that they have had problems wrestling with this so-called star system themselves and have not enforced the law, that we are now saying that they will not enforce the law until after they study the complexities and report back to the Congress in an additional 3 years.

In short, they have this star system and, as most people should recognize, that when you are dealing with old, fragile, sick, poor people, there are more complexities to performance than in ordinary programs that compete with Medicare Advantage.

We have this population, and they have penalized some of the providers because they have had just more problems to deal with than just medical problems, and they haven't been able to resolve them. They haven't enforced this provision.

Under this bill, which Mr. BUCHANAN and the other sponsors have agreed, it tells the CMS to go back and to find out a way that you can treat these recipients of health care in a fairer way. It also tells CMS to take into consideration that the problems that Medicare Advantage has still to come are far more severe and far more complex than in other areas.

This is particularly true with our citizens in Puerto Rico that don't really have an option to anything except Medicare Advantage. Of course, as we all know, the economic conditions and the poverty that prevails there is extreme.

I don't have any other requests for time, but I do want to thank my colleagues on the other side of the aisle for assisting to make certain that the Affordable Care program and other programs like it become more effective.

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

Mr. BRADY of Texas. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN), one of the thought leaders on health care on the Energy and Commerce Committee.

Mrs. BLACKBURN. Mr. Speaker, I do thank the gentleman from Texas for his leadership and for, really, his commitment to working these issues through. As you have heard him say, dealing with Medicare Advantage issues are important, and it is important that we get them right.

That is why I appreciate the fact that we come to the floor with these suspension bills to revisit these issues and say: Look, there are some things that just are not working as they were intended.

As you have heard, there has been bipartisan agreement, that the stars rating program needs a revisit, and CMS even agrees that the rules are not working.

As the gentleman from New York said, this has a specific effect on the frail, the low-income, those beneficiaries that are the most frail. It also affects the dual eligibles, those that are both Medicare and Medicaid eligible.

It is appropriate that we look at this rating program, that we back up and pause and consider the negative impact that some of these arbitrary ratings have on these programs when it may be the only program that is available that will meet these needs.

This is common sense. It is the right thing to do. I thank my colleagues that they are willing to say: CMS, it is not working; you have to come to the table with us.

This delay, this pause, and a review of the system is appropriate.

I thank everyone involved for their leadership, and I do express thanks to Mr. BUCHANAN and his team for the way they have worked with us and the Energy and Commerce Committee on the issue.

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

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACK), again, one of our key healthcare leaders on the Ways and Means Committee who is critical in the advancement of this legislation.

Mrs. BLACK. Mr. Speaker, I rise today in support of H.R. 2582, the Seniors' Health Care Plan Protection Act.

I am pleased that this legislation includes the language of my bill, the Securing Care for Seniors Act; and I thank Congressman BUCHANAN for his efforts to bring this important policy solution to the floor of the House today.

Across the country, 16 million seniors enjoy the flexibility of the Medicare Advantage plan. When we make changes to this program, seniors are the ones impacted. It just makes sense that they would have a place at the table when these changes are discussed.

Recently, CMS revised the Medicare Advantage risk adjustment model under the shroud of secrecy with little input from Congress and, most importantly, from Medicare beneficiaries.

Members of both parties have concerns that these modifications could discourage plans to detect and care for the chronic conditions in their early stages. That is why, today, we are calling for a timeout on CMS' changes.

We are instructing the agency to re-evaluate their risk adjustment model and to move forward with metrics that are accurate, evidence-based, and are transparent. This will ensure that seniors pay a fair cost for their healthcare plans, and that the MA program remains sustainable in the long term.

I urge a "yes" vote on H.R. 2582.

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

I would just like to say that this has been one of the most exciting recent legislative experiences I have had, where we are dealing with Americans who are not Republican and Democrat, but they are sick people; and, in this particular case, they are sick, and they are old, and they are fragile, and the government is not serving them.

Both sides of the aisle have agreed that the administration has to do something to make certain that they study how we can be fair to the providers and, at the same time, provide the service to those people that need it. They, themselves, agree that, for 3 years, they have not been able to find an answer.

What we have said jointly is you find that answer in 3 years. Until such time, don't you think about terminating these programs. It is with this cooperation that we both have a common sense of our obligation as legislators, and it has been really a legislative pleasure working with my colleagues on these suspensions this evening.

Mr. Speaker, I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

I agree with the gentleman from New York that this is a bill that brings, really, a team of Republicans and Democrats together with their best ideas on how we can help improve Medicare for our seniors.

This bill is titled "Securing Seniors' Health Care Act." It is aptly titled.

I am hopeful that today is just one example of more common ground between Republicans and Democrats, not just on the Ways and Means Committee, but through the House as well. I urge strong support for passage of 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. 2582, 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 to delay the authority to terminate Medicare Advantage contracts for MA plans failing to achieve minimum quality ratings, to make improvements to the Medicare Adjustment risk adjustment system, and for other purposes."

A motion to reconsider was laid on the table.

Mr. BRADY of Texas. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 9 a.m. tomorrow.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

(Mr. EMMER of Minnesota asked and was given permission to address the House for 1 minute.)

Mr. EMMER of Minnesota. Mr. Speaker, I rise today to urge this body to pass the Protect Medical Innovation Act, which will repeal the 2.3 percent medical device excise tax.

This harmful tax, mandated by ObamaCare, stifles innovation, sends jobs abroad, hurts consumers, and places a heavy burden on small businesses in my State and across the country.

More than 35,000 Minnesotans are employed in the medical device industry, and thousands of Minnesotans depend on these state-of-the-art devices to enhance or even save their lives.

This bill has been stalled for long enough. It is imperative that Congress pass this legislation now to encourage the development of these innovative technologies, rather than enact laws that discourage their creation and accessibility.

I am grateful for the tremendous work by my Minnesota colleague, ERIK PAULSEN. Representative PAULSEN has done much to ensure the medical device industry in Minnesota continues to thrive for many years to come with this legislation.

Again, I ask my colleagues to support the Protect Medical Innovation Act and pass it immediately.

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2015, the gentleman from Pennsylvania (Mr. FITZPATRICK) is recognized for 60 minutes as the designee of the majority leader.

Mr. FITZPATRICK. Mr. Speaker, there is no doubt that the medical device tax that is found within the President's Affordable Care Act sends American jobs overseas, hurts American jobs here in the United States, raises healthcare costs for all Americans, and stifles innovation.

While I have supported the House's action to repeal this onerous tax and support innovation, it is important that I highlight an important issue to my constituents back home in Bucks County, Pennsylvania, because it is tied into this whole debate. That issue is medical device safety, and it is patient safety.

Many who serve in this Chamber may have seen the headlines over the past several months regarding a medical device known as a power morcellator and, specifically, the devastating damage it has caused to women's health by spreading unsuspected cancer throughout their body.