



## **Summary of Senate Bill 1188**

### **Coordination of Benefits between PACE/PACENET and Medicare Part D**

April 4, 2006

#### **Synopsis**

Senate Bill 1188 provides for the comprehensive coordination of benefits between the new Medicare prescription drug program (Part D) and the longstanding Pennsylvania PACE/PACENET program.

#### **Overview**

The legislation establishes the PACE/PACENET program as a supplement to the benefits available under Medicare Part D. PACE/PACENET benefits would fill in the gaps of Part D by providing coverage to PACE/PACENET enrollees for prescription drugs not covered by the Part D plans and prescription drugs purchased in the deductible phase or the "donut hole" of Part D.

The program would cover the cost of Part D premiums for PACE enrollees. The PACENET \$40 per month deductible would be eliminated. In addition, the program would cover the difference between co-payments charged by the Part D plans and the PACE/PACENET co-payments.

#### **Impact**

The coordination of benefits between the Federal and State programs is designed to enable PACE/PACENET enrollees to maintain the same coverage they currently enjoy while shifting to the Federal program some costs that have typically been incurred by the State program.

Individuals meeting the income guidelines for PACE/PACENET who enroll in a Part D plan but who have not previously enrolled in PACE/PACENET may now have additional incentive to do so because of the changes implemented by legislation. Some current PACE/PACENET enrollees are expected to experience lower costs as a result of the elimination of the PACENET deductible or qualification for lower co-payments under the Low Income Subsidy (LIS) of Medicare Part D.

### **Details**

- The Department of Aging would be authorized to approve Part D prescription drug plans (PDPs) for the coordination of benefits. The department shall consider the following in making the plan selections:
  - The prescription drugs covered by the plan.
  - The pharmacy network maintained by the plan.
  - The cost to PACE/PACENET enrollees and the Commonwealth.
- The Department would be authorized to advise PACE/PACENET enrollees in identifying and enrolling in the Part D prescription drug plan that best suits their needs based on the enrollee's prescription drug usage and preferred pharmacy.
- The Department would assist eligible PACE/PACENET enrollees in applying for the Low Income Subsidy (LIS) offered as part of the Medicare Part D program. (Those qualified for the LIS will generally have lower co-payments on prescriptions than the regular PACE or PACENET co-payments.) The Department would be authorized to obtain information on the financial resources of individuals who appear to be qualified for the LIS in order to assist in the application process. The information would be subject to confidentiality requirements, with penalties for violations.
- The program would pay the Part D premium for PACE enrollees. The PACENET \$40 per month deductible would be eliminated and PACENET enrollees would pay the premium charged by their Part D provider. PACENET enrollees who do not enroll in a Part D plan would pay a premium equal to the regional benchmark premium for Part D providers.
- The program would pay any Part D plan co-payments in excess of PACE/PACENET co-payments.
- Enrollees in a Part D plan would be required to use the providers required by the Part D plan.
- Various technical changes are incorporated into the legislation.

## AN ACT

1 Amending the act of August 26, 1971 (P.L.351, No.91), entitled  
2 "An act providing for a State Lottery and administration  
3 thereof; authorizing the creation of a State Lottery  
4 Commission; prescribing its powers and duties; disposition of  
5 funds; violations and penalties therefor; exemption of prizes  
6 from State and local taxation and making an appropriation,"  
7 further providing for definitions, for physician, certified  
8 registered nurse practitioner and pharmacy participation, for  
9 reduced assistance, for program generally, for restricted  
10 formulary, for reimbursement, for income verification, for  
11 contracts and for the pharmaceutical assistance contract for  
12 the elderly needs enhancement tier, for pharmacy best  
13 practices and cost controls review; further providing for  
14 penalties; establishing the coordination of Federal and State  
15 benefits; and making editorial changes.

