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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2548 Session of 2006

INTRODUCED BY GERGELY, WHEATLEY, EACHUS, NICKOL, WALKO, BEBKO-JONES, BELARDI, BELFANTI, BEYER, BIANCUCCI, BISHOP, BLACKWELL, BUXTON, CALTAGIRONE, COHEN, CORRIGAN, CURRY, DALLY, DERMODY, DeWEESE, DIVEN, D. EVANS, FABRIZIO, FRANKEL, GEORGE, GERBER, GRUCELA, HALUSKA, HANNA, JAMES, JOSEPHS, KOTIK, LaGROTTA, LEACH, LEVDANSKY, MANDERINO, MARKOSEK, McCALL, McGEEHAN, MELIO, MICOZZIE, MUNDY, PALLONE, PARKER, PETRONE, RAMALEY, RAYMOND, READSHAW, ROEBUCK, RUFFING, SAINATO, SANTONI, SCHRODER, SHAPIRO, SIPTROTH, SOLOBAY, STABACK, STETLER, STURLA, SURRA, J. TAYLOR, THOMAS, TIGUE, VEON, VITALI, WANSACZ, WOJNAROSKI, YEWCIC, YOUNGBLOOD, YUDICHAK, HARHAI, FREEMAN, COSTA AND PISTELLA, APRIL 3, 2006

REFERRED TO COMMITTEE ON AGING AND OLDER ADULT SERVICES, APRIL 3, 2006

AN ACT

Amending the act of August 26, 1971 (P.L.351, No.91), entitled "An act providing for a State Lottery and administration thereof; authorizing the creation of a State Lottery Commission; prescribing its powers and duties; disposition of funds; violations and penalties therefor; exemption of prizes from State and local taxation and making an appropriation," further providing for definitions, for determination of eligibility, for physician, certified registered nurse practitioner and pharmacy participation, for reduced assistance, for rebates for expenses prohibited, for program generally, for generic drugs, for restricted formulary, for reimbursement, for income verification, for contracts and for the pharmaceutical assistance contract for the elderly needs enhancement tier, for pharmacy best practices and cost controls review; further providing for penalties; and establishing the coordination of Federal and State benefits.

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

Section 1. The definitions of "department," "eligible

claimant" and "program" in section 502 of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law, added November 21, 1996 (P.L.741, No.134), are amended and the section is amended by adding definitions to read:

Section 502. Definitions.

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

* * *

"Department." The Department of Aging of the Commonwealth or its designee.

"Eligible claimant." A resident of the Commonwealth for no less than 90 days, who is 65 years of age [and] or over, whose annual income is less than the maximum annual income and who is not otherwise qualified for public assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code[.], and who has enrolled in one of the programs established under this chapter.

* * *

"Medicare advantage." A plan of health benefits coverage offered under a policy, contract or plan by an organization certified under 42 U.S.C. § 1395w-26 (relating to establishment of standards) and formerly referred to as Medicare+Choice.

* * *

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

"Part D plan" or "PDP." A prescription drug plan approved

under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066) in the PDP region that includes this Commonwealth, and approved by the Department of Aging of the Commonwealth and the Centers for Medicare and Medicaid Services of the United States for coordination of benefits with the programs established under this chapter.

"PDP region." The service area for a PDP as determined by the Centers for Medicare and Medicaid Services of the United States and set forth in § 1860D-11(a)(2) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066).

* * *

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

* * *

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

Section 2. Sections 503 and 504 of the act, amended November 26, 2003 (P.L.212, No.37), are amended to read:

Section 503. Determination of eligibility.

The department shall adopt regulations relating to the determination of eligibility of prospective [claimants] participants in the program and providers, including dispensing physicians and certified registered nurse practitioners when acting in accordance with rules and regulations promulgated by

the State Board of Nursing as required by the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law, and the State Board of Pharmacy minimum standards of practice, and the determination and elimination of program abuse. To this end, the department shall establish a compliance unit staffed sufficiently to fulfill this responsibility. The department shall have the power to declare ineligible any eligible claimant or provider who abuses or misuses the established prescription plan. The department shall have the power to investigate cases of suspected provider or recipient fraud.

