## AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2581

## Offered by M\_.

Strike all after the enacting clause and insert the following:

## 1 SECTION 1. SHORT TITLE.

- 2 This Act may be cited as the "Preservation of Access
- 3 for Seniors in Medicare Advantage Act of 2015".
- 4 SEC. 2. DEMONSTRATION PROGRAM.
- 5 (a) IN GENERAL.—The Secretary of Health and
- 6 Human Services (in this section referred to as the "Sec-
- 7 retary") shall establish a 3-year demonstration program
- 8 to test the use of value-based insurance design methodolo-
- 9 gies (as defined in subsection (c)(1)) under eligible Medi-
- 10 care Advantage plans offered by Medicare Advantage or-
- 11 ganizations under part C of title XVIII of the Social Secu-
- 12 rity Act (42 U.S.C. 1395w–21 et seq.). The Secretary may
- 13 extend the program to a duration of 4 or 5 years, as deter-
- 14 mined necessary by the Secretary in coordination with the
- 15 Centers for Medicare and Medicaid Innovation.
- 16 (b) Demonstration Program Design.—
- 17 (1) Selection of medicare advantage
- 18 SITES AND ELIGIBLE MEDICARE ADVANTAGE

1	PLANS.—Not later than two years after the date of
2	the enactment of this Act, the Secretary shall—
3	(A) select at least two Medicare Advantage
4	sites with respect to which to conduct the dem-
5	onstration program under this section; and
6	(B) approve eligible Medicare Advantage
7	plans to participate in such demonstration pro-
8	gram.
9	In selecting Medicare Advantage sites under sub-
10	paragraph (A), the Secretary shall take into account
11	area differences as well as the availability of health
12	maintenance organization plans and preferred pro-
13	vider organization plans offered in such sites.
14	(2) Start of Demonstration.—The dem-
15	onstration program shall begin not later than the
16	third plan year beginning after the date of the en-
17	actment of this Act.
18	(3) Eligible medicare advantage plans.—
19	For purposes of this section, the term "eligible
20	Medicare Advantage plan" means a Medicare Ad-
21	vantage plan under part C of title XVIII of the So-
22	cial Security Act (42 U.S.C. 1395w-21 et seq.) that
23	meets the following requirements:
24	(A) The plan is an Medicare Advantage re-
25	gional plan (as defined in paragraph (4) of sec-