16 The General Assembly of the Commonwealth of Pennsylvania  
17 hereby enacts as follows:

18 Section 1. Chapter 5 of the act of August 26, 1971 (P.L.351,  
19 No.91), known as the State Lottery Law, is amended by adding a  
20 subchapter heading to read:

21 SUBCHAPTER A

22 PRELIMINARY PROVISIONS

23 Section 1.1. The definitions of "eligible claimant,"  
24 "maximum annual income" and "program" in section 502 of the act,

1 amended or added November 21, 1996 (P.L.741, No.134) and  
2 November 26, 2003 (P.L.212, No.37), are amended and the section  
3 is amended by adding definitions to read:

4 Section 502. Definitions.

5 The following words and phrases when used in this chapter  
6 shall have the meanings given to them in this section unless the  
7 context clearly indicates otherwise:

8 \* \* \*

9 "Claimant." An eligible person who is enrolled in the  
10 program.

11 \* \* \*

12 "Eligible [claimant] person." A resident of the Commonwealth  
13 for no less than 90 days, who is 65 years of age [and over] or  
14 older, whose annual income is less than the maximum annual  
15 income and who is not otherwise qualified for public assistance  
16 under the act of June 13, 1967 (P.L.31, No.21), known as the  
17 Public Welfare Code.

18 \* \* \*

19 "Maximum annual income." For PACE eligibility, the term  
20 shall mean annual income which shall not exceed \$14,500 in the  
21 case of single persons nor \$17,700 in the case of the combined  
22 annual income of persons married to each other. For PACENET  
23 eligibility, the term shall mean the annual income limits  
24 established under section 519. Persons may, in reporting income  
25 to the Department of Aging, round the amount of each source of  
26 income and the income total to the nearest whole dollar, whereby  
27 any amount which is less than 50¢ is eliminated.

28 "Medicare advantage." A plan of health benefits coverage  
29 offered under a policy, contract or plan by an organization  
30 certified under 42 U.S.C. § 1395w-26 (relating to establishment

1 of standards) and formerly referred to as Medicare+Choice.

2 \* \* \*

3 "Part D." A Federal program to offer voluntary prescription  
4 drug benefits to Medicare enrollees, as set forth in the  
5 Medicare Prescription Drug, Improvement, and Modernization Act  
6 of 2003 (Public Law 108-173, 117 Stat. 2066).

7 "Part D plan" or "PDP." A prescription drug plan approved  
8 under the Medicare Prescription Drug, Improvement, and  
9 Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066)  
10 in the PDP region that includes this Commonwealth, and approved  
11 by the Department of Aging of the Commonwealth and the Centers  
12 for Medicare and Medicaid Services of the United States for  
13 coordination of benefits with the programs established under  
14 this chapter.

15 \* \* \*

16 "Program." The Pharmaceutical Assistance Contract for the  
17 Elderly (PACE) and the Pharmaceutical Assistance Contract for  
18 the Elderly Needs Enhancement Tier (PACENET) as established by  
19 this chapter[, unless otherwise specified].

20 \* \* \*

21 "Regional benchmark premium." The average Part D premium  
22 calculated annually by the Centers for Medicare and Medicaid  
23 Services of the United States for PDPs in the PDP region that  
24 includes this Commonwealth.

25 Section 1.2. Chapter 5 of the act is amended by adding a  
26 subchapter heading to read:

27 SUBCHAPTER B

28 PROGRAMS

29 Section 2. Section 504 of the act, amended November 26, 2003  
30 (P.L.212, No.37), is amended to read:

1 Section 504. Physician, certified registered nurse practitioner  
2 and pharmacy participation.

3 Any physician, certified registered nurse practitioner,  
4 pharmacist, pharmacy or corporation owned in whole or in part by  
5 a physician, certified registered nurse practitioner or  
6 pharmacist enrolled as a provider in the program or who has  
7 prescribed medication for a claimant [in the program] who is  
8 precluded or excluded for cause from the Department of Public  
9 Welfare's Medical Assistance Program shall be precluded or  
10 excluded from participation in the program. No physician or  
11 certified registered nurse practitioner precluded or excluded  
12 from the Department of Public Welfare's Medical Assistance  
13 Program shall have claims resulting from prescriptions paid for  
14 by the program.

