



House of Representatives

General Assembly

File No. 411

January Session, 2001

Substitute House Bill No. 5607

House of Representatives, April 23, 2001

The Committee on Human Services reported through REP. GERRATANA of the 23rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING A COMPREHENSIVE AFFORDABLE PRESCRIPTION DRUG PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-490 of the general statutes is repealed and the
2 following is substituted in lieu thereof:

3 As used in sections 17b-490 to 17b-498, inclusive, as amended by
4 this act:

5 (a) "Pharmacy" means a pharmacy licensed under section 20-594 or
6 a pharmacy located in a health care institution, as defined in
7 subsection (a) of section 19a-490, which elects to participate in Part A
8 and Part B of the program;

9 (b) "Prescription drugs" means (1) legend drugs, as defined in
10 section 20-571, (2) any other drugs which by state law or regulation
11 require the prescription of a licensed practitioner for dispensing,
12 except products prescribed for cosmetic purposes as specified in

13 regulations adopted pursuant to section 17b-494, as amended by this
14 act, and on and after September 15, 1991, diet pills, smoking cessation
15 gum, contraceptives, multivitamin combinations, cough preparations
16 and antihistamines, and (3) insulin, insulin syringes and insulin
17 needles;

18 (c) "Reasonable cost" means the cost of the prescription drug
19 determined in accordance with the formula adopted by the
20 Commissioner of Social Services in regulations for medical assistance
21 purposes plus a dispensing fee equal to the fee determined by said
22 commissioner for medical assistance purposes;

23 (d) "Resident" means a person legally domiciled within the state for
24 a period of not less than one hundred eighty-three days immediately
25 preceding the date of application for inclusion in Part A or Part B of
26 the program. Mere seasonal or temporary residences within the state,
27 of whatever duration, shall not constitute domicile;

28 (e) "Disabled" means a person over eighteen years of age who is
29 receiving disability payments pursuant to either Title 2 or Title 16 of
30 the Social Security Act of 1935, as amended;

31 (f) "Commissioner" means the Commissioner of Social Services;

32 (g) "Income" means adjusted gross income as determined for
33 purposes of the federal income tax plus any other income of such
34 person not included in such adjusted gross income minus Medicare
35 Part B premium payments. The amount of any Medicaid payments
36 made on behalf of such person or the spouse of such person shall not
37 constitute income;

38 (h) "Program" means the Connecticut Pharmaceutical Assistance
39 Contract to the Elderly and the Disabled Program otherwise known as
40 ConnPACE. The program shall consist of Part A and Part B;

41 (i) "Pharmaceutical manufacturer" means any entity holding legal

42 title to or possession of a national drug code number issued by the
43 federal Food and Drug Administration;

44 (j) "Average manufacturer price" means the average price paid by a
45 wholesaler to a pharmaceutical manufacturer, after the deduction of
46 any customary prompt payment discounts, for a product distributed
47 for retail sale.

48 Sec. 2. Section 17b-491 of the general statutes is repealed and the
49 following is substituted in lieu thereof:

50 (a) There shall be a "Connecticut Pharmaceutical Assistance
51 Contract to the Elderly and the Disabled Program", Part A and Part B,
52 which shall be within the Department of Social Services. [The] Part A
53 of the program shall consist of payments by the state to pharmacies for
54 the reasonable cost of prescription drugs dispensed to eligible persons
55 minus a copayment charge, effective July 1, 1993, of twelve dollars for
56 each prescription dispensed under Part A of the program. The
57 pharmacy shall collect the copayment charge from the eligible person
58 at the time of each purchase of prescription drugs, and shall not waive,
59 discount or rebate in whole or in part such amount. Part B of the
60 program shall consist of a drug benefit that allows recipients to
61 purchase prescriptions at the average wholesale price reduced by
62 twelve per cent or other such price as may be calculated under the
63 Medicaid program.

64 (b) Notwithstanding the provisions of subsection (a) of this section,
65 effective September 15, 1991, payment by the state to a pharmacy
66 under Part A of the program may be based on the price paid directly
67 by a pharmacy to a pharmaceutical manufacturer for drugs dispensed
68 under the program minus the copayment charge, plus the dispensing
69 fee, if the direct price paid by the pharmacy is lower than the
70 reasonable cost of such drugs.