2 (28(b))) or Medicare Advantage local plan (a defined in paragraph (5) of such section) of fered in the Medicare Advantage region selected under paragraph (1)(A).  (B) The plan has—  (i)(I) a quality rating under section (1853(o)) of such Act (42 U.S.C. 1395wc)  23(o)) of 4 stars or higher based on the most recent data available for such year or (II) in the case of a specialized Medicare Advantage plan for special needs indicated viduals, as defined in section (14 1859(b)(6)(A) of such Act (42 U.S.C. 1395wc)(6)(A)), a quality rating under section 1853(o) of such Act (44 U.S.C. 1395wc)(6)(A)), a quality rating under section 1853(o) of such Act (44 U.S.C. 1395wc)(1395wc)		
defined in paragraph (5) of such section) of fered in the Medicare Advantage region selected under paragraph (1)(A).  (B) The plan has—  (i)(I) a quality rating under section 1853(o) of such Act (42 U.S.C. 1395wd 23(o)) of 4 stars or higher based on the most recent data available for such year or (II) in the case of a specialized Medicare Advantage plan for special needs industrial viduals, as defined in section 1859(b)(6)(A) of such Act (42 U.S.C. 1395w-28(b)(6)(A)), a quality rating under section 1853(o) of such Act (44 U.S.C. 1395w-23(o)) equal to or higher than the national average for special needs plans (excluding Institutional-Special needs plans) based on the most recent data available for such year; and  (ii) at least 20 percent of the population to whom the plan is offered in	1	tion 1859(b) of such Act (42 U.S.C. 1395w-
fered in the Medicare Advantage region selected under paragraph (1)(A).  (B) The plan has—  (i)(I) a quality rating under section 1853(o) of such Act (42 U.S.C. 1395wc)  23(o)) of 4 stars or higher based on the most recent data available for such year or (II) in the case of a specialized Medicare Advantage plan for special needs ind viduals, as defined in section 1859(b)(6)(A) of such Act (42 U.S.C. 1395w-28(b)(6)(A)), a quality rating under section 1853(o) of such Act (43 U.S.C. 1395w-23(o)) equal to or higher than the national average for special needs plans (excluding Institutional-Special needs plans) based on the most recent data available for such year; and (ii) at least 20 percent of the population to whom the plan is offered in	2	28(b))) or Medicare Advantage local plan (as
under paragraph (1)(A).  (B) The plan has—  (i)(I) a quality rating under section 1853(o) of such Act (42 U.S.C. 1395wc)  23(o)) of 4 stars or higher based on the most recent data available for such year or (II) in the case of a specialized Medicare Advantage plan for special needs industrial viduals, as defined in section 1859(b)(6)(A) of such Act (42 U.S.C. 1395w-28(b)(6)(A)), a quality rating under section 1853(o) of such Act (42 U.S.C. 1395w-23(o)) equal to or higher than the national average for special needs plans (excluding Institutional-Special needs plans) based on the most recent data available for such year; and  (ii) at least 20 percent of the population to whom the plan is offered in	3	defined in paragraph (5) of such section) of-
(B) The plan has—  (i)(I) a quality rating under section 1853(o) of such Act (42 U.S.C. 1395wth 9 23(o)) of 4 stars or higher based on the most recent data available for such year or (II) in the case of a specialized Medicare Advantage plan for special needs individuals, as defined in section 13 viduals, as defined in section 14 1859(b)(6)(A) of such Act (42 U.S.C. 1395w-28(b)(6)(A)), a quality rating under section 1853(o) of such Act (43 U.S.C. 1395w-23(o)) equal to or higher than the national average for special needs plans (excluding Institutional-Special needs plans) based on the most recent data available for such year; and  (ii) at least 20 percent of the population to whom the plan is offered in	4	fered in the Medicare Advantage region selected
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than the national average for special need plans (excluding Institutional-Special need plans) based on the most recent data available for such year; and  (ii) at least 20 percent of the population to whom the plan is offered in	16	under section 1853(o) of such Act (42
plans (excluding Institutional-Special need plans) based on the most recent data available for such year; and (ii) at least 20 percent of the population to whom the plan is offered in	17	U.S.C. 1395w-23(o)) equal to or higher
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21 able for such year; and 22 (ii) at least 20 percent of the population to whom the plan is offered in	19	plans (excluding Institutional-Special needs
22 (ii) at least 20 percent of the population to whom the plan is offered in	20	plans) based on the most recent data avail-
lation to whom the plan is offered in	21	able for such year; and
	22	(ii) at least 20 percent of the popu-
24 service area consists of subsidy eligible in	23	lation to whom the plan is offered in a
·	24	service area consists of subsidy eligible in-
25 dividuals (as defined in section 1860F	25	dividuals (as defined in section 1860D-

1	14(a)(3)(A) of the Social Security Act (42
2	U.S.C. $1395w-114(a)(3)(A))$ .
3	(4) Disclosure to beneficiaries.—The Sec-
4	retary shall provide to each individual eligible to en-
5	roll under a Medicare Advantage plan approved to
6	participate under the demonstration program during
7	a plan year for which the plan is so selected—
8	(A) notification that the plan is partici-
9	pating in such demonstration program;
10	(B) background information on the dem-
11	onstration program;
12	(C) clinical data derived from the studies
13	resulting from the demonstration program; and
14	(D) notification of the potential benefits
15	that the individual will receive, and of the other
16	potential impacts that the individual will experi-
17	ence, on account of the participation of the plan
18	in the demonstration program.
19	(c) Value-Based Insurance Design Methodolo-
20	GIES.—
21	(1) Definition.—For purposes of this section,
22	the term "value-based insurance design method-
23	ology" means a methodology for identifying specific
24	prescription medications, and clinical services that
25	are payable under title XVIII of the Social Security

1	Act, for which the reduction of copayments, coinsur-
2	ance, or both, would improve the management of
3	specific chronic clinical conditions because of the
4	high value and effectiveness of such medications and
5	services for such specific chronic clinical conditions,
6	as approved by the Secretary.
7	(2) Use of methodologies to reduce co-
8	PAYMENTS AND COINSURANCE.—A Medicare Advan-
9	tage organization offering an eligible Medicare Ad-
10	vantage plan approved to participate under the dem-
11	onstration program, for each plan year for which the
12	plan is so selected and using value-based insurance
13	design methodologies—
14	(A) shall identify each prescription medica-
15	tion and clinical service covered under such
16	plan for which the plan proposes to reduce or
17	eliminate the copayment or coinsurance, with
18	respect to the management of specific chronic
19	clinical conditions (as specified by the Sec-
20	retary) of Medicare Advantage eligible individ-
21	uals (as defined in section 1851(a)(3) of the
22	Social Security Act (42 U.S.C. 1395w-
23	21(a)(3))) enrolled under such plans, for such
24	plan year;