15 Section 3. Section 506 of the act, added November 21, 1996  
16 (P.L.741, No.134), is amended to read:

17 Section 506. Reduced assistance.

18 Any [eligible] claimant whose prescription drug costs are  
19 covered in part by any other plan of assistance or insurance,  
20 including Part D, may be required to receive reduced assistance  
21 under the provisions of this [chapter] subchapter or be subject  
22 to coordination of benefits under this chapter.

23 Section 4. Section 509 of the act, amended November 26, 2003  
24 (P.L.212, No.37), is amended to read:

25 Section 509. Program generally.

26 The program shall include the following:

27 (1) Participating pharmacies shall be paid within 21  
28 days of the contracting firm receiving the appropriate  
29 substantiation of the transaction. Pharmacies shall be  
30 entitled to interest for payment not made within the 21-day

1 period at a rate approved by the board.

2 (2) Collection of the copayment by pharmacies shall be  
3 mandatory.

4 (3) [Senior citizens participating in the program]  
5 Claimants are not required to maintain records of each  
6 transaction.

7 (4) A system of rebates or reimbursements to [eligible]  
8 claimants for pharmaceutical expenses shall be prohibited.

9 (5) PACE shall include participant copayment schedules  
10 for each prescription, including a copayment for generic or  
11 multiple-source drugs that is less than the copayment for  
12 single-source drugs. The department shall annually calculate  
13 the copayment schedules based on the Prescription Drugs and  
14 Medical Supplies Consumer Price Index. When the aggregate  
15 impact of the Prescription Drugs and Medical Supplies  
16 Consumer Price Index equals or exceeds \$1, the department  
17 shall adjust the copayment schedules. Each copayment schedule  
18 shall not be increased by more than \$1 in a calendar year.

19 (6) The program payment shall be the lower of the  
20 following amounts determined as follows:

21 (i) 90% of the average wholesale cost of the  
22 prescription drug dispensed:

23 (A) with the addition of a dispensing fee of the  
24 greater of:

25 (I) \$4; or

26 (II) the amount set by the department by  
27 regulation;

28 (B) the subtraction of the copayment; and

29 (C) if required, the subtraction of the generic  
30 differential; or

1 (ii) the pharmacy's usual charge for the drug  
2 dispensed with the subtraction of the copayment and, if  
3 required, the subtraction of the generic differential; or

4 (iii) if a generic drug, the most current Federal  
5 upper payment limits established in the Medicaid Program  
6 under 42 CFR § 447.332 (relating to upper limits for  
7 multiple source drugs), plus a dispensing fee of \$4 or  
8 the amount set by the department by regulation, whichever  
9 is greater minus the copayment. The department shall  
10 update the average wholesale costs and the Federal upper  
11 payment limits at least every 30 days.

12 (7) In no case shall the Commonwealth or any [person  
13 enrolled in the program] claimant be charged more than the  
14 price of the drug at the particular pharmacy on the date of  
15 the sale.

16 (8) The Governor may, based upon certified State Lottery  
17 Fund revenue that is provided to both the chairman and  
18 minority chairman of the Appropriations Committee of the  
19 Senate and the chairman and minority chairman of the  
20 Appropriations Committee of the House of Representatives, and  
21 after consultation with the board, decrease the eligibility  
22 limits established in this [chapter] subchapter.

23 Section 5. Section 510 of the act, amended or added November  
24 21, 1996 (P.L.741, No.134) and November 30, 2004 (P.L.1722,  
25 No.219), is amended to read:

26 Section 510. Generic drugs.

27 (a) In general.--Notwithstanding any other statute or  
28 regulation, a brand name product shall be dispensed and not  
29 substituted with an A-rated generic therapeutically equivalent  
30 drug if it is less expensive to the program. If a less expensive

1 A-rated generic therapeutically equivalent drug is available for  
2 dispensing to a claimant, the provider shall dispense the A-  
3 rated generic therapeutically equivalent drug to the claimant.  
4 The department shall reimburse providers based upon the most  
5 current listing of Federal upper payment limits established in  
6 the Medicaid Program under 42 CFR § 447.332 (relating to upper  
7 limits for multiple source drugs), plus a dispensing fee as set  
8 forth in section 509(6). The department shall update the average  
9 wholesale costs and the Federal upper payment limits on a  
10 regular basis, at least every 30 days. The department shall not  
11 reimburse providers for brand name products except in the  
12 following circumstances:

