108TH CONGRESS
2D SESSION

S. 2343

To amend title XVIII of the Social Security Act to improve the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 22, 2004

Mr. CONRAD (for himself and Mrs. LINCOLN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to improve the medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO THE SOCIAL SECURITY ACT; REFERENCES TO MMA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Modernization Improvement Act of 2004''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever an amendment is expressed in terms of an amendment to or

repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO MMA AND SECRETARY.—In this Act:

(1) MMA.—The term ''MMA'' means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (117 Stat. 2066 et seq.).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—PROVIDING MEDICARE BENEFICIARIES WITH LOWER, NEGOTIATED PRESCRIPTION DRUG PRICES

SEC. 101. NEGOTIATING FAIR PRICES FOR MEDICARE PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1860D–11(i) (42 U.S.C. 1395w–111(i)) is amended to read as follows:

''(i) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—In order to ensure that beneficiaries enrolled under prescription drug plans and MA–PD plans pay the lowest possible price, the Secretary shall have authority to negotiate contracts with manufacturers of cov-

ered part D drugs as necessary to reduce prices and protect access to needed drugs, consistent with the requirements and in furtherance of the goals of providing quality care and containing costs under this part.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

SEC. 102. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 535) is amended—

(1) by striking subsection (l); and

(2) by redesignating subsection (m) as subsection (l).

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 1121 of MMA (117 Stat. 2464).

TITLE II—STABILIZING THE MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 201. REQUIRING TWO PRESCRIPTION DRUG PLANS TO AVOID FEDERAL FALLBACK.

Section 1860D–3(a) (42 U.S.C. 1395w–103(a)) is amended—

(1) in paragraph (1)—

(A) by striking ''qualifying plans (as defined in paragraph (3))'' and inserting ''prescription drug plans''; and

(B) by striking '', at least one of which is a prescription drug plan'';

(2) in paragraph (2), by striking ''qualifying plans'' and inserting ''prescription drug plans''; and

(3) by striking paragraph (3).

SEC. 202. IMPROVING THE STABILITY OF THE DRUG BENEFIT.

(a) IN GENERAL.—Section 1860D–3 (42 U.S.C. 1395w–103) is amended by adding at the end the following new subsection:

''(e) FALLBACK PRESCRIPTION DRUG PLANS TO BE AVAILABLE FOR 2 YEARS.—Notwithstanding subsection (b)(2), if the Secretary provides for the offering of a fallback prescription drug plan under subsection (a) in an area for a year, the following rules shall apply:

''(1) The fallback prescription drug plan shall be available for not less than a 2-year period.

''(2) The Secretary is not required to make the determination under subsection (a)(1) with respect to the second year in which the fallback prescription drug plan is offered in the area.

''(3) During the second year in which the fallback prescription drug plan is offered in an area, any part D eligible individual residing in the area (regardless of whether such individual was enrolled in the fallback prescription drug plan during the previous year) may elect to receive prescription drug coverage under the fallback prescription drug plan or through any other type of qualified prescription drug coverage available in the area, subject to the requirements of section 1860D–1.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

TITLE III—PROVIDING MEDICARE BENEFICIARIES WITH SOURCES OF ADDITIONAL PRESCRIPTION DRUG COVERAGE

SEC. 301. MAKING AVAILABLE WRAPAROUND COVERAGE THROUGH MEDIGAP.

(a) IN GENERAL.—Section 1882(v)(1) (42 U.S.C. 1395ss(v)(1)) is amended—

(1) in subparagraph (A), by inserting '', other than such a policy that provides wraparound prescription drug coverage included within a range of

such coverage approved under subparagraph (D)(ii),'' after ''paragraph (6)(A))''; and

(2) by adding at the end the following new subparagraph:

''(D) WRAPAROUND PRESCRIPTION DRUG COVERAGE.—

''(i) IN GENERAL.—Notwithstanding any other provision of this subsection, a medigap Rx policy that provides wraparound prescription drug coverage included within a range of such coverage approved by the Secretary under clause (ii) may be offered to part D enrollees.

''(ii) DEVELOPMENT OF STANDARDS.—The Secretary shall approve a range of wraparound prescription drug coverage that may be offered under this subparagraph to part D enrollees.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 104 of MMA (117 Stat. 2161).

TITLE IV—IMPROVED ACCESS TO PHARMACY CARE FOR MEDICARE BENEFICIARIES

SEC. 401. IMPROVING ACCESS TO PHARMACY CARE.

(a) APPLICATION OF TRICARE PHARMACY ACCESS STANDARDS.—Section 1860D–4(b)(1)(C)(ii) (42 U.S.C. 1395w–104(b)(1)(C)(ii)) is amended—

(1) by striking: ''APPLICATION OF TRICARE STANDARDS.—The Secretary shall'' and inserting the following: ''APPLICATION OF TRICARE STANDARDS.—

''(I) The Secretary shall''; and

(2) by adding at the end the following new subclauses:

''(II) In determining whether convenient access has been provided under subclause (I), the Secretary may only consider community retail pharmacies (as defined by the Secretary) that are accessible to the general public. The Secretary may not consider pharmacies located in long-term care facilities, pharmacies located in skilled nursing facilities, pharmacies operated by the Indian

Health Service, Indian tribes or tribal organizations, or urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act), mail order pharmacies, or pharmacies located in community health centers receiving funds under section 330 of the Public Health Service Act.