71 (c) Effective September 15, 1991, reimbursement to a pharmacy for

72 prescription drugs dispensed under Part A of the program shall be
73 based upon actual package size costs of drugs purchased by the
74 pharmacy in units larger than or smaller than one hundred.

75 (d) The commissioner shall establish an application form whereby a
76 pharmaceutical manufacturer may apply to participate in the program.
77 Participation in the program shall require participation in both Part A
78 and Part B. Upon receipt of a completed application, the department
79 shall issue a certificate of participation to the manufacturer.
80 Participation by a pharmaceutical manufacturer shall require that the
81 department shall receive a rebate from the pharmaceutical
82 manufacturer. Rebate amounts for brand name prescription drugs
83 shall be equal to those under the Medicaid program. Rebate amounts
84 for generic prescription drugs shall be established by the
85 commissioner, provided such amounts may not be less than those
86 under the Medicaid program. A participating pharmaceutical
87 manufacturer shall make quarterly rebate payments to the department
88 for the total number of dosage units of each form and strength of a
89 prescription drug which the department reports as reimbursed to
90 providers of prescription drugs, provided such payments shall not be
91 due until thirty days following the manufacturer's receipt of utilization
92 data from the department including the number of dosage units
93 reimbursed to providers of prescription drugs during the quarter for
94 which payment is due.

95 (e) All prescription drugs of a pharmaceutical manufacturer that
96 participates in the program pursuant to subsection (d) of this section
97 shall be subject to prospective drug utilization review. Any
98 prescription drug of a manufacturer that does not participate in the
99 program shall not be reimbursable, unless the department determines
100 the prescription drug is essential to program participants.

101 Sec. 3. Section 17b-491a of the general statutes is repealed and the
102 following is substituted in lieu thereof:

103 [(a) The Commissioner of Social Services may establish a plan for
104 the prior authorization of (1) any initial prescription for a drug covered
105 under the Medicaid, state-administered general assistance, general
106 assistance or ConnPACE program that costs five hundred dollars or
107 more for a thirty-day supply, or (2) any early refill of a prescription
108 drug covered under any of said programs. The Commissioner of Social
109 Services shall establish a procedure by which prior authorization
110 under this subsection shall be obtained from an independent
111 pharmacy consultant acting on behalf of the Department of Social
112 Services, under an administrative services only contract. If prior
113 authorization is not granted or denied within two hours of receipt by
114 the commissioner of the request for prior authorization, it shall be
115 deemed granted.]

116 [(b)] (a) The Commissioner of Social Services shall, to increase cost-
117 efficiency or enhance access to a particular prescription drug, establish
118 a plan under which the commissioner may designate specific suppliers
119 of a prescription drug from which a dispensing pharmacy shall order
120 the prescription to be delivered to the pharmacy and billed by the
121 supplier to the department. For each prescription dispensed through
122 designated suppliers, the department shall pay the dispensing
123 pharmacy a handling fee not to exceed four hundred per cent of the
124 dispensing fee established pursuant to section 17b-280. In no event
125 shall the provisions of this subsection be construed to allow the
126 commissioner to purchase all prescription drugs covered under the
127 Medicaid, state-administered general assistance, general assistance and
128 ConnPACE programs under one contract.

129 [(c)] (b) Notwithstanding the provisions of section 17b-262 and any
130 regulation adopted thereunder, on or after July 1, 2000, the
131 Commissioner of Social Services may establish a schedule of maximum
132 quantities of oral dosage units permitted to be dispensed at one time
133 for prescriptions covered under the Medicaid, state-administered
134 general assistance and general assistance programs based on a review

135 of utilization patterns.

136 [(d)] (c) A plan or schedule established pursuant to subsection (a) [,
137 (b) or (c)] or (b) of this section and any revisions thereto shall be
138 submitted to the joint standing committees of the General Assembly
139 having cognizance of matters relating to public health, human services
140 and appropriations and the budgets of state agencies. Within sixty
141 days of receipt of such a plan or schedule or revisions thereto, said
142 joint standing committees of the General Assembly shall approve or
143 deny the plan or schedule or any revisions thereto and advise the
144 commissioner of their approval or denial of the plan or schedule or
145 any revisions thereto. The plan or schedule or any revisions thereto
146 shall be deemed approved unless all committees vote to reject such
147 plan or schedule or revisions thereto within sixty days of receipt of
148 such plan or schedule or revisions thereto.