1	(B) may, for such plan year, reduce or
2	eliminate copayments, coinsurance, or both for
3	such prescription medication and clinical serv-
4	ices so identified with respect to the manage-
5	ment of such conditions of such individuals—
6	(i) if such reduction or elimination is
7	evidence-based and for the purpose of en-
8	couraging such individuals in such plan to
9	use such prescription medications and clin-
10	ical services (such as preventive care, pri-
11	mary care, specialty visits, diagnostic tests,
12	procedures, and durable medical equip-
13	ment) with respect to such conditions; and
14	(ii) for the purpose of encouraging
15	such individuals in such plan to use health
16	care providers that such organization has
17	identified with respect to such plan year as
18	being high value providers; and
19	(C) if a reduction or elimination is applied
20	pursuant to subparagraph (B), with respect to
21	such medication and clinical services, shall, for
22	such plan year, count toward the deductible ap-
23	plicable to such individual under such plan
24	amounts that would have been payable by the
25	individual as copayment or coinsurance for such

1	medication and services if the reduction or
2	elimination had not been applied.
3	(3) Prohibition of increases of copay-
4	MENTS AND COINSURANCE.—In no case may any
5	Medicare Advantage plan participating in the dem-
6	onstration program increase, for any plan year for
7	which the plan is so participating, the amount of co-
8	payments or coinsurance for any item or service cov-
9	ered under such plan for purposes of discouraging
10	the use of such item or service.
11	(d) Report on Implementation.—
12	(1) IN GENERAL.—Not later than 1 year after
13	the date on which the demonstration program under
14	this section begins under subsection (b)(2), the Sec-
15	retary shall submit to Congress a report on the sta-
16	tus of the implementation of the demonstration pro-
17	gram.
18	(2) Elements.—The report required by para-
19	graph (1) shall, with respect to eligible Medicare Ad-
20	vantage plans participating in the demonstration
21	program for the first plan year of such program, in-
22	clude the following:
23	(A) A list of each medication and service
24	identified pursuant to subsection (c)(2)(A) for
25	such plan with respect to such plan year.

1	(B) For each such medication or service so
2	identified, the amount of the copayment or co-
3	insurance required under such plan with respect
4	to such plan year for such medication or service
5	and the amount of the reduction of such copay-
6	ment or coinsurance from a previous plan year.
7	(C) For each provider identified pursuant
8	to subsection (c)(2)(B)(ii) for such plan with
9	respect to such plan year, a statement of the
10	amount of the copayment or coinsurance re-
11	quired under such plan with respect to such
12	plan year and the amount of the reduction of
13	such copayment or coinsurance from the pre-
14	vious plan year.
15	(e) REVIEW AND ASSESSMENT OF UTILIZATION OF
16	Value-Based Insurance Design Methodologies.—
17	(1) IN GENERAL.—The Secretary shall enter
18	into a contract or agreement with an independent
19	entity to review and assess the implementation of
20	the demonstration program under this section. The
21	review and assessment shall include the following:
22	(A) An assessment of the utilization of
23	value-based insurance design methodologies by
24	Medicare Advantage plans participating under
25	such program.

1	(B) An analysis of whether reducing or
2	eliminating the copayment or coinsurance for
3	each medication and clinical service identified
4	pursuant to subsection (c)(2)(A) resulted in in-
5	creased adherence to medication regimens, in-
6	creased service utilization, improvement in qual-
7	ity metrics, better health outcomes, and en-
8	hanced beneficiary experience.
9	(C) An analysis of the extent to which
10	costs to Medicare Advantage plans under part
11	C of title XVIII of the Social Security Act par-
12	ticipating in the demonstration program is less
13	than costs to Medicare Advantage plans under
14	such part that are not participating in the dem-
15	onstration program.
16	(D) An analysis of whether reducing or
17	eliminating the copayment or coinsurance for
18	providers identified pursuant to subsection
19	(c)(2)(B)(ii) resulted in improvement in quality
20	metrics, better health outcomes, and enhanced
21	beneficiary experience.
22	(E) An analysis, for each provider so iden-
23	tified, the extent to which costs to Medicare Ad-
24	vantage plans under part C of title XVIII of the
25	Social Security Act participating in the dem-

