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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 668 Session of 2021

INTRODUCED BY J. WARD, COLLETT, HUGHES, GORDNER, MENSCH, STEFANO, COSTA, FONTANA, KANE, PITTMAN, YUDICHAK, COMITTA AND BAKER, MAY 11, 2021

REFERRED TO AGING AND YOUTH, MAY 11, 2021

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," in pharmaceutical assistance for the elderly, further providing for the Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier, for powers of the department and for coordination of benefits.

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

Section 1. Sections 519, 533 and 534 of the act of August 26, 1971 (P.L.351, No.91), known as the State Lottery Law, are 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 person with an annual income of not less than $14,500 and not more than [$27,500] $33,500 in the case of a single person and of not less than $17,700 and not more than [$35,500] $41,500 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 50¢ is eliminated.

[(c.1) Premium.--In those instances in which a PACENET claimant is not enrolled in Part D pursuant to section 533, the claimant shall be required to pay a monthly premium equivalent to the regional benchmark premium.]

(d) Copayment.--

(1) For 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 533. Powers of the department.

The department shall:

(1) Identify the Part D plan or plans with which the department has entered into a contract under section 534 that meet the prescription drug needs and pharmacy preferences of a claimant.

(2) [Recommend] Have the discretion to require that the claimant enroll in the Part D plan or program that meets the prescription drug needs and pharmacy preferences of the claimant in the most cost-effective manner for the Commonwealth.

(3) Initiate enrollment on behalf of the claimant in the Part D plan recommended by the department unless the claimant notifies the department that the claimant wishes to enroll in another Part D plan.

(4) File and pursue appeals in accordance with CMS regulations with a claimant's Part D plan on the claimant's behalf to request exceptions to the plan's tiered cost-sharing structure or to request a nonformulary Part D drug.

(5) Assist claimants the department believes to be eligible for the LIS in making an application to the Social Security Administration.

(6) Provide at least ten days for the claimant to decline enrollment in the recommended plan.

(7) Develop and distribute language, when recommending enrollment, notifying claimants of:

(i) The ability to decline enrollment in the recommended Part D plan.

(ii) The ability to file and pursue appeals to the recommended Part D plan on their own behalf.

(iii) The possibility that their choice of plan may affect their medical coverage if they are enrolled in a

Medicare advantage plan, if applicable.

Section 534. 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 claimants who are also Part D enrollees:

(1) The primary payor shall be the PDP or the Medicare Advantage Prescription Drug Plan, as appropriate.

(2) Part D enrollees shall be required to utilize providers authorized by their PDPs or Medicare Advantage Prescription Drug Plans.

(3) The program shall pay the premium assessed by a PACE or PACENET enrollee's PDP or, with respect to the prescription drug plan, Medicare Advantage Prescription Drug Plan in an amount not to exceed the regional benchmark premium and any copayments in excess of those set forth in section 509.

[(4) Part D enrollees enrolled in PACENET shall pay the Part D premiums charged by their PDP or, with respect to the prescription drug plan, Medicare Advantage Prescription Drug Plan and the program shall pay any copayments in excess of those set forth in section 519.]

(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 noncoverage phase of Part D. For Part D enrollees enrolled in PACENET, PACENET shall reimburse Part D providers for prescription drugs in any noncoverage

phase of Part D.

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

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

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

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

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

(iv) File and pursue appeals in accordance with CMS regulations with a claimant's Part D plan on the claimant's behalf to request exceptions to the plan's tiered cost-sharing structure or to request a nonformulary Part D drug.

(8) Notwithstanding the provisions of sections 511 and 513(a), for purposes of coordination of benefits with Medicare Part D plans and to minimize disruption to enrollees, the program shall be authorized to reimburse Part D providers, including mail-order pharmacies, for more than a 30-day supply of prescription drugs.

(c) Contracts.--The department is authorized to enter into contracts with Part D plans to provide for prescription drugs to Part D enrollees through Part D pursuant to this subchapter. A Part D plan selected by the department shall meet all of the following requirements:

(1) The Part D plan has a retail pharmacy network that includes at least 90% of the pharmacies in the PACE network.

(2) The Part D plan has a premium at or below the regional benchmark premium.

(c.1) Authorization.--The department may pay the LEP of Part D enrollees in excess of the regional benchmark premium.

(d) Rebates.--The department may only receive rebates as provided in Chapter 7 where the program is the only payor for a Part D enrollee's covered prescription drugs.

Section 2. This act shall take effect in 60 days.