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

Any physician, certified registered nurse practitioner, pharmacist, pharmacy or corporation owned in whole or in part by a physician, certified registered nurse practitioner or pharmacist enrolled as a provider in the program or who has prescribed medication for [a claimant in the program] an eligible claimant who is precluded or excluded for cause from the Department of Public Welfare's Medical Assistance Program shall be precluded or excluded from participation in the program. No physician or certified registered nurse practitioner precluded or excluded from the Department of Public Welfare's Medical Assistance Program shall have claims resulting from prescriptions paid for by the program.

Section 3. Sections 506 and 507 of the act, added November 21, 1996 (P.L.741, No.134), are amended to read:

Section 506. Reduced assistance.

Any eligible claimant whose prescription drug costs are covered in part by any other plan of assistance or insurance, including Part D, may be required to receive reduced assistance

under the provisions of this chapter or be subject to coordination of benefits under the provisions of Chapter 10 and this chapter.

Section 507. Rebates for expenses prohibited.

A system of rebates or reimbursements to [the] an eligible claimant for prescription drugs shall be prohibited.

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

Section 509. Program generally.

The program shall include the following:

(1) Participating pharmacies shall be paid within 21 days of the contracting firm receiving the appropriate substantiation of the transaction. Pharmacies shall be entitled to interest for payment not made within the 21-day period at a rate approved by the board.

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

(3) [Senior citizens participating in the program] Eligible claimants are not required to maintain records of each transaction.

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

(5) PACE shall include participant copayment schedules for each prescription, including a copayment for generic or multiple-source drugs that is less than the copayment for single-source drugs. The department shall annually calculate the copayment schedules based on the Prescription Drugs and Medical Supplies Consumer Price Index. When the aggregate impact of the Prescription Drugs and Medical Supplies Consumer Price Index equals or exceeds $1, the department

shall adjust the copayment schedules. Each copayment schedule shall not be increased by more than $1 in a calendar year.

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

(i) [90%] 84% of the average wholesale cost of the prescription drug dispensed:

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

(I) $4; or

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

(B) the subtraction of the copayment; and

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

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

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

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

(8) The Governor may, based upon certified State Lottery

Fund revenue that is provided to both the chairman and minority chairman of the Appropriations Committee of the Senate and the chairman and minority chairman of the Appropriations Committee of the House of Representatives, and after consultation with the board, decrease the eligibility limits established in this chapter.

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

Section 510. Generic drugs.

(a) In general.--Notwithstanding any other statute or regulation, a brand name product shall be dispensed and not substituted with an A-rated generic therapeutically equivalent drug if it is less expensive to the program. If a less expensive A-rated generic therapeutically equivalent drug is available for dispensing to [a] an eligible claimant, the provider shall dispense the A-rated generic therapeutically equivalent drug to the eligible claimant. The department shall reimburse providers based upon the most current listing of Federal upper payment limits established in the Medicaid Program under 42 CFR § 447.332 (relating to upper limits for multiple source drugs), plus a dispensing fee as set forth in section 509(6). The department shall update the average wholesale costs and the Federal upper payment limits on a regular basis, at least every 30 days. The department shall not reimburse providers for brand name products except in the following circumstances:

(1) There is no A-rated generic therapeutically equivalent drug available on the market. This paragraph does not apply to the lack of availability of an A-rated generic therapeutically equivalent drug in the providing pharmacy

unless it can be shown to the department that the provider made reasonable attempts to obtain the A-rated generic therapeutically equivalent drug or that there was an unforeseeable demand and depletion of the supply of the A-rated generic therapeutically equivalent drug. In either case, the department shall reimburse the provider for [90%] 84% of the average wholesale cost plus a dispensing fee based on the least expensive A-rated generic therapeutically equivalent drug for the brand drug dispensed.