149 Sec. 4. Section 17b-492 of the general statutes is repealed and the
150 following is substituted in lieu thereof:

151 (a) Eligibility for participation in Part A of the program shall be
152 limited to any resident (1) who is sixty-five years of age or older or
153 who is disabled, (2) whose annual income, if unmarried, is less than
154 [thirteen thousand eight hundred dollars] three hundred per cent of
155 the federal poverty level for a one person household, or whose annual
156 income, if married, when combined with that of [his] such resident's
157 spouse is less than [sixteen thousand six hundred dollars] three
158 hundred per cent of the federal poverty level for a two person
159 household, (3) who is not insured under a policy which provides full
160 or partial coverage for prescription drugs once a deductible amount is
161 met, and (4) on and after September 15, 1991, who pays an annual
162 twenty-five-dollar registration fee to the Department of Social Services.
163 [On January 1, 1998, and annually thereafter, the] On or after July 1,
164 2001: (A) Any married applicant may elect to apply for participation in
165 the program under the annual income for a one person household; and

166 (B) when applying for the program, any applicant may deduct from
167 such applicant's annual income verifiable medical and prescription
168 drug expenses incurred for such applicant during the twelve-month
169 period preceding the date of application. Any applicant who makes
170 the deduction contained in this subparagraph shall make available for
171 review by the Department of Social Services documentation of the
172 claimed medical and prescription drug expenses. The commissioner
173 shall, annually, by the adoption of regulations in accordance with
174 chapter 54, increase the income limits established under this subsection
175 over those of the previous fiscal year to reflect the annual inflation
176 adjustment in Social Security income, if any, or any change in the
177 federal poverty levels, whichever is higher. Each such adjustment shall
178 be determined to the nearest one hundred dollars.

179 (b) Eligibility for participation in Part B of the program shall be
180 limited to any resident who: (1) Is sixty-five years of age or older or
181 who is disabled and does not qualify for Part A of the program; or (2)
182 is under sixty-five years of age and is not insured under a policy that
183 provides full or partial coverage for prescription drugs once a
184 deductible amount is met and whose annual income, if unmarried, is
185 not more than three hundred per cent of the federal poverty level for a
186 one person household or whose annual income, if married, when
187 combined with that of such resident's spouse is not more than three
188 hundred per cent of the federal poverty level for a two person
189 household. Any person who participates in Part B of the program shall
190 pay an annual registration fee of twenty-five dollars to the Department
191 of Social Services. In determining income eligibility under this
192 subdivision, annual income shall be reduced by the amount of verified
193 annual medical and prescription costs for any applicant. On January 1,
194 2002, and annually thereafter, the commissioner shall, by the adoption
195 of regulations in accordance with chapter 54, increase the income
196 limits established under this subsection over those of the previous
197 fiscal year to reflect the annual inflation adjustment in Social Security
198 income, if any, or any change in the federal poverty levels, whichever

199 is higher. Each such adjustment shall be determined to the nearest one
200 hundred dollars.

201 [(b)] (c) Payment for a prescription under the program shall be
202 made only if no other plan of insurance or assistance is available to an
203 eligible person for such prescription at the time of dispensing. The
204 pharmacy shall make reasonable efforts to ascertain the existence of
205 other insurance or assistance.

206 [(c)] (d) Any eligible resident who (1) is insured under a policy
207 [which] that provides full or partial coverage for prescription drugs,^z
208 and (2) expects to exhaust such coverage, may apply to participate in
209 the program prior to the exhaustion of such coverage. Such application
210 shall be valid for the applicable income year. To be included in the
211 program, on or after the date the applicant exhausts such coverage, [he
212 or his] the applicant or the applicant's designee shall notify the
213 department that such coverage is exhausted and, if required by the
214 department, shall submit evidence of exhaustion of coverage. Not later
215 than ten days after an eligible resident submits such evidence, [he]
216 such resident shall be included in Part A or Part B of the program. The
217 program shall (A) cover prescriptions that are not covered by any
218 other plan of insurance or assistance available to the eligible resident
219 and that meet the requirements of this chapter,^z and (B) retroactively
220 cover such prescriptions filled after or concurrently with the
221 exhaustion of such coverage. Nothing in this subsection shall be
222 construed to prevent a resident from applying to participate in Part A
223 or Part B of the program as otherwise permitted by this chapter and
224 regulations adopted pursuant to this chapter.

