No. 2006-111

AN ACT

SB 1188

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 physician, certified registered nurse practitioner and pharmacy participation, for reduced assistance, for program generally, 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; establishing the coordination of Federal and State benefits; providing for continued eligibility under certain circumstances; and making editorial changes.

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

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

SUBCHAPTER A
PRELIMINARY PROVISIONS

Section 1.1. The definitions of "eligible claimant," "maximum annual income" and "program" in section 502 of the act, amended or added November 21, 1996 (P.L.741, No.134) and November 26, 2003 (P.L.212, No.37), 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:

* * *

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

* * *

"Eligible **[claimant]** ***person***." A resident of the Commonwealth for no less than 90 days, who is 65 years of age **[and over]** ***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.

* * *

"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 the annual income limits established under section 519.*** 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 50¢ is eliminated.

"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.

"Medicare Advantage Prescription Drug Plan." A Medicare advantage plan that provides qualified prescription drug coverage as set forth in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066).

* * *

"Part D." 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.

* * *

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

SUBCHAPTER B
PROGRAMS

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

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]** 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 505 and 506 of the act, added November 21, 1996 (P.L.741, No.134), are amended to read:

Section 505. Drug utilization review system.

(a) Establishment.—The department shall ensure that a state-of-the-art therapeutic drug utilization review system is established to monitor and correct misutilization of drug therapies.

(b) Review.—The department shall review utilization data provided from a PDP to monitor increases in drug utilization among claimants and determine if disease management intervention is needed.

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]** ***subchapter or be subject to coordination of benefits under this chapter.***

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]** ***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%]** ***88%*** of the average wholesale cost of the prescription drug dispensed:

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

(I) $4 ***per prescription***; 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]** ***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]** ***subchapter***.

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 claimant, the provider shall dispense the A-rated generic therapeutically equivalent drug to the 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%]** ***88%*** 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 claimant chooses not to accept the A-rated generic therapeutically equivalent drug required by subsection (a), the 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]** ***subchapter*** 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. Section 512 of the act, amended November 26, 2003 (P.L.212, No.37), is amended to read:

Section 512. **[Restricted formulary]** ***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]** ***subchapter.***

Section 6.1. Section 513 of the act, added November 21, 1996 (P.L.741, No.134), is amended to read:

Section 513. Mail order system.

(a) The department may not enter into a contract with a private contractor for an exclusive mail-order system for the delivery of prescription drugs under this program. Only mail-order pharmacy services provided by pharmacies which are licensed by the Commonwealth and which have their principal place of business within this Commonwealth may participate as providers under the program. The department shall develop and promulgate specific regulations governing the practice of mail-order pharmacy and other enrolled providers to include the following minimum standards of practice to ensure the health, safety and welfare of program participants:

(1) The appropriate method or methods by which such pharmacies shall verify the identity of the program recipient and the authenticity of prescriptions received.

(2) The appropriate method or methods by which such pharmacies shall mail or deliver prescription drugs to program recipients ensuring, to the maximum extent possible, that the intended program recipient is the actual ultimate recipient of any prescription dispensed by such pharmacies.

(3) The appropriate method or methods by which such pharmacies shall communicate with program participants in emergency situations.

(b) Notwithstanding any provision of law to the contrary, a claimant may use any and all pharmacy services offered by a PDP or Medicare Advantage Prescription Drug Plan to receive drugs and shall be permitted to continue to use those services throughout the noncoverage phase.

(c) Nothing in this section shall require a claimant to use mail-order services.

Section 6.2. Section 515 of the act, amended November 26, 2003 (P.L.212, No.37), is amended to read:

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 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 of **[eligible]** claimants. The department shall verify the income of **[eligible]** claimants by requiring income documentation from the claimants. An application for benefits under this **[chapter]** ***subchapter*** shall constitute a waiver to the department of all relevant confidentiality requirements relating to the claimant's Pennsylvania State income tax information in the possession of the Department of Revenue. The Department of Revenue shall provide the department with the necessary income information shown on the claimant'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 the Department of Revenue information except for official income verification purposes under this **[chapter]** ***subchapter or as authorized under section 535.***

(c) Penalty.—A person who violates this **[act]** ***section*** 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.

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

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]** ***person*** 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 50¢ 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.]

(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 **[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]** ***subchapter***, 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]** ***subchapter***;

(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]** ***subchapter***.

(b) Civil penalty.—In addition to any appropriate criminal penalty for prohibited acts under this **[chapter]** ***subchapter*** 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]** ***subchapter*** shall be suspended for a period of one year. The license of any provider who has committed three or more violations of this **[chapter]** ***subchapter*** may be suspended for a period of one year.

(d) Reparation.—Any provider, **[recipient]** ***claimant*** or other person who is found guilty of a crime for violating this **[chapter]** ***subchapter*** 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]** ***claimant*** or other person to repay up to three times the value of any material gain to PACE or PACENET.

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

SUBCHAPTER C
COORDINATION OF FEDERAL AND STATE BENEFITS

Section 531. Definitions.

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

"LIS." Low-income subsidy assistance from Part D 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 and copayments charged to individuals enrolled in Part D by prescription plans approved under that act.

"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).

"Part D eligible individual." An eligible person 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 claimant enrolled in a Part D plan.