13 (1) There is no A-rated generic therapeutically  
14 equivalent drug available on the market. This paragraph does  
15 not apply to the lack of availability of an A-rated generic  
16 therapeutically equivalent drug in the providing pharmacy  
17 unless it can be shown to the department that the provider  
18 made reasonable attempts to obtain the A-rated generic  
19 therapeutically equivalent drug or that there was an  
20 unforeseeable demand and depletion of the supply of the A-  
21 rated generic therapeutically equivalent drug. In either  
22 case, the department shall reimburse the provider for 90% of  
23 the average wholesale cost plus a dispensing fee based on the  
24 least expensive A-rated generic therapeutically equivalent  
25 drug for the brand drug dispensed.

26 (2) An A-rated generic therapeutically equivalent drug  
27 is deemed by the department, in consultation with a  
28 utilization review committee, to have too narrow a  
29 therapeutic index for safe and effective dispensing in the  
30 community setting. The department shall notify providing

1 pharmacies of A-rated generic therapeutically equivalent  
2 drugs that are identified pursuant to this paragraph on a  
3 regular basis.

4 (3) The Department of Health has determined that a drug  
5 shall not be recognized as an A-rated generic therapeutically  
6 equivalent drug for purpose of substitution under section  
7 5(b) of the act of November 24, 1976 (P.L.1163, No.259),  
8 referred to as the Generic Equivalent Drug Law.

9 (4) At the time of dispensing, the provider has a  
10 prescription on which the brand name drug dispensed is billed  
11 to the program by the provider at a usual and customary  
12 charge which is equal to or less than the least expensive  
13 usual and customary charge of any A-rated generic  
14 therapeutically equivalent drug reasonably available on the  
15 market to the provider.

16 (5) The brand name drug is less expensive to the  
17 program.

18 (b) Generic not accepted.--If a claimant chooses not to  
19 accept the A-rated generic therapeutically equivalent drug  
20 required by subsection (a), the claimant shall be liable for the  
21 copayment and 70% of the average wholesale cost of the brand  
22 name drug.

23 (c) Generic drugs not deemed incorrect substitution.--The  
24 dispensing of an A-rated generic therapeutically equivalent drug  
25 in accordance with this [chapter] subchapter shall not be deemed  
26 incorrect substitution under section 6(a) of the Generic  
27 Equivalent Drug Law.

28 (d) Medical exception.--A medical exception process shall be  
29 established by the department, which shall be published as a  
30 notice in the Pennsylvania Bulletin and distributed to providers

1 and recipients in the program.

2 Section 6. Sections 512 and 515 of the act, amended November  
3 26, 2003 (P.L.212, No.37), are amended to read:

4 Section 512. Restricted formulary.

5 The department may establish a restricted formulary of the  
6 drugs which will not be reimbursed by the program. This  
7 formulary shall include only experimental drugs and drugs on the  
8 Drug Efficacy Study Implementation List prepared by CMS. A  
9 medical exception may be permitted by the department for  
10 reimbursement of a drug on the Drug Efficacy Study  
11 Implementation List upon declaration of its necessity on the  
12 prescription by the treating physician or certified registered  
13 nurse practitioner, except that, for DESI drugs for which the  
14 FDA has issued a Notice for Opportunity Hearing (NOOH) for the  
15 purpose of withdrawing the New Drug Application approved for  
16 that drug, reimbursement coverage shall be discontinued under  
17 the provisions of this [chapter] subchapter.

18 Section 515. Reimbursement.

19 For-profit third-party insurers, health maintenance  
20 organizations, preferred provider organizations [and], not-for-  
21 profit prescription plans, Medicare advantage plans and PDPs  
22 shall be responsible for any payments made to a providing  
23 pharmacy on behalf of a claimant covered by such a third party.  
24 Final determination as to the existence of third-party coverage  
25 shall be the responsibility of the department.

