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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1203 Session of 2001

INTRODUCED BY CONTI, HELFRICK, ORIE, ERICKSON AND TOMLINSON, NOVEMBER 8, 2001

REFERRED TO AGING AND YOUTH, NOVEMBER 8, 2001

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 annual income limitations for PACE and PACENET; providing for best price for pharmaceuticals; establishing the Prescription Drug Access Clearinghouse Authority and providing for its powers and duties; providing for the Medicare Managed Care Fair Share Program; and establishing the Medicare Participation Fund.

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

Section 1. The definition of "maximum annual income" 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), is amended 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:

* * *

"Maximum annual income."

(1) For PACE eligibility, the term shall mean annual income which shall not exceed [$14,000] $15,000 in the case of single persons nor [$17,200] $18,200 in the case of the combined annual 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.

(2) The maximum annual income amounts under this definition shall be increased each year after the effective date of this paragraph by the percentage, if any, by which the Consumer Price Index for the most recent calendar year exceeds the Consumer Price Index for the immediate preceding calendar year.

* * *

Section 2. Sections 509, 515 and 519 of the act, added November 21, 1996 (P.L.741, No.134), are 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 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 a participant copayment schedule for each prescription. The copayment may increase or decrease on an annual basis by the average percent change of ingredient costs for all prescription drugs, plus a differential to raise the copayment to the next highest 25ç increment. In addition, the department may approve a request for increase or decrease in the level of copayment based upon the financial experience and projections of PACE and after consultation with the board. The department is prohibited from approving adjustments to the copayment on more than an annual basis.

(6) The program shall consist of payments to pharmacies on behalf of eligible claimants for 90% of the average wholesale costs of prescription drugs which exceed the copayment, plus a dispensing fee of at least $3.50 or the dispensing fee established by the department by regulation, whichever is greater.

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

(8) Payments for multiple source drugs, meeting the criteria set forth in 42 C.F.R. 447.332 (relating to upper limits for multiple source drugs) and § 1927(e) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), must not exceed an amount based on the limit per unit which the Health Care Financing Administration has determined to be equal to 150% applied to the lowest price listed, in package sizes of 100 units, unless otherwise noted, in any of the published compendia of cost information of drugs.

Section 515. Reimbursement.

[For-profit] Health maintenance organizations, for-profit third-party insurers and not-for-profit prescription plans shall be responsible for any payments made by the program to a providing pharmacy or dispensing physician on behalf of a claimant covered by such a third party.

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 with an annual income of not less than [$14,000] $15,000 and not more than [$16,000] $17,000 in the case of a single person and of not less than [$17,200] $18,200 and not more than [$19,200] $20,200 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 [an annual] monthly deductible in unreimbursed prescription drug expenses of [$500] $40 per person. 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.

(d) Copayment.--For eligible claimants under this section, the copayment schedule, which may be adjusted by the department on an annual basis after consultation with the board, 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.

(e) Annual increase in eligibility limits.--The maximum annual income amounts for PACENET eligibility under subsection (b) shall be increased each year after the effective date of this subsection by the percentage, if any, by which the Consumer Price Index for the most recent calendar year exceeds the Consumer Price Index for the immediate preceding calendar year.

Section 3. The act is amended by adding chapters to read:

CHAPTER 7-A

BEST NEGOTIATED PRICE FOR PHARMACEUTICALS

Section 701-A. Short title of chapter.

This chapter shall be known and may be cited as the Best Price for Pharmaceuticals Act.

Section 702-A. 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:

"A-rated generically equivalent drug." A drug product that the Commissioner of Food and Drugs of the Food and Drug Administration has approved as safe and effective and has determined to be equivalent as listed in "The Approved Drug Products with Therapeutic Equivalence Evaluations" (Food and Drug Administration "Orange Book"), with a specific "A" code

designation only.

"Committee." A drug utilization review committee formed in accordance with section 705-A.

