111TH CONGRESS
1ST SESSION

S. 1630

To amend title XVIII of the Social Security Act to improve prescription drug coverage under Medicare part D and to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986, to improve prescription drug coverage under private health insurance, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 6, 2009

Mr. ROCKEFELLER (for himself and Mr. FRANKEN) 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 prescription drug coverage under Medicare part D and to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986, to improve prescription drug coverage under private health insurance, 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.

This Act may be cited as the ''Affordable Access to Prescription Medications Act of 2009''.

SEC. 2. MEDICARE PART D PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended by adding at the end the following new subparagraph:

"(E) ADDITIONAL PROTECTIONS.—

"(i) IN GENERAL.—Notwithstanding any other provision of this part, effective for plan years beginning on or after January 1, 2011, a PDP sponsor of a prescription drug plan and an MA organization offering an MA–PD plan shall, with respect to any co-payment or coinsurance requirements applicable to covered part D drugs under the plan, ensure that—

"(I) such required co-payment or coinsurance does not exceed the base cost of the covered part D drug (as determined by the Secretary);

"(II) such required co-payment or coinsurance does not exceed $200 per month for any single covered part D drug (30-day supply); and

"(III) such required co-payment or coinsurance does not exceed, in the aggregate for all covered part D drugs, $500 per month.

''(ii) ADJUSTMENTS.—The amounts described in clauses (II) and (III) of clause (i) shall be annually adjusted to reflect the average of the percentage increase or decrease in the Consumer Price Index for all urban consumers (U.S. city average) and the percentage increase or decrease in the medical care component of such Consumer Price Index during the calendar year preceding the year for which the adjustment is being made.''.

(b) EXPANSION OF EXCEPTIONS PROCESS.—Effective for plan years beginning on or after January 1, 2011, the Secretary shall expand the formulary tier exception request process under sections 423.560 through 423.636 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), to allow individuals enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act or an MA–PD plan under part C of such title to request an exception for a specialty prescription drug to a plan's designation of a covered part D drug (as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102(e)) as a non-preferred prescription drug.

(c) MEDPAC STUDIES AND REPORTS.—

(1) STUDY AND REPORT ON THE MEDICARE PART D ANTI-DISCRIMINATION CLAUSE.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on various aspects of the prescription drug program under part D of title XVIII of the Social Security Act and, to the greatest extent practicable, the interaction of such program with Medicare beneficiary access to covered drugs under part B of such title. Such study shall include the following:

(i) An analysis of—

(I) the use of specialty tiers for covered part D drugs under prescription drug plans and MA–PD plans; and

(II) the effect of such specialty tiers on access to care for Medicare beneficiaries.

(ii) Consideration of the mechanisms described in subparagraph (B) in the context of the provisions of section 1860D–11(e)(2)(D) of the Social Security Act (42 U.S.C. 1395w–111(e)(2)(D)) (in this para-

graph referred to as the ''Medicare part D anti-discrimination clause'').

(B) MECHANISMS DESCRIBED.—The following mechanisms are described in this subparagraph:

(i) The use of specialty tiers for covered part D drugs under prescription drug plans and MA–PD plans.

(ii) The application of segmented coinsurance or copayment structures to covered part D drugs based on certain categories of such drugs or diagnoses.

(iii) The utilization of other differential benefit structures based on certain conditions and Medicare beneficiaries under prescription drug plans and MA–PD plans, including an analysis of the interaction between such utilization and the effects of such utilization with the Medicare part D anti-discrimination clause.

(C) REPORT.—Not later than 1 year after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subparagraph (A), to-

gether with recommendations for such legislation and administrative action as the Commission determines appropriate.

(D) REVISED GUIDANCE.—Based on the results of the study conducted under subparagraph (A), the Secretary shall issue revised guidance regarding the use of mechanisms described in subparagraph (B) to all PDP sponsors offering prescription drug plans under part D of title XVIII of the Social Security Act and Medicare Advantage organizations offering MA–PD plans under part C of such title.