(2) An A-rated generic therapeutically equivalent drug is deemed by the department, in consultation with a utilization review committee, to have too narrow a therapeutic index for safe and effective dispensing in the community setting. The department shall notify providing pharmacies of A-rated generic therapeutically equivalent drugs that are identified pursuant to this paragraph on a regular basis.

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

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

(5) The brand name drug is less expensive to the

program.

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

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

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

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

Section 512. Restricted formulary.

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

the provisions of this chapter.

Section 515. Reimbursement.

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

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

Section 517. Income verification.

(a) Procedure.--The department shall [annually] verify the income and may also verify the financial resources of prospective participants in the program upon application for enrollment in the program and, once enrolled, of eligible claimants annually thereafter. [The department shall verify the income of eligible claimants by requiring income documentation from the claimants.] An application for benefits under this chapter shall constitute a waiver to the department of all relevant confidentiality requirements relating to the [claimant's] applicant's Pennsylvania State income tax information in the possession of the Department of Revenue[.] and other relevant information in the possession of any Commonwealth agency or third party relating to the applicant's financial resources. This waiver shall extend to both the application phase and throughout the entire time the applicant is enrolled in the program. The Department of Revenue shall provide the department with the necessary income information shown on the [claimant's] person's Pennsylvania State income tax

return solely for income verification purposes.

(b) Information confidential.--It shall be unlawful for any officer, agent or employee of the department to divulge or make known in any manner whatsoever any information [gained through access to] obtained from the Department of Revenue [information] and any other Commonwealth agency or third party except for official income verification purposes under this chapter.

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

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

Section 518. [Contract] Contracts.

The department is authorized to enter into [a contract] contracts providing for prescription drugs to eligible [persons] claimants pursuant to this chapter. The department shall select [a proposal] proposals that [includes] include, but [is] are not limited to, the criteria set forth in this chapter.

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

Section 519. The Pharmaceutical Assistance Contract for the

Elderly Needs Enhancement Tier.

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

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

[(c) Deductible.--Upon enrollment in PACENET, eligible claimants in the income ranges set forth in subsection (b) shall be required to meet a deductible in unreimbursed prescription drug expenses of $40 per person per month. The $40 monthly deductible shall be cumulative and shall be applied to subsequent months to determine eligibility. The cumulative deductible shall be determined on an enrollment year basis for an annual total deductible not to exceed $480 in a year. To qualify for the deductible set forth in this subsection the prescription drug must be purchased for the use of the eligible claimant from a provider as defined in this chapter. The department, after consultation with the board, may approve an adjustment in the deductible on an annual basis.]

<u>(c.1) Premium.--In those instances in which a PACENET-eligible claimant does not enroll in Part D, the eligible claimant shall be required to pay an annual premium equivalent</u>

to the regional benchmark Part D premium.

(d) Copayment.--

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

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

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

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

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

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

(a) Review process.--The secretary shall review and recommend pharmacy best practices and cost control mechanisms that maintain high quality in prescription drug therapies but are designed to reduce the cost of providing prescription drugs for PACE and PACENET enrollees, including:

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

(2) A drug utilization review procedure, incorporating a

prescription review process for copayment schedules.

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

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

(b) Report and recommendations.--No later than two years from the effective date of this section, the department shall submit a report with recommendations to the Aging and Youth Committee, the Appropriations Committee and the Public Health and Welfare Committee of the Senate and the Aging and Older Adult Services Committee, the Appropriations Committee and the Health and Human Services Committee of the House of Representatives. The report shall include information regarding the efficacy of the pharmacy best practices and control mechanisms set forth in subsection (a), including recommended copayment schedules with impacted classes of drugs, exceptions, cost effectiveness, improved drug utilization and therapies, movement of market share and increased utilization of generic drugs.]

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

Section 521. Penalties.

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

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

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

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

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

(5) otherwise violating any provision of this chapter.

(b) Civil penalty.--In addition to any appropriate criminal penalty for prohibited acts under this chapter whether or not that act constitutes a crime under 18 Pa.C.S. (relating to crimes and offenses), a provider who violates this section may be liable for a civil penalty in an amount not less than $500 and not more than $10,000 for each violation of this act which shall be collected by the department. Each violation constitutes a separate offense. If the department collects three or more civil penalties against the same provider, the provider shall be ineligible to participate in either PACE or PACENET for a period of one year. If more than three civil penalties are collected from any provider, the department may determine that the provider is permanently ineligible to participate in PACE or PACENET.