26 Section 7. Sections 517 and 518 of the act, added November  
27 21, 1996 (P.L.741, No.134), are amended to read:

28 Section 517. Income verification.

29 (a) Procedure.--The department shall annually verify the  
30 income of [eligible] claimants. The department shall verify the

1 income of [eligible] claimants by requiring income documentation  
2 from the claimants. An application for benefits under this  
3 [chapter] subchapter shall constitute a waiver to the department  
4 of all relevant confidentiality requirements relating to the  
5 claimant's Pennsylvania State income tax information in the  
6 possession of the Department of Revenue. The Department of  
7 Revenue shall provide the department with the necessary income  
8 information shown on the claimant's Pennsylvania State income  
9 tax return solely for income verification purposes.

10 (b) Information confidential.--It shall be unlawful for any  
11 officer, agent or employee of the department to divulge or make  
12 known in any manner whatsoever any information gained through  
13 access to the Department of Revenue information except for  
14 official income verification purposes under this [chapter]  
15 subchapter or as authorized under section 534.

16 (c) Penalty.--A person who violates this [act] section  
17 commits a misdemeanor and shall, upon conviction, be sentenced  
18 to pay a fine of not more than \$1,000 or to imprisonment for not  
19 more than one year, or both, together with the cost of  
20 prosecution, and, if the offender is an officer or employee of  
21 the Commonwealth, he shall be dismissed from office or  
22 discharged from employment.

23 (d) Coordination with Department of Public Welfare.--To the  
24 extent possible, the department and the Department of Public  
25 Welfare shall coordinate efforts to facilitate the application  
26 and enrollment of eligible older people in the Medicaid Healthy  
27 Horizons Program by processing these applications at senior  
28 citizens centers and other appropriate facilities providing  
29 services to the elderly.

30 Section 518. Contract.

1 The department is authorized to enter into a contract  
2 providing for prescription drugs to [eligible persons] claimants  
3 pursuant to this [chapter] subchapter. The department shall  
4 select a proposal that includes, but is not limited to, the  
5 criteria set forth in this [chapter] subchapter.

6 Section 8. Section 519 of the act, amended November 26, 2003  
7 (P.L.212, No.37), is amended to read:

8 Section 519. The Pharmaceutical Assistance Contract for the  
9 Elderly Needs Enhancement Tier.

10 (a) Establishment.--There is hereby established within the  
11 department a program to be known as the Pharmaceutical  
12 Assistance Contract for the Elderly Needs Enhancement Tier  
13 [(PACENET)].

14 (b) PACENET eligibility.--A [claimant] person with an annual  
15 income of not less than \$14,500 and not more than \$23,500 in the  
16 case of a single person and of not less than \$17,700 and not  
17 more than \$31,500 in the case of the combined income of persons  
18 married to each other shall be eligible for enhanced  
19 pharmaceutical assistance under this section. A person may, in  
20 reporting income to the department, round the amount of each  
21 source of income and the income total to the nearest whole  
22 dollar, whereby any amount which is less than 50¢ is eliminated.

23 [(c) Deductible.--Upon enrollment in PACENET, eligible  
24 claimants in the income ranges set forth in subsection (b) shall  
25 be required to meet a deductible in unreimbursed prescription  
26 drug expenses of \$40 per person per month. The \$40 monthly  
27 deductible shall be cumulative and shall be applied to  
28 subsequent months to determine eligibility. The cumulative  
29 deductible shall be determined on an enrollment year basis for  
30 an annual total deductible not to exceed \$480 in a year. To

1 qualify for the deductible set forth in this subsection the  
2 prescription drug must be purchased for the use of the eligible  
3 claimant from a provider as defined in this chapter. The  
4 department, after consultation with the board, may approve an  
5 adjustment in the deductible on an annual basis.]

6 (c.1) Premium.--In those instances in which a PACENET  
7 claimant does not enroll in Part D, the claimant shall be  
8 required to pay a monthly premium equivalent to the regional  
9 benchmark premium.

