114TH CONGRESS
1ST SESSION

S. _____

To establish a demonstration program requiring the utilization of Value-Based Insurance Design in order 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, enhance beneficiary satisfaction, and lower health care expenditures.

IN THE SENATE OF THE UNITED STATES

Mr. THUNE introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To establish a demonstration program requiring the utilization of Value-Based Insurance Design in order 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, enhance beneficiary satisfaction, 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 Seniors Copayment Reduction Act of 2015''.

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 reduces the use of such services. 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.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration program to test Value-Based Insurance Design methodologies in Medicare Advantage plans under part C of title XVIII of the Social Security Act for beneficiaries with chronic clinical conditions.

(b) DEMONSTRATION PROGRAM DESIGN.—

(1) IN GENERAL.—The Secretary shall select not less than 2 Medicare Advantage plans to participate in the demonstration program under this section.

(2) REQUIREMENTS.—A Medicare Advantage plan selected to participate in the demonstration program under paragraph (1) shall meet the following requirements:

(A) The plan offers a coordinated Medicare Part D drug benefit.

(B) The plan and the Medicare Advantage organization offering the plan meet such other criteria as the Secretary determines appropriate.

(c) EXPANSION OF DEMONSTRATION PROGRAM.—The Secretary shall expand the demonstration program by

issuing regulations 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 (e) or (f)(3) contains an evaluation that the demonstration program under this section—

(1) increases Medicare program expenditures for beneficiaries participating in the demonstration program; or

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

(d) VALUE-BASED INSURANCE DESIGN METHODOLOGY.—

(1) VALUE-BASED INSURANCE DESIGN.—For purposes of this section, ''Value-Based Insurance Design'' is a methodology for identifying specific prescription medications and clinical services for which copayments or coinsurance should be reduced or eliminated due to the high-value and effectiveness of such medications and services for specific clinical conditions.

(2) REDUCTION OF COPAYMENTS AND COINSURANCE.—Under the demonstration program, a Medicare Advantage organization, using Value-Based In-

surance Design methodologies, shall identify each prescription medication and clinical service for which the amount of the copayment or coinsurance payable should be reduced or eliminated.

(3) REDUCTION OF COPAYMENTS AND COINSURANCE TO ENCOURAGE USE OF SPECIFIC CLINICAL SERVICES.—Under the demonstration program, the Medicare Advantage organization, using Value-Based Insurance Design, may lower cost-sharing under the plan for the purpose of encouraging enrollees to use prescription medications and clinical services (such as preventive care, primary care, specialty visits, diagnostic tests, procedures, and durable medical equipment) that such organization has identified as high-value for the management of specified clinical conditions in paragraph (5). Any such variation on copayment or coinsurance by a Medicare Advantage organization must occur on an annual basis and be evidence-based.

(4) REDUCTION OF COPAYMENTS AND COINSURANCE TO ENCOURAGE USE OF SPECIFIC HIGH-PERFORMING PROVIDERS.—Under the demonstration program, the Medicare Advantage organization, using Value-Based Insurance Design, may lower cost-sharing under the plan for the purpose of en-

couraging enrollees to use providers that such organization has identified as high-performing based on quality metrics. Any such variation on copayment or coinsurance by a Medicare Advantage organization must occur on an annual basis.

(5) SPECIFIC CLINICAL CONDITIONS.—In identifying clinical conditions for purposes of paragraph (3), the Medicare Advantage organization shall, at a minimum, consider the services utilized across the spectrum of care in the management of the following clinical conditions:

(A) Asthma.

(B) Atrial fibrillation.

(C) Deep venous thrombosis.

(D) Cancer.

(E) Chronic obstructive pulmonary disease.

(F) Chronic renal failure/End stage renal disease.

(G) Congestive heart failure.

(H) Ischemic heart disease/Myocardial infarction.

(I) Depression.

(J) Diabetes mellitus.

(K) Hyperlipidemia.

(L) Hypertension.

(M) Osteoporosis.

(N) Stroke.

(O) Tobacco abuse disorder.

(6) PROHIBITION OF INCREASES OF COPAYMENTS AND COINSURANCE.—A Medicare Advantage plan selected to participate in the demonstration program under paragraph (1) may not raise cost-sharing on any item or service to discourage its use.

(e) REPORT ON IMPLEMENTATION.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the implementation by the Secretary of the demonstration program under this section.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A statement setting forth each medication and clinical service identified pursuant to subsection (d)(3).

(B) For each such medication or clinical service identified pursuant to subsection (d)(3), a statement of the amount of the copayment or coinsurance required to be paid for such service and the amount of the reduction from previous cost-sharing levels.

(C) For each such high-performing provider identified pursuant to subsection (d)(4), a statement of the amount of the copayment or coinsurance required to be paid for such clinician visit and the amount of the reduction from previous cost-sharing levels.

(f) 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, nonbiased entity having expertise in Value-Based Insurance Design 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 referred to in subsection (d).

(B) An analysis of whether reducing or eliminating the copayment or coinsurance for each medication and clinical service identified pursuant to subsection (d)(3) resulted in increased adherence to medication regimens, increased service utilization, improvement in qual-

ity metrics, better health outcomes, or enhanced beneficiary experience.

(C) An analysis of the cost-savings resulting from reducing or eliminating the copayment or coinsurance for each medication or clinical service so identified.

(D) An analysis of whether reducing or eliminating the copayment or coinsurance for each high-performing provider identified pursuant to subsection (d)(4) resulted in improvement in quality metrics, better health outcomes, or enhanced beneficiary experience.

(E) An analysis of the cost-savings resulting from reducing or eliminating the copayment or coinsurance for each high-performing provider so identified.

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

(2) REPORT.—The contract or agreement entered into under paragraph (1) shall require the entity concerned to submit to the Secretary a report on the review and assessment conducted by the entity under that 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 of the enactment of this Act, the Secretary shall submit to Congress a report on the review and assessment conducted under this subsection. The report shall include the following:

(A) A description of the results of the review and assessment.

(B) Such recommendations as the Secretary considers appropriate for enhancing the utilization of the methodologies referred to in subsection (d)(1) so as to reduce copayments and coinsurance paid by Medicare beneficiaries for high-value prescription medications and clinical services furnished under the Medicare program and to otherwise improve the quality of health care provided under such Medicare program.

(g) WAIVER.—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.