''(III) The Secretary shall make a separate determination under subclause (I) with respect to each State within the region served by the prescription drug plan or MA–PD plan.''.

(b) LEVEL PLAYING FIELD.—Section 1860D–4(b)(1)(D) (42 U.S.C. 1395w–104(b)(1)(D)) is amended to read as follows:

''(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive the same amount, scope, and duration of drugs and biologicals (which may include a 90-day supply of drugs or biologicals) and medication therapy management services through any pharmacy (other than a mail order pharmacy) as the sponsor permits enrollees to receive through a

mail order pharmacy, with any differential in charge paid by such enrollees.''.

(c) PROVISION OF COVERAGE INFORMATION BY PHARMACIES.—Section 1860D–4(a) is amended by adding at the end the following new paragraph:

''(5) DISSEMINATION OF INFORMATION BY PHARMACISTS.—

''(A) PAYMENT TO PHARMACIES.—Subject to subparagraph (C)(ii), beginning on January 1, 2006, and annually thereafter, the Secretary shall make an annual payment to each pharmacy participating in a pharmacy network of a PDP sponsor for providing information to enrollees in prescription drug plans and MA–PD plans offered by that sponsor in an amount determined by the Secretary based on an estimate of the number of enrollees in prescription drug plans and MA–PD plans served by the pharmacy and taking into account the costs of the pharmacy in distributing such information and the availability of funding under subparagraph (C).

''(B) PROVISION OF INFORMATION TO PHARMACIES.—Each PDP sponsor offering a prescription drug plan or an MA–PD plan shall

furnish each pharmacy that participates in its network with the information to be provided under subparagraph (A).

''(C) FUNDING.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall make payments under subparagraph (A) from the Medicare Prescription Drug Account.

''(ii) LIMITATION.—The Secretary may not make any payments under subparagraph (A) after the date on which a total of $500,000,000 have been expended from such Account as a result of the application of this paragraph.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

TITLE V—REPEAL OF HEALTH SAVINGS ACCOUNTS AND OTHER EMPLOYER RELATED PROVISIONS

SEC. 501. REPEAL OF HEALTH SAVINGS ACCOUNTS.

Section 1201 of MMA (117 Stat. 2469) is repealed and any provisions of law amended by such section are restored as if such section had not been enacted.

TITLE VI—IMPROVEMENT OF CHRONIC CARE MANAGEMENT

SEC. 601. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate 10 sites at which to conduct the demonstration program under this section, of which at least 4 shall be in a rural area. One of the sites shall be located in the State of Arkansas and 1 of the sites shall be in the State of North Dakota.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care coordinator who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) CARE COORDINATOR RESPONSIBILITIES.—The Secretary shall enter into an agreement with each care coordinator who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the care coordinator shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other care coordinators, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each care coordinator, on behalf of each eligible beneficiary under the care of that care coordinator, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) DEVELOPMENT OF FEE.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions

performed by the care coordinator under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the care coordinator, appropriate staff under the supervision of the care coordinator, and any other person under a contract with the care coordinator, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $1,000,000,000 for the costs of carrying out the demonstration program under this section.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such

legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE COORDINATOR.—The term ''care coordinator'' means a physician (as defined in subsection (r)(1)) or an entity that meets such conditions as the Secretary may specify (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) working in collaboration with a physician that—

(A) has entered into a care coordination agreement with the Secretary; and

(B) meets such other criteria as the Secretary may establish (which may include experience in the provision of care coordination).

(2) CHRONIC CONDITION.—The term ''chronic condition'' means an illness, functional limitation, or cognitive impairment that is expected to last at least one year, limits the activities of an individual, and requires ongoing care.

(3) ELIGIBLE INDIVIDUAL.—For purposes of this subsection, the term ''eligible individual'' means an individual who has—

(A) multiple chronic conditions, including dementia;

(B) a high rate of use of covered part D drugs (as defined in section 1860D–2(e)(1)); and

(C) a high rate of use of services for which payment is made under this title.

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(i) CONFORMING REPEAL.—

(1) REPEAL.—Section 649 of MMA (42 U.S.C. 1395b–1 note) is repealed.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if such section 649 was not included in the enactment of MMA (117 Stat. 2066 et seq.).

TITLE VII—REQUIRING MORE APPROPRIATE PAYMENTS TO PRIVATE PLANS

SEC. 701. ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND (SLUSH FUND).

(a) IN GENERAL.—Subsection (e) of section 1858 (42 U.S.C. 1395w–27a) is repealed.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if such subsection had not been included in the enactment of section 221(c) of MMA (117 Stat. 2181).