10 (d) Copayment.--

11 (1) For [eligible] claimants under this section, the  
12 copayment schedule shall be:

13 (i) eight dollars for noninnovator multiple source  
14 drugs as defined in section 702; or

15 (ii) fifteen dollars for single-source drugs and  
16 innovator multiple-source drugs as defined in section  
17 702.

18 (2) The department shall annually calculate the  
19 copayment schedules based on the Prescription Drugs and  
20 Medical Supplies Consumer Price Index. When the aggregate  
21 impact of the Prescription Drugs and Medical Supplies  
22 Consumer Price Index equals or exceeds \$1, the department  
23 shall adjust the copayment schedules. Each copayment schedule  
24 shall not be increased by more than \$1 in a calendar year.

25 Section 9. Section 520.1 of the act, added November 26, 2003  
26 (P.L.212, No.37), is amended to read:

27 [Section 520.1. Pharmacy best practices and cost controls  
28 review.

29 (a) Review process.--The secretary shall review and  
30 recommend pharmacy best practices and cost control mechanisms

1 that maintain high quality in prescription drug therapies but  
2 are designed to reduce the cost of providing prescription drugs  
3 for PACE and PACENET enrollees, including:

4 (1) A list of covered prescription drugs with  
5 recommended copayment schedules. In developing the schedules,  
6 the department shall take into account the standards  
7 published in the United States Pharmacopeia Drug Information.

8 (2) A drug utilization review procedure, incorporating a  
9 prescription review process for copayment schedules.

10 (3) A step therapy program that safely and effectively  
11 utilizes in a sequential manner the least costly  
12 pharmacological therapy to treat the symptoms of or effect a  
13 cure for the medical condition or illness for which the  
14 therapy is prescribed.

15 (4) Education programs designed to provide information  
16 and education on the therapeutic and cost-effective  
17 utilization of prescription drugs to physicians, pharmacists,  
18 certified registered nurse practitioners and other health  
19 care professionals authorized to prescribe and dispense  
20 prescription drugs.

21 (b) Report and recommendations.--No later than two years  
22 from the effective date of this section, the department shall  
23 submit a report with recommendations to the Aging and Youth  
24 Committee, the Appropriations Committee and the Public Health  
25 and Welfare Committee of the Senate and the Aging and Older  
26 Adult Services Committee, the Appropriations Committee and the  
27 Health and Human Services Committee of the House of  
28 Representatives. The report shall include information regarding  
29 the efficacy of the pharmacy best practices and control  
30 mechanisms set forth in subsection (a), including recommended

1 copayment schedules with impacted classes of drugs, exceptions,  
2 cost effectiveness, improved drug utilization and therapies,  
3 movement of market share and increased utilization of generic  
4 drugs.]

5 Section 10. Section 521 of the act, amended or added  
6 November 21, 1996 (P.L.741, No.134) and November 26, 2003  
7 (P.L.212, No.37), is amended to read:

8 Section 521. Penalties.

9 (a) Prohibited acts.--It shall be unlawful for any person to  
10 submit a false or fraudulent claim or application under this  
11 [chapter] subchapter, including, but not limited to:

12 (1) aiding or abetting another in the submission of a  
13 false or fraudulent claim or application;

14 (2) receiving benefits or reimbursement under a private,  
15 Federal or State program for prescription assistance and  
16 claiming or receiving duplicative benefits hereunder;

17 (3) soliciting, receiving, offering or paying any  
18 kickback, bribe or rebate, in cash or in kind, from or to any  
19 person in connection with the furnishing of services under  
20 this [chapter] subchapter;

21 (4) engaging in a pattern of submitting claims that  
22 repeatedly uses incorrect National Drug Code numbers [for the  
23 purpose of obtaining wrongful enhanced reimbursement]; or

24 (5) otherwise violating any provision of this [chapter]  
25 subchapter.