"DESI drug." A drug product for which Federal financial participation is not available under 42 CFR 441.25 (relating to prohibition on FFP for certain prescribed drugs).

"Experimental drug." A drug or product currently being investigated under an investigational or new drug application filed with the Food and Drug Administration to determine its safety and effectiveness.

"Licensed prescriber." A person currently licensed under the law of a state to order medication for patient treatment.

"PACE." As defined in section 502.

"PACENET." As defined in section 502.

"Participant." A person who receives pharmacy services from PACE or PACENET.

"Pharmaceutical manufacturer." A manufacturer of prescription drugs, insulin, insulin needles or insulin syringes.

"Pharmacy." A pharmacy licensed by the Commonwealth.

"Pharmacy services." Medically necessary prescription drugs and other pharmacy services furnished directly to eligible participants by pharmacies.

"Prescription drug." A drug requiring a prescription in this Commonwealth, insulin, insulin syringes and insulin needles. Experimental drugs or drugs prescribed for wrinkle removal or hair growth are excluded.

"Prior authorization." A procedure established by the Secretary of Aging under which the delivery of a pharmacy service is either conditioned upon or delayed by a prior

determination by the Secretary of Aging or his agent that a person is eligible for a particular pharmacy service, that there is medical necessity for a particular pharmacy service or that a particular pharmacy service is suitable to a particular participant.

"Private contracted entity." An entity under contract with the Secretary of Aging to administer PACE and PACENET.

"Provider." A pharmacy or licensed prescriber who provides pharmacy services to a PACE or PACENET recipient.

"Secretary." The Secretary of Aging of the Commonwealth.

"Wholesaler." A licensed person or entity within this Commonwealth which legally purchases pharmaceuticals for resale or distribution to persons other than recipients or consumers.

Section 703-A. Private contracted entities.

(a) Administration.--The secretary shall administer a pharmacy benefits management program for all participants.

(b) Request for proposal.--Not later than 90 days from the effective date of this chapter, the secretary shall issue a request for proposal for a three-year contract with four private contracted entities to administer pharmacy services for participants Statewide.

(c) Requirements.--The proposal shall require the private contracted entities to perform prospective, concurrent and retrospective drug utilization review and education of providers and participants.

(d) Criteria.--The selection process shall include criteria designed to choose the private contracted entities best able to provide a prescription drug benefit program for participants in a way that maximizes savings for the Commonwealth and participants without reducing the quality of prescription drug

benefits now being provided to the participants. The selection process shall also include criteria designed to choose those private contracted entities that offer participants choices among prescription drug benefits with different formulary options and cost-sharing arrangements.

(e) Decision.--All participants may choose the private contracted entity of their preference for the delivery of their pharmacy services. Each private contracted entity shall make available information to all potential participants so an informed decision may be made. Participants shall have the option of changing the private contracted entity at their discretion in an open enrollment period every 12 months.

(f) Execution.--The contracts under this section shall be executed within six months from the effective date of this chapter.

Section 704-A. Private contracted entity functions.

(a) Requirements.--The secretary shall require each private contracted entity to:

(1) develop and update a formulary of drugs with the advice of its committee utilizing disease and care management. Formulary options may include an open formulary, closed formulary or a modified closed formulary with an opportunity for substitution upon prior authorization;

(2) manage a drug formulary;

(3) ensure that any pharmacy licensed in this Commonwealth which is willing to accept the terms and conditions of the private contracted entity is eligible to provide pharmacy services according to any regulations in effect on the effective date of this chapter and that regulate pharmacy providers;

(4) negotiate drug rebates with manufacturers;

(5) in accordance with the act of November 24, 1976 (P.L.1163, No.259), referred to as the Generic Equivalent Drug Law, make provisions for generic substitutions and require pharmacists to disclose any affiliation with a generic manufacturer;

(6) provide for prospective drug utilization review which precludes overriding alerts without intervention;

(7) provide for prior authorization in accordance with regulations of the secretary;