SEC. 702. REQUIRING PRIVATE PLAN PAYMENTS TO REFLECT APPROPRIATE HEALTH RISK ADJUSTMENT.

Effective January 1, 2005, in applying risk adjustment factors to payments to organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) in a budget neutral manner—

(1) the Secretary shall ensure that such factors, in the aggregate, take into account the actuarial characteristics of the entire medicare population, and not merely the population of individuals enrolled under a plan under part C of title XVIII of such Act; and

(2) the Secretary shall not make any adjustments in the aggregate amount of payments under this part solely for the purpose of ensuring that such aggregate payments are not affected in whole or in part by the application of such risk adjustment factors.

SEC. 703. PHASE-IN PRIVATE PLAN PAYMENT TO 100 PERCENT OF FEE-FOR-SERVICE RATE.

Notwithstanding any other provision of law, the Secretary shall provide, in a phased-in manner over a 5-year period beginning with 2005, for adjustment of payment rates to organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) so that, at the end of such phase-in period, such payment rates reflect only the payment rate described in subsection (c)(1)(D) of such section (relating to 100 percent fee-for-service payment).

TITLE VIII—REPEAL OF PREMIUM SUPPORT PROGRAM

SEC. 801. REPEAL OF PREMIUM SUPPORT PROGRAM.

Subtitle E of title II of MMA (117 Stat. 2214) is repealed and any provisions of law amended by such section are restored as if such subtitle had not been enacted.

TITLE IX—PROVIDING BETTER INFORMATION TO MEDICARE BENEFICIARIES

SEC. 901. PROVIDING ACCURATE INFORMATION TO BENEFICIARIES.

(a) IN GENERAL.—Section 1860D–1(c)(1) (42 U.S.C. 1395w–101(c)(1)) is amended by striking ''Such activities shall ensure that such information is first made available'' and inserting ''Such activities shall ensure that such information is not misleading, false, or deceptive and

appropriately targets part D eligible individuals (and prospective eligible individuals). Funding expended for these activities shall give priority to activities that directly target part D eligible individuals (and prospective eligible individuals), including face-to-face educational sessions with such individuals. This information shall be made available''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

SEC. 902. PROVIDING MEDICARE BENEFICIARIES WITH BETTER UPFRONT DRUG COVERAGE INFORMATION.

(a) IN GENERAL.—Section 1860D–1(c) (42 U.S.C. 1395w–101(c)) is amended by adding at the end the following new paragraph:

''(5) DISCLOSURE BY PLAN SPONSORS OF DRUG-SPECIFIC COVERAGE INFORMATION PRIOR TO ENROLLMENT.—

''(A) IN GENERAL.—Upon the request of any part D eligible individual, a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall disclose to the individual the information described in subparagraph (B) during the period in which the individual is eligible to elect coverage under

the plan so that such individual may take such information into account in determining whether to enroll under the plan.

''(B) INFORMATION DESCRIBED.—The information described in this subparagraph is as follows:

''(i) Access to specific covered part D drugs, including access through pharmacy networks.

''(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with section 1860D–4(a)(3).

''(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with section 1860D–4(a)(3).

''(iv) The medication therapy management program required under section 1860D–4(c). The provisions of section

1927(b)(3)(D) shall apply to information disclosed to the Secretary under this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

SEC. 903. ENSURING MEDICARE BENEFICIARIES ARE INFORMED OF FORMULARY CHANGES.

(a) IN GENERAL.—Section 1860D–4(a)(3)(B) (42 U.S.C. 1395w–104(a)(3)(B)) is amended to read as follows:

''(B) NOTIFICATION OF CHANGES IN FORMULARY THROUGH THE INTERNET, MAIL, AND TELEPHONE.—A PDP sponsor offering a prescription drug plan shall make available information on specific changes in the formulary under the plan (including changes to tiered or preferred status of covered part D drugs) on a timely basis—

''(i) through an Internet website;

''(ii) by mailing a notice of the specific changes to each enrollee who may be affected by such changes; and

"(iii) through the toll-free telephone number established under subparagraph (A).".

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 101 of MMA (117 Stat. 2071).

TITLE X—FULL FUNDING AND EXPANSION FOR DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS

SEC. 1001. FULL FUNDING AND EXPANSION FOR DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 641 of MMA (42 U.S.C. 1395*l* note) is amended—

(1) by striking subsection (b) and inserting the following new subsection:

"(b) NATIONWIDE COVERAGE.—The project established under this section shall be conducted throughout the entire United States."; and

(2) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''may not'' and inserting ''shall'';

(B) by striking paragraph (1) and inserting the following new paragraph:

''(1) coverage for each medicare beneficiary for whom a drug or biological described in subsection (a) is prescribed; and''; and

(C) in paragraph (2), by striking ''more than $500,000,000 in funding'' and inserting ''for not more than $2,100,000,000 in funding''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 641 of MMA (177 Stat. 2321).

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