26 (b) Civil penalty.--In addition to any appropriate criminal  
27 penalty for prohibited acts under this [chapter] subchapter  
28 whether or not that act constitutes a crime under 18 Pa.C.S.  
29 (relating to crimes and offenses), a provider who violates this  
30 section may be liable for a civil penalty in an amount not less

1 than \$500 and not more than \$10,000 for each violation of this  
2 act which shall be collected by the department. Each violation  
3 constitutes a separate offense. If the department collects three  
4 or more civil penalties against the same provider, the provider  
5 shall be ineligible to participate in either PACE or PACENET for  
6 a period of one year. If more than three civil penalties are  
7 collected from any provider, the department may determine that  
8 the provider is permanently ineligible to participate in PACE or  
9 PACENET.

10 (c) Suspension of license.--The license of any provider who  
11 has been found guilty under this [chapter] subchapter shall be  
12 suspended for a period of one year. The license of any provider  
13 who has committed three or more violations of this [chapter]  
14 subchapter may be suspended for a period of one year.

15 (d) Reparation.--Any provider, [recipient] claimant or other  
16 person who is found guilty of a crime for violating this  
17 [chapter] subchapter shall repay three times the value of the  
18 material gain received. In addition to the civil penalty  
19 authorized pursuant to subsection (b), the department may  
20 require the provider, [recipient] claimant or other person to  
21 repay up to three times the value of any material gain to PACE  
22 or PACENET.

23 Section 11. Chapter 5 of the act is amended by adding a  
24 subchapter to read:

25 SUBCHAPTER C

26 COORDINATION OF FEDERAL AND STATE BENEFITS

27 Section 531. Definitions.

28 The following words and phrases when used in this subchapter  
29 shall have the meanings given to them in this section unless the  
30 context clearly indicates otherwise:

1 "LIS." Low-income subsidy assistance from Part D provided by  
2 the Medicare Prescription Drug, Improvement, and Modernization  
3 Act of 2003 (Public Law 108-173, 117 Stat. 2066) to help pay for  
4 annual premiums, deductibles and copayments charged to  
5 individuals enrolled in Part D by prescription plans approved  
6 under that act.

7 "Noncoverage phase." The deductible phase or the difference  
8 between Part D initial coverage and catastrophic coverage for  
9 certain Part D enrollees, as set forth in section 1860D-2 of the  
10 Medicare Prescription Drug, Improvement, and Modernization Act  
11 of 2003 (Public Law 108-173, 117 Stat. 2066).

12 "Part D eligible individual." An eligible person who is  
13 entitled to benefits under Part A of Medicare, or enrolled in  
14 Part B of Medicare, as specified in section 1860D-1 of the  
15 Medicare Prescription Drug, Improvement, and Modernization Act  
16 of 2003 (Public Law 108-173, 117 Stat. 2066.).

17 "Part D enrollee." A claimant enrolled in a Part D plan.

18 "Part D provider." A pharmacy or other prescription drug  
19 dispenser authorized by a Part D enrollee's Part D plan.

20 Section 532. Purpose.

21 The benefits available to a claimant enrolled in the program  
22 under Subchapter B shall be a supplement to the benefits  
23 available under Part D. The department may require claimants to  
24 utilize Part D benefits prior to utilizing benefits provided  
25 under either program and shall coordinate the benefits of the  
26 programs with those provided under Part D.

27 Section 533. Coordination of benefits.

28 (a) General coordination.--In addition to the specific  
29 provisions of subsection (b), the department shall establish  
30 standards and minimum requirements it deems necessary to allow

1 for the coordination of benefits between the program and Part D.

2 (b) Specific coordination provisions.--The following  
3 provisions shall apply to claimants who are also Part D  
4 enrollees:

5 (1) The primary payor shall be the PDP.

6 (2) Part D enrollees shall be required to utilize  
7 providers authorized by their PDPs.

8 (3) The program shall pay the premium assessed by a PACE  
9 enrollee's PDP in an amount not to exceed the regional  
10 benchmark premium and any copayments in excess of those set  
11 forth in section 509.

12 (4) Part D enrollees enrolled in PACENET shall pay the  
13 Part D premiums charged by their PDP and the program shall  
14 pay any copayments in excess of those set forth in section  
15 519.