(8) provide for prospective and concurrent and retrospective drug utilization review to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results and to educate providers and participants and to correct and report misutilization and abuse by licensed prescribers and participants and provide for fraud and abuse audits, coordinating its activities with the secretary to support compliance with applicable laws and regulations;

(9) educate providers on disease and care management;

(10) provide educational materials for participants on disease and care management;

(11) seek best price from pharmaceutical manufacturers under prevailing private market conditions;

(12) negotiate with drug manufacturers to maximize savings to the Commonwealth in a way that does not reduce the quality of existing prescription drug services for participants;

(13) adjudicate claims through a Statewide point-of-sale electronic verification and claims processing system which

will allow for intervention upon receipt of a prospective drug utilization review alert and will allow for an emergency supply of prescribed medication in the event of equipment failures;

(14) create an audit and recoupment system for providers and participants, and third-party medical resources; and

(15) reimburse pharmacies on a fee-for-service basis.

(b) Formulary.--The private contracted entities, with the advice of their committees, shall prepare a formulary of drugs and, in accordance with the Generic Equivalent Drug Law, include generically equivalent drugs to be used in PACE or PACENET. In evaluating drugs for the formulary, each private contracted entity shall consider their therapeutic efficacy and take into consideration all discounts, rebates or other concessions provided by manufacturers. The formulary must indicate that drugs will not be reimbursed if they are experimental or on the Drug Efficacy Study Implementation list (DESI) prepared by the Health Care Financing Administration. The formulary shall provide for a medical exception for a drug on the latter list upon a handwritten declaration of its necessity on the prescription by the treating prescriber.

(c) Conflicts.--In developing the formulary, the private contracted entity shall demonstrate how it will avoid a conflict of interest with any pharmaceutical manufacturer, wholesaler or drug store chain that holds an interest in the private contracted entity or in which the private contracted entity has an interest and shall indicate how it will prevent the sharing of nonpublic information concerning other drug manufacturers' bids, proposals, contracts, prices, rebates or discounts.

(d) Considerations.--In preparing and managing the

formulary, the private contracted entity shall ensure that they will consider all discounts, rebates or other concessions offered by manufacturers, drug chains or wholesale drug companies. In no event shall such considerations exclude a drug recommended for inclusion by the committee in its recommendations regarding the clinical basis of the formulary. No formulary or other restriction affecting payment for a drug by the program shall be adopted if it is not supported by the clinical recommendations of the committee.

(e) Continuation.--Upon making changes to the formulary the private contracted entities shall allow a participant to continue to receive a drug which is part of an ongoing treatment regimen until such time as the prescriber evaluates the medical need for the specific drug and determines the clinical suitability of a change of therapy. In no event shall a formulary change result in denial of a patient's access to covered care by denial of payment or mandatory switch of therapy as long as previously authorized refills remain for the prescription.

(f) Nontermination.--The private contracted entities shall not terminate any contract currently in existence with any agency or program which cannot be favorably renegotiated.

Section 705-A. Drug utilization review committees.

(a) Requirement.--The secretary shall require each private contracted entity to form a drug utilization review committee.

(b) Composition.--Each committee shall be comprised of nine members, five of whom shall be actively practicing physicians licensed in this Commonwealth and four of whom shall be actively practicing pharmacists licensed in this Commonwealth. None of the members may hold a 5% or greater interest in the private

contracted entity, its parent company or companies, or in a company or companies owned by the private contracted entity.

(c) Functions.--

(1) The committees shall develop a system that provides prospective, concurrent and retrospective review of drug utilization to ensure that pharmacy services provided are or were appropriate and medically necessary and not likely to result in adverse medical results. The review program shall be designed to educate licensed prescribers and pharmacists as provided in paragraph (4) on the proper utilization of drugs in disease and care management. In reviewing drug utilization, the committee shall assess data on drug use against predetermined standards consistent with the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia-Drug Information, American Medical Association Drug Evaluations or peer-reviewed medical literature.