(2) STUDY AND REPORT ON COST-SHARING FOR PRESCRIPTION DRUGS UNDER PARTS B AND D.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on cost-sharing for prescription drugs under parts B and D of title XVIII of the Social Security Act. Such study shall include an analysis of the impact of eliminating cost-sharing for covered part D drugs for Medicare beneficiaries who—

(i) incur annual out-of-pocket cost-sharing after the initial coverage limit under section 1860D–2(b)(3) of such Act (42 U.S.C. 1395w–102) that exceeds 5

percent of the income of the beneficiary (as determined under section 1860D–14(a)(3)(C) of such Act (42 U.S.C. 1395w–114(a)(3)(C)); and

(ii) do not otherwise qualify for an income-related subsidy under section 1860D–14(a) of such Act (42 U.S.C. 1395w–114(a)) or other extra help or cost-sharing relief.

(B) REPORT.—Not later than 6 months after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term ''covered part D drug'' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) MA–PD PLAN.—The term ''MA–PD'' plan has the meaning given such term in para-

graph (9) of section 1860D–41(a) of such Act (42 U.S.C. 1395w–151(a)).

(C) MEDICARE ADVANTAGE ORGANIZATION.—The term ''Medicare Advantage organization'' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28(a)(1)).

(D) PDP SPONSOR.—The term ''PDP sponsor'' has the meaning given such term in paragraph (13) of such section 1860D–41(a).

(E) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in paragraph (14) of such section.

SEC. 3. PRIVATE HEALTH INSURANCE.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2708. PROVISIONS RELATING TO PRESCRIPTION DRUGS.

''(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for prescription drugs shall, with respect to any co-payment or coinsurance requirements applicable to such drug coverage, ensure that—

''(1) such required co-payment or coinsurance does not exceed the base cost of the prescription drug (as determined by the Secretary);

''(2) such required co-payment or coinsurance does not exceed $200 per month for any single prescription drug (30-day supply); and

''(3) such required co-payment or coinsurance does not exceed, in the aggregate for all prescription drugs, $500 per month.

''(b) ADJUSTMENTS.—The amounts described in paragraphs (2) and (3) of subsection (a) shall be annually adjusted to reflect the average of the percentage increase or decrease in the Consumer Price Index for all urban consumers (U.S. city average) and the percentage increase or decrease in the medical care component of such Consumer Price Index during the calendar year preceding the year for which the adjustment is being made.

''(c) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 714(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 715. PROVISIONS RELATING TO PRESCRIPTION DRUGS.

''(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for prescription drugs shall, with respect to any co-payment or coinsurance requirements applicable to such drug coverage, ensure that—

''(1) such required co-payment or coinsurance does not exceed the base cost of the prescription

drug (as determined by the Secretary of Health and Human Services);

''(2) such required co-payment or coinsurance does not exceed $200 per month for any single prescription drug (30-day supply); and

''(3) such required co-payment or coinsurance does not exceed, in the aggregate for all prescription drugs, $500 per month.

''(b) ADJUSTMENTS.—The amounts described in paragraphs (2) and (3) of subsection (a) shall be annually adjusted to reflect the average of the percentage increase or decrease in the Consumer Price Index for all urban consumers (U.S. city average) and the percentage increase or decrease in the medical care component of such Consumer Price Index during the calendar year preceding the year for which the adjustment is being made.

''(c) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 714(b) with respect to the requirements of this section as if such section applied to such plan.''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Provisions relating to prescription drugs.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9813. PROVISIONS RELATING TO PRESCRIPTION DRUGS.

''(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for prescription drugs shall, with respect to any co-payment or coinsurance requirements applicable to such drug coverage, ensure that—

''(1) such required co-payment or coinsurance does not exceed the base cost of the prescription drug (as determined by the Secretary of Health and Human Services);

''(2) such required co-payment or coinsurance does not exceed $200 per month for any single prescription drug (30-day supply); and

''(3) such required co-payment or coinsurance does not exceed, in the aggregate for all prescription drugs, $500 per month.

''(b) ADJUSTMENTS.—The amounts described in paragraphs (2) and (3) of subsection (a) shall be annually adjusted to reflect the average of the percentage increase or decrease in the Consumer Price Index for all urban consumers (U.S. city average) and the percentage increase or decrease in the medical care component of such Consumer Price Index during the calendar year preceding the year for which the adjustment is being made.

''(c) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 714(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CLERICAL AMENDMENT.—The table of sections for such subchapter is amended by adding at the end the following new item:

''Sec. 9813. Provisions relating to prescription drugs.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2754. PROVISIONS RELATING TO PRESCRIPTION DRUGS.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply

to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2754''.

(c) APPLICATION TO FEHBP.—The amendments made by this section shall apply to the administration of chapter 89 of title 5, United States Code.

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