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

Section 532. Purpose.

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

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 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 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.

(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 535. Financial resource information.

(a) Procedure.—The department may obtain information on the financial resources of a Part D eligible individual for the purpose of determining the individual's potential eligibility for the LIS. The authority granted under this subsection shall be exercised only with respect to a Part D eligible individual who has income which is below the applicable threshold established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173, 117 Stat. 2066) for qualification under the LIS.

(b) Waiver.—An application by a Part D eligible individual for enrollment in the program shall constitute a waiver to the department of relevant confidentiality requirements relating to the prospective claimant's financial resources in the possession of any Commonwealth agency or third party when the information is required for the purposes listed under subsection (a). This waiver shall extend to the application phase and throughout the entire time the claimant is in the program.

(c) Information confidential.—

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

(2) A person that violates this subsection commits a misdemeanor of the third degree 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, and to pay the costs of prosecution. If the offender is an officer or employee of the Commonwealth, the offender shall be dismissed from office or discharged from employment.

(d) Upon request of the claimant, the department shall provide a copy of any and all filings that are processed or submitted under this subchapter.

Section 536. 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 537. Collection.

The department shall have the authority to collect any amounts from the payment by the department of pharmacy claims that are the responsibility of a PDP or Medicare Advantage Prescription Drug Plan as a primary payor pursuant to section 534(b)(1).

Section 12. Section 706 of the act, added November 21, 1996 (P.L.741, No.134), is amended to read:

Section 706. Excessive pharmaceutical price inflation discount.

(a) General rule.—A discount shall be provided to the department for all covered prescription drugs ***except those excluded under subsection (d)***. The discount shall be calculated as follows:

(1) For each quarter for which a rebate under section 705(a) and (b) is to be paid after December 31, 1991, and before January 1, 1997, the average manufacturer price for each dosage form and strength of a covered prescription drug shall be compared to the average manufacturer price for the same form and strength in the previous calendar year, and a percentage increase shall be calculated.

(2) For each quarter under paragraph (1), the average percentage increase in the Producer Price Index for Pharmaceuticals over the same quarter in the previous calendar year shall be calculated.

(3) If the calculation under paragraph (1) is greater than the calculation under paragraph (2), the discount amount for each quarter shall be equal to the product of:

(i) the difference between the calculations under paragraphs (1) and (2); and

(ii) the total number of units of each dosage form and strength reimbursed by PACE and General Assistance and the average manufacturer price reported by the manufacturer under section 704(c)(1).

(b) Revised general rule.—A discount shall be provided to the department for all covered prescription drugs ***except those excluded under subsection (d)***. The discount shall be calculated as follows:

(1) For each quarter for which a rebate under section 705(a) and (c) is to be paid after December 31, 1996, the average manufacturer price for each dosage form and strength of a covered prescription drug shall be compared to the average manufacturer price for the same form and strength in the previous calendar year and a percentage increase shall be calculated.

(2) For each quarter under paragraph (1), the average percentage increase in the Consumer Price Index-Urban over the same quarter in the previous calendar year shall be calculated.

(3) If the calculation under paragraph (1) is greater than the calculation under paragraph (2), the discount amount for each quarter shall be equal to the product of:

(i) the difference between the calculations under paragraphs (1) and (2); and

(ii) the total number of units of each dosage form and strength reimbursed by PACE, PACENET and designated pharmaceutical programs and the average manufacturer price reported by the manufacturer under section 704(c)(1).

(c) New bimarketed drugs.—For covered prescription drugs that have not been marketed for a full calendar year, subsection (a) shall apply after the covered prescription drug has been on the market for four consecutive quarters. The drug's initial average manufacturer price shall be based on the first day of the first quarter that the drug was marketed.

(d) Applicability.—This section shall not apply to a noninnovator multiple-source prescription drug or generic prescription drug.

Section 13. 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 14. (a) Notwithstanding any other provision of law to the contrary, persons who, as of December 31, 2005, are enrolled in the PACE or PACENET program as defined in section 502 of the act shall remain eligible for the PACE or PACENET program if the maximum income limit is exceeded due solely to a Social Security cost-of-living adjustment.

(b) Funding, to the extent authorized by section 306(b)(1)(vii) of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, shall continue to be appropriated to the Pharmaceutical Assistance Contract for the Elderly Fund to support the program expansions contained in this section. The Department of Aging shall also designate funds from the fund to continue eligibility under this section; however, these funds shall not exceed the funding designated under section 306(b)(1)(vii) of the Tobacco Settlement Act. If eligibility under this section requires that funds from the fund exceed those from section 306(b)(1)(vii) of the Tobacco Settlement Act, then the Department of Aging is authorized to determine eligibility requirements.

(c) Eligibility in the PACE program pursuant to this section shall expire December 31, 2006.

(d) Eligibility in the PACENET program pursuant to this section shall expire December 31, 2007.

Section 15. This act shall take effect as follows:

(1) The amendment of section 512 of the act shall take effect January 1, 2008.

(2) The amendment of section 706 of the act shall take effect January 1, 2007.

(3) The remainder of this act shall take effect immediately.

APPROVED—The 7th day of July, A.D. 2006.

EDWARD G. RENDELL