(2) The committees shall develop a system to utilize the compendia and literature referred to in paragraph (1) as its source of standards to screen for potential drug problems before a prescription is filled or delivered to a participant. Prospective drug use review shall include consultation with participants by pharmacists.

(3) The secretary and the private contracted entities shall provide data to the committees, through mechanized drug claims processing and retrieval systems, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among licensed prescribers, pharmacists and participants or associated with

specific drugs or groups of drugs. The committees shall, on an ongoing basis, assess data on drug use against explicit predetermined standards using the compendia and literature referred to in this subsection and to introduce, as necessary, remedial strategies to improve the quality of care and to conserve program funds or patient expenditures.

(4) The committees shall, using drug use data on common therapy problems, develop active and ongoing educational outreach programs to disseminate information to providers on common drug therapy problems with the aim of improving prescribing or dispensing practices. The educational programs shall include interventions for providers targeting therapy problems or individuals identified in the course of retrospective drug reviews. The committees shall reevaluate interventions from time to time to determine if the interventions were successful in improving the quality of drug therapy and shall make modifications as necessary. Intervention programs shall include:

(i) information dissemination sufficient to ensure the ready availability to providers of information concerning the committees' duties, powers and basis for their standards;

(ii) written, oral or electronic reminders containing patient-specific and/or drug-specific information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(iii) use of communication between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been

targeted for educational intervention, including discussion of optimal prescribing, dispensing or pharmacy care practices and follow-up communications; and

(iv) intensified review or monitoring of selected prescribers or dispensers.

(5) The committees shall, using practices and formats generally accepted in the professional practice of pharmacy, develop recommendations for the structure and specific products to be included on the formulary. The recommendations shall be appropriate for the clinical needs of the enrollee population and shall be entirely independent of any and all financial considerations that may be relevant to the program's implementation of the formulary recommendations. The committee's recommendations shall be consistent with the following:

(i) All new drugs shall be available without restriction upon being approved by the Federal Food and Drug Administration and made available in the marketplace until such time as a committee completes its clinical evaluation of the relative place of the new drug on the formulary. A drug is considered "new" for purposes of this subparagraph if the drug is a newly released drug or compound that has never before been marketed or a drug that has been approved by the Federal Food and Drug Administration for a new indication or treatment use. A drug is "available" in the marketplace for purposes of this subparagraph if the drug can be readily obtained in commercial quantities by pharmacies in this Commonwealth.

(ii) No drug may be recommended for exclusion from the formulary until is has been included for a period of

at least 12 months to provide a committee with data regarding its use and potential misuse in the enrollee population.

(iii) Any recommendation by a committee that access to a drug be restricted either by exclusion from the formulary or by prior authorization that limits conditions of use for a drug shall be based on committee analysis of retrospective data using the criteria to identify a drug whose use is likely not to be medically appropriate or medically necessary or likely to result in adverse medical outcomes in the enrollee population.

(6) A committee shall issue all recommendations regarding the program formulary in writing for at least a 30-day period of public inspection before they are submitted to the program for adoption and implementation.

(7) Any interested party, including, but not limited to, physicians, pharmacists, beneficiaries and manufacturers or distributors of the drug proposed to be restricted may submit additional clinical information relevant to determining the formulary status of the drug. All relevant clinical information shall be considered by a committee before the recommendation is finalized and submitted to the program.

(8) Any interested party, including, but not limited to, physicians, pharmacists, beneficiaries and manufacturers or distributors of the drug proposed to be restricted may request an opportunity to make an oral presentation to the committee. Upon timely receipt of a request for an oral hearing, a committee shall schedule a hearing and provide any interested party with an opportunity to express clinical concerns related to the proposed formulary status of such

drug. A committee shall consider the record of any hearing prior to submitting its formulary recommendation to the program.

(d) Misutilization.--Should licensed prescribers or participants continue to misutilize drugs or abuse the system, a committee shall provide information to the secretary for corrective action. In the case of prescribers, a committee shall submit a report and recommendations to the secretary for appropriate action. The secretary shall inform the private contracted entity and the appropriate Commonwealth licensing body of any final administrative sanctions.