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

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

Section 11. The act is amended by adding a chapter to read:

CHAPTER 10

COORDINATION OF FEDERAL AND STATE BENEFITS

Section 1001. Definitions.

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

"CMS." The Centers for Medicare and Medicaid Services of the United States.

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

"Department." The Department of Aging of the Commonwealth or its designee.

"Eligible claimant." A resident of this Commonwealth for no

less than 90 days who is 65 years of age or older, whose annual income is less than the maximum annual income and who is not otherwise qualified for public assistance under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, and who has enrolled in one of the programs established under Chapter 5.

"Income." All income from whatever source derived, including, but not limited to, salaries, wages, bonuses, commissions, income from self-employment, alimony, support money, cash public assistance and relief, the gross amount of any pensions or annuities, including railroad retirement benefits, all non-Medicare benefits received under the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), all benefits received under State unemployment insurance laws and veterans' disability payments, all interest received from the Federal Government, a state government or any instrumentality or political subdivision thereof, realized capital gains, income from rentals, workers' compensation and the gross amount of loss of time insurance benefits, life insurance benefits and proceeds, except the first $10,000 of the total of death benefit payments and gifts of cash or property, other than transfers by gift between members of a household, in excess of a total value of $300, but shall not include surplus food or other relief in kind supplied by a government agency or property tax rebate.

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

act.

"Maximum annual income." For PACE eligibility, the term shall mean annual income which shall not exceed $14,500 in the case of single persons nor $17,700 in the case of the combined annual income of persons married to each other. For PACENET eligibility, the term shall mean annual income not less than $14,500 and not more than $23,500 in the case of a single person and of not less than $17,700 and not more than $31,500 in the case of the combined income of persons married to each other. Persons may, in reporting income to the Department of Aging, round the amount of each source of income and the income total to the nearest whole dollar, whereby any amount which is less than 50ç is eliminated.

"MMA." The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173, 117 Stat, 2066).

"PACE." The Pharmaceutical Assistance Contract for the Elderly program established under Chapter 5.

"PACENET." The Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier established under Chapter 5.

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

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

"Part D enrollee." A person enrolled in one of the programs

established under Chapter 5 who also enrolls in a Part D plan.

"Part D formulary." Those prescription drugs covered by a Part D enrollee's Part D plan.

"Part D plan" or "PDP." A prescription drug approved under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066) in the PDP region that includes the Commonwealth, and approved by the Department of Aging of the Commonwealth and the Centers for Medicare and Medicaid Services of the United States for coordination of benefits with the program established under Chapter 5.

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

"Prescription drugs excluded or limited." The prescription drugs listed or identified in section 1860D-2(e)(2) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066).

"Program." The Pharmaceutical Assistance Contract for the Elderly and the Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier established under Chapter 5.

"Provider." A pharmacy, dispensing physician or certified registered nurse practitioner enrolled as a provider in the program.

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

Section 1002. Purpose.

(a) General rule.--The General Assembly intends for persons enrolled in a program established under Chapter 5 who are also

enrolled in Part D that the benefits of the programs established under Chapter 5 shall be construed only as a supplement to Part D benefits. Persons who are enrolled in either of such programs who are eligible for coverage under Part D may be required by the department to utilize the Part D benefits before utilizing benefits provided under either State program.

(b) Coordination with Part D.--The General Assembly further intends to continue a State pharmaceutical assistance program for persons enrolled in one of the programs established under Chapter 5 who are also enrolled in Part D. In addition, the General Assembly authorizes the department to coordinate the benefits of the State program with those provided under Part D in order to provide the most efficient and cost-effective program for those persons.

Section 1003. Coordination of benefits.

(a) General coordination.--In addition to the specific provisions of subsection (b), the department shall establish standards and minimum requirements it deems necessary to allow for the coordination of benefits between the program and Part D.