16 (5) For Part D enrollees enrolled in PACE who are not  
17 eligible for LIS, PACE shall reimburse Part D providers for  
18 prescription drugs in any noncoverage phase of Part D. For  
19 Part D enrollees enrolled in PACENET, PACENET shall reimburse  
20 Part D providers for prescription drugs in any noncoverage  
21 phase of Part D.

22 (6) The provisions of Chapter 7 shall apply to all  
23 payments made by the program in the noncoverage phase.

24 (7) The department shall advise a claimant on the  
25 various benefits and drugs provided by each PDP approved by  
26 the department as follows:

27 (i) Analyze the claimant's eligibility for and  
28 assist the claimant in applying for LIS.

29 (ii) Identify the claimant's prescription drug needs  
30 and preferred pharmacy.

1           (iii) Assist the claimant in enrolling in the PDP  
2           that best fits the claimant's prescription drug needs.

3           (iv) File and pursue appeals with the claimant's PDP  
4           to convert noncovered drugs to covered drugs or  
5           nonpreferred brand drugs to preferred drugs.

6           (c) Contracts.--The department is authorized to enter into  
7           contracts with Part D plans to provide for prescription drugs to  
8           Part D enrollees through Part D pursuant to this subchapter. In  
9           selecting Part D plans, the department shall consider all of the  
10           following:

11           (1) The extensiveness of the prescription drugs covered  
12           by the PDP.

13           (2) The adequacy of the PDP pharmacy network.

14           (3) The cost to claimants and the Commonwealth.

15           Section 534. Application for low-income subsidy.

16           (a) Procedure.--The department may obtain information on the  
17           financial resources of a Part D eligible individual for the  
18           purpose of determining the individual's potential eligibility  
19           for the LIS and assisting the individual in making an  
20           application to the Social Security Administration for  
21           qualification under the LIS. The authority granted under this  
22           subsection shall be exercised only with respect to a Part D  
23           eligible individual who has income which is below the applicable  
24           threshold established by the Medicare Prescription Drug,  
25           Improvement, and Modernization Act of 2003 (Public Law 108-173,  
26           117 Stat. 2066) for qualification under the LIS.

27           (b) Waiver.--An application by a Part D eligible individual  
28           for enrollment in the program shall constitute a waiver to the  
29           department of relevant confidentiality requirements relating to  
30           the prospective claimant's financial resources in the possession

1 of any Commonwealth agency or third party when the information  
2 is required for the purposes listed under subsection (a). This  
3 waiver shall extend to the application phase and throughout the  
4 entire time the claimant is in the program.

5 (c) Information confidential.--

6 (1) It shall be unlawful for an officer, agent or  
7 employee of the department to divulge or make known  
8 information obtained from a Commonwealth agency or third  
9 party except for the purposes under subsection (a).

10 (2) A person that violates this subsection commits a  
11 misdemeanor of the third degree and shall, upon conviction,  
12 be sentenced to pay a fine of not more than \$1,000 or to  
13 imprisonment for not more than one year, or both, and to pay  
14 the cost of prosecution. If the offender is an officer or  
15 employee of the Commonwealth, the offender shall be dismissed  
16 from office or discharged from employment.

17 Section 535. Reimbursement.

18 For-profit insurers, health maintenance organizations,  
19 preferred provider organizations, not-for-profit prescription  
20 plans, Medicare Advantage plans and PDPs shall be responsible  
21 for any payments made to a pharmacy on behalf of a Part D  
22 enrollee covered by any such third party. Final determination as  
23 to the existence of third-party coverage shall be the  
24 responsibility of the department.

25 Section 12. Section 2103 of the act, added November 26, 2003  
26 (P.L.212, No.37), is amended to read:

27 Section 2103. Federal programs.

28 If the Federal Government enacts pharmacy programs similar to  
29 PACE or PACENET, the State programs shall be construed to only  
30 supplement the Federal pharmacy programs. [, and all] All persons

1 qualified for coverage under [the] a Federal pharmacy program  
2 [shall], including the prescription drug benefit program  
3 provided by the Medicare Prescription Drug, Improvement, and  
4 Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066),  
5 may be required by the department to utilize [that] the Federal  
6 program before utilizing any State program.

7 Section 13. This act shall take effect immediately.