(e) Nonliability.--Any person rendering service as a member of a committee for this program shall not be liable for any civil damages as a result of any acts or omissions in rendering the service as a member of any such committee except any acts or omissions intentionally designed to harm or any grossly negligent acts or omissions which result in harm to the person receiving such service.

(f) Report.--The secretary shall require the committees to provide an annual report describing the committees' activities, including the nature and scope of the prospective, concurrent and retrospective drug reviews, a summary of interventions used, an assessment of the impact of these educational interventions on quality of care and an estimate of the cost savings generated as a result of the program.

Section 706-A. Copayments.

Except for services which are excluded under the Commonwealth's medical assistance program, a participant is liable for a copayment in an amount set by the secretary, and collection of the copayment by pharmacies shall be mandatory.

The amount of the copayment paid to pharmacy providers by participants shall be deducted from the Commonwealth's fee to pharmacy providers.

Section 707-A. Administration of contract.

(a) Secretary.--The secretary shall administer the contract with the private contracted entities and shall promulgate rules and regulations, as necessary, to carry out the provisions of this chapter.

(b) Data.--The secretary and the private contracted entities shall provide data necessary to the committees to develop provider prescribing profiles and participant utilization profiles to perform utilization review and disease and care management through the coordination of health care and pharmacy services to ensure that participants are receiving and complying with appropriate therapies.

Section 708-A. Drug prior authorization review process.

Any drug prior authorization program shall meet all of the following conditions:

(1) The program shall provide telephone, fax or other electronically transmitted authorization or denial within 24 hours after receipt of the prior authorization request.

(2) In an emergency situation, including a situation in which a response to a prior authorization request is unavailable while the patient waits in the pharmacy, a 72-hour supply of the prescribed drug shall be dispensed and paid for by the program.

(3) A prescription will only be changed upon the orders of the prescriber.

Section 709-A. Studies required.

(a) General.--

(1) The secretary shall select a competent contractor to analyze and compare expenditures, utilization rates and utilization patterns for pharmacy services provided to PACE or PACENET.

(2) To effectuate the purposes of this chapter, all participating pharmacy providers, manufacturers, drug chains and wholesalers shall, as a condition of participation, be required to cooperate with the secretary in preparing the required report.

(3) The secretary shall report preliminary findings to the President pro tempore of the Senate and the Speaker of the House of Representatives by September 30, 2002. The secretary shall report finally on June 30, 2004.

(b) Report.--The Legislative Budget and Finance Committee shall evaluate and prepare a report to be submitted no later than June 30, 2004, to the General Assembly on the best price for pharmaceuticals program under this chapter.

Section 710-A. Applicability of chapter.

This chapter shall apply to PACE and PACENET.

Section 711-A. Prohibited activities.

It shall be unlawful for any individual, partnership or corporation to solicit, receive, offer or pay 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.

Section 712-A. Expiration of chapter.

This chapter shall expire December 31, 2004, unless reauthorized by the General Assembly.

CHAPTER 7-B

PRESCRIPTION DRUG ACCESS CLEARINGHOUSE AUTHORITY

Section 701-B. 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:

"Authority." The Prescription Drug Access Clearinghouse Authority established by this chapter.

"Board." The board of directors of the Prescription Drug Access Clearinghouse Authority.

"Discount plan." A prescription drug discount plan.

"Discount program." The Prescription Drug Discount Program under section 707-B.

"PACE." As defined in section 502.

"PACENET." As defined in section 502.

Section 702-B. Establishment and duties of authority.

(a) Authority established.--The Prescription Drug Access Clearinghouse Authority is hereby established to assist citizens with accessing prescription drug services at affordable prices.

(b) Duties of authority.--The authority shall:

(1) Disseminate information and advertise programs that will assist citizens with purchasing prescription drugs at a lower cost.