1	onstration program is less than costs to Medi-
2	care Advantage plans under such part that are
3	not participating in the demonstration program.
4	(F) Such other matters as the Secretary
5	considers appropriate.
6	(2) Report.—The contract or agreement en-
7	tered into under paragraph (1) shall require such
8	entity to submit to the Secretary a report on the re-
9	view and assessment conducted by the entity under
10	such paragraph in time for the inclusion of the re-
11	sults of such report in the report required by para-
12	graph (3). Such report shall include a description, in
13	clear language, of the manner in which the entity
14	conducted the review and assessment.
15	(3) Report to congress.—Not later than 4
16	years after the date on which the demonstration pro-
17	gram begins under subsection (b)(2), the Secretary
18	shall submit to Congress a report on the review and
19	assessment of the demonstration program conducted
20	under this subsection. The report shall include the
21	following:
22	(A) A description of the results of the re-
23	view and assessment included in the report sub-
24	mitted pursuant to paragraph (2).

1	(B) Such recommendations as the Sec-
2	retary considers appropriate for enhancing the
3	utilization of the methodologies applied under
4	the demonstration program to all Medicare Ad-
5	vantage plans under part C of title XVIII of the
6	Social Security Act so as to reduce copayments
7	and coinsurance under such plans paid by
8	Medicare beneficiaries for high-value prescrip-
9	tion medications and clinical services for which
10	coverage is provided under such plans and to
11	otherwise improve the quality of health care
12	provided under such plans.
13	(4) Oversight report.—Not later than three
14	years after the date of the enactment of this Act, the
15	Comptroller General of the United States shall sub-
16	mit to Congress a report on the demonstration pro-
17	gram that includes an assessment, with respect to
18	individuals enrolled under Medicare Advantage plans
19	approved to participate under the demonstration
20	program, of the impact that the age, co-morbidities,
21	and geographic regions of such individuals had upon
22	the implementation of the demonstration program by
23	the plans with respect to such individuals.
24	(f) SAVINGS.—In no case may any reduction in bene-
25	ficiary copayments or coinsurance resulting from the im-

- 1 plementation of the demonstration program under this
- 2 section result in expenditures under parts A, B, and D
- 3 of the title XVIII of the Social Security Act that are great-
- 4 er than such expenditures without application of this sec-
- 5 tion.
- 6 (g) Expansion of Demonstration Program.—
- 7 Taking into account the review and assessment conducted
- 8 under subsection (e), the Secretary may, through notice
- 9 and comment rulemaking, expand (including implementa-
- 10 tion on a nationwide basis) the duration and scope of the
- 11 demonstration program under title XVIII of the Social Se-
- 12 curity Act, other than under the original medicare fee-for-
- 13 service program under parts A and B of such title, to the
- 14 extent determined appropriate by the Secretary, if the re-
- 15 quirements of paragraphs (1), (2) and (3) of subsection
- 16 (c) of section 1115A of the Social Security Act (42 U.S.C.
- 17 1315a), as applied to the testing of a model under sub-
- 18 section (b) of such section, applied to the demonstration
- 19 under this section.
- 20 (h) WAIVER AUTHORITY.—The Secretary may waive
- 21 such provisions of titles XI and XVIII of the Social Secu-
- 22 rity Act as may be necessary to carry out the demonstra-
- 23 tion program under this section.
- 24 (i) Implementation Funding.—For purposes of
- 25 carrying out the demonstration program under this sec-

1	tion, the Secretary shall provide for the transfer from the
2	Federal Hospital Insurance Trust Fund under section
3	1817 of the Social Security Act (42 U.S.C. 1395i) and
4	the Federal Supplementary Insurance Trust Fund under
5	section 1841 of the Social Security Act (42 U.S.C. 1395t),
6	including the Medicare Prescription Drug Account in such
7	Trust Fund, in such proportion as determined appropriate
8	by the Secretary, of such sums as may be necessary.
9	SEC. 3. PRESERVATION OF MEDICARE BENEFICIARY
10	CHOICE UNDER MEDICARE ADVANTAGE.
11	Section 1851(e)(2) of the Social Security Act (42
12	U.S.C. 1395w-21(e)(2)) is amended—
13	(1) in subparagraph (C)—
14	(A) in the heading, by inserting "FROM
15	2011 THROUGH 2015" after "45-DAY PERIOD";
16	and
17	(B) by inserting "and ending with 2015"
18	after "beginning with 2011"; and
19	(2) by adding at the end the following new sub-
20	paragraph:
21	"(G) Continuous open enrollment
22	AND DISENROLLMENT FOR FIRST 3 MONTHS IN
23	2016 AND SUBSEQUENT YEARS.—
24	"(i) In general.—Subject to clause
25	(ii) and subparagraph (D)—