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

(1) The primary payor shall be the PDP.

(2) The program shall not reimburse providers for prescription drugs not on Part D enrollees' PDPs' formularies, except for those prescription drugs excluded or limited by the MMA.

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

(4) For Part D enrollees enrolled in PACE, PACE shall

pay the premium assessed by the Part D enrollee's PDP in an amount not to exceed the regional benchmark Part D premium, and any copayments in excess of those set forth in section 509. Part D enrollees enrolled in PACENET shall be responsible for payment of the Part D premiums charged by their PDP.

(5) For Part D enrollees enrolled in PACE who are not eligible for LIS, PACE shall reimburse Part D providers for prescription drugs in any coverage gaps or noncoverage phase of Part D. For Part D enrollees enrolled in PACENET, PACENET shall reimburse Part D providers for prescription drugs in any coverage gaps or noncoverage phase of Part D.

(6) The provisions of Chapter 7 shall apply to all payments made by either program under the provisions of this chapter.

(7) The department shall be authorized to act as an eligible claimant's authorized representative for the following purposes:

(i) Analyzing the eligible claimant's eligibility for and assisting him in applying for LIS.

(ii) Evaluating an eligible claimant's prescription drug needs and the Part D formularies as well as Part D providers.

(iii) Assisting an eligible claimant in enrolling in the PDP that best fits his prescription drug needs.

(iv) Filing and pursuing appeals with an eligible claimant's PDP to convert noncovered drugs to covered drugs or nonpreferred brand drugs to preferred drugs.

(c) Contracts.--The department is authorized to enter into contracts providing for prescription drugs to Part D enrollees

through Part D pursuant to this chapter. The department shall select proposals that include, but are not limited to, the criteria set forth in this chapter.

Section 1004. Financial verification.

(a) Procedure.--The department shall verify the income and may also verify the financial resources of Part D eligible individuals upon their application for enrollment in the program and, once enrolled, annually thereafter. The department may also require verification of resources for Part D or LIS eligibility. An application by a Part D eligible individual for enrollment in the program shall constitute a waiver to the department of all relevant confidentiality requirements relating to the applicant's Pennsylvania State income tax information in the possession of the Department of Revenue and other relevant information in the possession of any Commonwealth agency or third party relating to the applicant's financial resources. This waiver shall extend to both the application phase and throughout the entire time the applicant is enrolled in the program. The Department of Revenue shall provide the department with the necessary income information shown on the person's Pennsylvania State income tax return solely for income verification purposes.

(b) Information confidential.--It shall be unlawful for any officer, agent or employee of the department to divulge or make known in any manner whatsoever any information obtained from the Department of Revenue, any other Commonwealth agency or third party except for financial verification purposes under this chapter.

(c) Penalty.--A person who violates the provisions of subsection (b) commits a misdemeanor and shall, upon conviction,

be sentenced to pay a fine of not more than $1,000 or to imprisonment for not more than one year, or both, together with the cost of prosecution and, if the offender is an officer or employee of the Commonwealth, he shall be dismissed from office or discharged from employment.

Section 1005. Nonliability.

Any employee of the department rendering service to a Part D eligible individual, as the Part D eligible individual's designated representative, by providing assistance in completing LIS or Part D applications, in selection of a PDP or by appealing to a Part D enrollee's PDP to convert noncovered drugs or nonpreferred brand drugs to preferred drugs covered under the PDP formulary, shall not be liable for any civil damages as a result of any such acts or omissions or any determinations made by the Social Security Administration, CMS or a PDP.

Section 1006. Reimbursement.

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

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

Section 2103. Federal programs.

If the Federal Government enacts pharmacy programs similar to PACE or PACENET, the State programs shall be construed to only supplement the Federal pharmacy programs.[, and all] All persons qualified for coverage under [the] a Federal pharmacy program

[shall], including the prescription drug benefit program provided by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066), may be required by the department to utilize [that] the Federal program before utilizing any State program.

Section 13. This act shall take effect in 60 days.