(2) Provide specific assistance to State residents to facilitate greater participation in the PACE and PACENET programs.

(3) Assist State residents with enrolling in programs such as PACE, PACENET and Medicaid and that may provide for prescription drug coverage for which they may be eligible.

(4) Assist residents of this Commonwealth with assessing discount programs or insurance programs that may be of benefit to them.

(5) Perform studies to identify additional strategies

that may help improve access by Commonwealth residents to prescription drugs and provide appropriate reports to the Governor and General Assembly.

(6) Serve as a general resource responsible for promoting the interest of residents of this Commonwealth on prescription drug access issues.

Section 703-B. Authority board of directors.

(a) Membership.--The authority shall be governed by a 13-member board of directors as follows:

(1) Four members appointed by the Governor, one of whom shall be a consumer representative and one of whom shall have knowledge of pharmaceutical benefit programs.

(2) Two members appointed by the Majority Leader of the Senate, one of whom shall be a practicing pharmacist.

(3) Two members appointed by the Minority Leader of the Senate, one of whom shall have knowledge of group procurement practices.

(4) Two members appointed by the Majority Leader of the House of Representatives, one of whom shall have experience in operations of group health plans.

(5) Two members appointed by the Minority Leader of the House of Representatives, one of whom shall represent individuals in this Commonwealth who are elderly or have disabilities.

(6) The executive director of the authority, to be selected by the other members of the board, who shall serve as an ex officio, voting member of the board.

(b) Executive director.--The executive director of the authority shall be the chief executive officer of the authority and presiding officer of the board of directors.

(c) Compensation.--Except for the executive director, members of the board shall receive no compensation for their services but shall be reimbursed for their necessary expenses incurred while serving as board members.

(d) Vacancies.--A vacancy on the board shall be filled by the appointing authority for the balance of the term.

(e) Terms of members.--

(1) Initial terms of appointed members shall be as follows:

(i) The Governor shall appoint one member for two years.

(ii) The Majority Leader of the Senate shall appoint one member for two years.

(iii) The Minority Leader of the Senate shall appoint one member for two years.

(iv) The Majority Leader of the House of Representatives shall appoint one member for two years.

(v) The Minority Leader of the House of Representatives shall appoint one member for two years.

(vi) The remaining members shall be appointed for four years.

(2) Each subsequent term of a member shall be for four years and until a successor is appointed and qualified. Except for the executive director, members may serve only two consecutive full terms. Any member of the board may be removed by the Governor or by a majority of the other board members for malfeasance in office, failure to attend regularly scheduled meetings, or for any cause that renders the member incapable of for unfit to discharge the duties of a director.

(f) Meetings.--Meetings of the board shall be subject to 65 Pa.C.S. Ch. 7 (relating to open meetings) and the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law. A quorum for a meeting shall be a majority of the total membership of the board. Any action of the board of directors requires the affirmative vote of a majority of a quorum.

(g) Conflicts of interest.--No part of the revenues or assets of the authority may inure to the benefit of, or be distributed to, its board of directors or officers or any other private person or entity. Any member of the board of directors and any employee or other agent or advisor of the authority, who has a direct or indirect interest in a pharmaceutical manufacturer, pharmacy, discount program, insurance program or in any contract or transaction with the authority, must disclose this interest to the authority. If a board member has an interest in a transaction, then the member may not participate in the deliberations or voting on such a transaction. The status of the authority's chief executive officer, in and of itself, does not constitute a conflicting interest.

(h) Personnel.--A State employee who elects to become an employee of the authority shall receive full credit from the authority for sick leave and annual leave accrued while employed by the State. The authority may establish and administer its own personnel program, including a wage and benefit structure for authority employees. Authority employees may participate in and be eligible for enrollment in the Commonwealth retirement system established pursuant to 71 Pa.C.S. Pt. XXV (relating to retirement for State employees and officers).

Section 704-B. General powers of authority.

The authority shall have the general powers of an independent

corporate entity, including the following:

(1) To have the duties, privileges, immunities, rights, powers, liabilities and obligations of a body corporate and politic.