1	"(I) in the case of an MA eligible
2	individual who is enrolled in an MA
3	plan, at any time during the first 3
4	months of a year (beginning with
5	2016); or
6	"(II) in the case of an individual
7	who first becomes an MA eligible indi-
8	vidual during a year (beginning with
9	2016) and enrolls in an MA plan, dur-
10	ing the first 3 months during such
11	year in which the individual is an MA
12	eligible individual;
13	such MA eligible individual may change the
14	election under subsection $(a)(1)$ .
15	"(ii) Limitation of one change
16	DURING OPEN ENROLLMENT PERIOD EACH
17	YEAR.—An individual may change the elec-
18	tion pursuant to clause (i) only once dur-
19	ing the applicable 3-month period de-
20	scribed in such clause in each year. The
21	limitation under this clause shall not apply
22	to changes in elections effected during an
23	annual, coordinated election period under
24	paragraph (3) or during a special enroll-
25	ment period under paragraph (4).

1	"(iii) Limited application to part
2	D.—Clauses (i) and (ii) of this subpara-
3	graph shall only apply with respect to
4	changes in enrollment in a prescription
5	drug plan under part D in the case of an
6	individual who, previous to such change in
7	enrollment, is enrolled in a Medicare Ad-
8	vantage plan.
9	"(iv) Limitations on Marketing.—
10	Pursuant to subsection (j), no unsolicited
11	marketing or marketing materials may be
12	sent to an individual described in clause (i)
13	during the continuous open enrollment and
14	disenrollment period established for the in-
15	dividual under such clause, notwith-
16	standing marketing guidelines established
17	by the Centers for Medicare & Medicaid
18	Services.".
19	SEC. 4. TREATMENT OF INFUSION DRUGS FURNISHED
20	THROUGH DURABLE MEDICAL EQUIPMENT.
21	Section 1842(o)(1) of the Social Security Act (42
22	U.S.C. 1395u(o)(1)) is amended—
23	(1) in subparagraph (C), by inserting "(and in-
24	cluding a drug or biological described in subpara-

1	graph (D)(i) furnished on or after January 1,
2	2017)" after "2005"; and
3	(2) in subparagraph (D)—
4	(A) by striking "infusion drugs" and in-
5	serting "infusion drugs or biologicals" each
6	place it appears; and
7	(B) in clause (i)—
8	(i) by striking "2004" and inserting
9	"2004, and before January 1, 2017"; and
10	(ii) by striking "for such drug".
11	SEC. 5. SENSE OF CONGRESS REGARDING THE IMPLEMEN-
12	TATION AND DISTRIBUTION OF QUALITY IN-
13	CENTIVE PAYMENTS TO MEDICARE ADVAN-
13 14	CENTIVE PAYMENTS TO MEDICARE ADVAN- TAGE PLANS.
14	TAGE PLANS.
14 15	TAGE PLANS.  It is the sense of Congress that—
14 15 16	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Serv-
14 15 16 17	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of sec-
14 15 16 17	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of section 1853 of the Social Security Act (42 U.S.C.
114 115 116 117 118	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of section 1853 of the Social Security Act (42 U.S.C. 1395w–23) as prohibiting the provision of any Medi-
14 15 16 17 18 19 20	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of section 1853 of the Social Security Act (42 U.S.C. 1395w–23) as prohibiting the provision of any Medicare quality incentive payments under subsection (o)
14 15 16 17 18 19 20 21	TAGE PLANS.  It is the sense of Congress that—  (1) the Secretary of Health and Human Services has incorrectly interpreted subsection (n) of section 1853 of the Social Security Act (42 U.S.C. 1395w–23) as prohibiting the provision of any Medicare quality incentive payments under subsection (o) of such section with respect to Medicare Advantage

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1	(2) the Secretary should immediately apply
2	quality incentive payments under such subsection (o)
3	with respect to such Medicare Advantage plans with-
4	out regard to the limits set forth in such subsection
5	(n).