(2) To enroll residents in State programs offering a prescription drug benefit after entering into a memorandum of understanding with the relevant agency regarding coordination of enrollment procedures.

(3) To provide counseling and guidance to residents of this Commonwealth regarding existing Federal, State or private programs, including manufacturer assistance programs, that may be available to help address individual needs.

(4) To evaluate or rate prescription drug programs, insurance programs and discount programs according to criteria determined by the authority in advance, so long as the authority deems the evaluation or ratings useful to members of the public.

(5) To advertise the availability of any public or private program offering prescription drug benefits to members of the public in accordance with criteria the authority determines will advance the public's ability to acquire quality prescription drugs at lower cost.

(6) To enter into any contract, agreement or other instrument necessary or convenient in the exercise of the powers and functions of the authority that are not inconsistent with the laws of this Commonwealth.

(7) To manage its own finances and deposit funds into independent banking accounts.

(8) To contract for and to accept any grants and loans of funds, property or any other aid in any form from the

Federal or State government sources, or any other source, or any combination thereof.

(9) To appoint agents, employees and professional and business advisers as may from time to time be necessary in its judgment to accomplish the purposes of the authority and to fix the compensation of its officers, employees, agents and advisers, and to establish the powers and duties of its agents, officers, employees and other persons contracting with the authority.

Section 705-B. Construction.

Nothing in this chapter shall be construed as a restriction or limitation upon any other powers which the authority might otherwise have under any other law of this Commonwealth.

Section 706-B. Exemption from taxation.

Any real property acquired, maintained and operated by the authority under this act shall not be subject to taxation by any political subdivision or local taxing authority. The authority is exempt from sales and use taxes imposed under Article II of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, for purchases acquired and used for its public purposes.

Section 707-B. Availability of discount programs.

(a) General rule.--The authority shall administer a prescription drug discount program. The authority shall establish public-private partnerships using a process to identify multiple-private sector prescription drug discount plans that will accept enrollment from any eligible resident of this Commonwealth; provide enrollees with enhanced access to prescription drugs; and engage in ongoing competition for enrollees on the basis of access, cost and quality of service

and product offered.

(b) Contract standards.--The authority shall issue requests for proposals for participation by private sector prescription drug discount plans on an annual or biannual basis as necessary, to ensure that residents of this Commonwealth have access to multiple plans throughout this Commonwealth.

(c) Eligibility.--Any resident of this Commonwealth is eligible for the discount program under this chapter.

(d) Subsidy.--The Commonwealth shall subsidize administrative costs associated with the discount program, including the authority's efforts to actively endorse and promote the selected discount plans. The Commonwealth is not responsible for subsidizing the direct cost of prescription drugs under this discount program.

(e) Out-of-pocket costs.--Enrollees in the discount program are responsible for all costs of prescription drugs that they may purchase at discounted rates as available under competing prescription drug plans participating in the discount program.

(f) Enrollment.--Participation in the discount program is contingent upon enrollment and selection of a discount plan. The authority shall establish an annual open enrollment period and may prevent residents from changing plans during the course of a year unless a discount plan's contract is revoked or the discount plan becomes unable to deliver services.

(g) Participation.--Participation in the discount program is voluntary. Enrollees are permitted to purchase prescription drugs outside of the discount program at any time.

(h) Enrollment fee.--The authority may authorize discount plans to collect a modest enrollment fee up to $25 from each individual enrolling in the discount plans on a sliding fee

schedule.

(i) Consumer choice.--Eligible residents shall be given a choice of discount plans in which to participate. The authority may, at its discretion, create categories of plans to address different consumer needs.

(j) Nonexclusivity.--Residents of this Commonwealth may enroll in a discount plan regardless of whether they have other prescription drug insurance coverage or other coverage.

(k) Plan selection.--Subject to public notice and comment and in consultation with industry representatives, the authority shall issue requests for proposals from discount plans, such as discount card programs, pharmacy chain discount programs, pharmaceutical benefit managers and other qualifying entities capable of delivering lower prices to residents of this Commonwealth. In designing the criteria for evaluating the responses, the authority shall take into account the quality of the services to be provided and the savings generated for residents of this Commonwealth. The authority may take into account other factors, including geographic coverage, product differentiation, the need to target different populations within this Commonwealth, mail order service, coverage of rural areas and other factors as determined by the authority. If the authority receives multiple qualifying proposals in a category, the authority must approve at least two contractors in each category, but may, at its sole discretion, limit the maximum number of contractors in each category.

(l) Applicability.--The discount program applies to medically necessary prescription drugs and biologicals provided to patients in outpatient pharmacies. Under all circumstances, there must be at least two drugs equally available to enrollees

in each therapeutic class or subclass of pharmaceutical agents. The authority, through the contracting process, shall ensure adequate access to medically necessary prescription drugs.

CHAPTER 7-C

MEDICARE MANAGED CARE FAIR SHARE PROGRAM

Section 701-C. Short title of chapter.

This chapter shall be known and may be cited as the Medicare Managed Care Fair Share Program.

Section 702-C. Declaration of policy.

The General Assembly finds and declares as follows:

(1) The PACE program provides prescription drug coverage to this Commonwealth's low-income seniors who do not qualify for Medicaid.

(2) Presently, out of the 11 Medicare managed care providers who operate in this Commonwealth, one Medicare managed care provider does not provide prescription drug coverage to its Medicare beneficiaries.

(3) A total of 43,300 low-income Medicare beneficiaries who are enrolled in Medicare managed care receive their prescription drug benefit through the State-administered PACE program.

(4) A Medicare managed care provider who does not provide prescription drug coverage to its Medicare enrollees benefits from the Commonwealth's provision of a pharmaceutical benefit through the PACE program.

(5) Prescription drugs are a cost-effective therapy that has been shown to offer significant savings in other aspects of health care, particularly in the hospital and urgent-care setting.

(6) Medicare managed care providers who directly benefit

in terms of cost savings as a result of healthier seniors who participate in the PACE program should be required to contribute their fair share of costs presently borne by the Commonwealth in its administration of the PACE program.

Section 703-C. 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:

"Contribution amount." The amount due to the Commonwealth under the Medicare Managed Care Fair Share Program.

"Covered Medicare manage care provider." A managed care entity, plan or provider that participates in the Medicare program and does not provide outpatient prescription drug coverage as a covered benefit to its Medicare beneficiaries.

"Department." The Department of Aging of the Commonwealth.

"Fund." The Medicare Participation Fund established under section 705-C.

"Program." The Medicare Managed Care Fair Share Program established under this chapter.

Section 704-C. Program administration.

The program shall be administered by the department. The department shall promulgate and adopt rules and regulations as are necessary to implement the program in a cost-effective manner and that are consistent with the purposes outlined in this chapter.

Section 705-C. Contribution amount and fund.

(a) Fund.--There is hereby established a separate account in the State Treasury to be known as the Medicare Participation Fund. Moneys collected from covered Medicare managed care providers under subsection (b) shall be deposited in the fund.

All moneys in the fund are continuously appropriated to the department solely for purposes of the PACE program. The department shall collect the contributions under subsection (b) on a quarterly basis.

(b) Collection of contribution.--The department shall collect a contribution amount from covered Medicare managed care providers in an amount equal to a $20 charge per patient per month for each patient who is:

(1) enrolled and participates in a covered Medicare managed care provider plan; and

(2) enrolled and participates in the PACE program.

(c) Adjustments.--The department may consider adjustments to the contribution amount on an annual basis.

Section 706-C. Annual report.

The department shall prepare and submit annually a report to the Governor and General Assembly which shall include the department's findings and recommendations relating to the program's cost and effectiveness, including recommended adjustments to the contribution amount.

Section 4. This act shall take effect in 60 days.