225 [(d)] (e) The Commissioner of Social Services may adopt
226 regulations,^z in accordance with the provisions of chapter 54,^z to
227 implement the provisions of subsection [(c)] (d) of this section. Such
228 regulations may provide for the electronic transmission of relevant
229 coverage information between a pharmacist and the department or

230 between an insurer and the department in order to expedite
231 applications and notice.

232 Sec. 5. Section 17b-493 of the general statutes is repealed and the
233 following is substituted in lieu thereof:

234 A pharmacist shall, except as limited by subsection (c) of section 20-
235 619 and section 17b-274, substitute a therapeutically and chemically
236 equivalent generic drug product for a prescribed drug product when
237 filling a prescription for an eligible person under Part A or Part B of
238 the program.

239 Sec. 6. Section 17b-494 of the general statutes is repealed and the
240 following is substituted in lieu thereof:

241 The Commissioner of Social Services shall adopt regulations, in
242 accordance with the provisions of chapter 54, to establish (1) a system
243 for determining eligibility and disqualification under Part A and Part B
244 of the program, including provisions for an identification number and
245 a renewable, nontransferable identification card; (2) requirements for
246 the use of the identification number and card by the pharmacy and the
247 eligible person; (3) a system of payments; (4) limitations on the
248 maximum quantity per prescription which shall not exceed a thirty-
249 day supply or one hundred twenty oral dosage units whichever is
250 greater; (5) requirements as to records to be kept by the pharmacy,
251 including patient profiles; (6) products prescribed for cosmetic and
252 other purposes which shall not be covered under the program; and (7)
253 such other provisions as are necessary to implement the provisions of
254 sections 17b-490 to 17b-495, inclusive, as amended by this act.

255 Sec. 7. Section 17b-495 of the general statutes is repealed and the
256 following is substituted in lieu thereof:

257 (a) The commissioner may enter into an agreement with a fiscal
258 intermediary [which] that may be an agency of the state, or a person,

259 firm or public or nonprofit corporation, for the administration of the
260 whole or any part of Part A and Part B of the program. Any such
261 contract shall be subject to the provisions of sections 4a-57 and 4a-59,
262 except that preference shall be given to persons, firms or corporations
263 doing business in the state.

264 (b) The contract shall require the fiscal intermediary to submit
265 quarterly reports to the commissioner on the operation of Part A and
266 Part B of the program, including financial and utilization statistics as to
267 drug use by therapeutic category, actuarial projections, an outline of
268 problems encountered in the administration of the program and
269 suggested solutions to the same and any recommendations to enhance
270 the program.

271 (c) The commissioner shall verify the propriety and reasonableness
272 of payments to providers, through field audit examinations and other
273 reasonable means, to the extent possible within available
274 appropriations. The commissioner shall submit an annual report, on or
275 before February first of each year, to the Secretary of the Office of
276 Policy and Management and the chairpersons of the joint standing
277 committee of the General Assembly having cognizance of matters
278 relating to appropriations and the budgets of state agencies outlining
279 the program for carrying out such verifications and including the
280 results of such verifications.

281 (d) The commissioner shall submit quarterly reports, within thirty
282 days after the end of each fiscal quarter, to the Governor and the
283 chairpersons of the joint standing committees of the General Assembly
284 having cognizance of matters relating to appropriations and the
285 budgets of state agencies and public health. The report shall include a
286 copy of the most recent report of the fiscal intermediary, if any, and (1)
287 the number of consumers eligible for Part A and Part B of the program,
288 (2) the number of consumers utilizing Part A and Part B of the
289 program, (3) an outline of and a report on the educational outreach

290 program, (4) the number of appeals, (5) an outline of problems
291 encountered in the administration of Part A and Part B of the program
292 and suggested solutions and any recommendations to enhance Part A
293 and Part B of the program.

294 Sec. 8. Section 17b-496 of the general statutes is repealed and the
295 following is substituted in lieu thereof:

296 Any person aggrieved by any action of the commissioner in
297 connection with the administration of Part A or Part B of the program
298 shall have a right to a hearing before the commissioner in accordance
299 with the provisions of chapter 54.

300 Sec. 9. Section 17b-498 of the general statutes is repealed and the
301 following is substituted in lieu thereof:

302 The Commissioner of Social Services shall undertake an educational
303 outreach program to make known the provisions of Part A and Part B
304 of the program to the public, with emphasis on reaching the elderly
305 and the disabled in the state through the various local and state-wide
306 agencies and organizations concerned with the elderly and the
307 disabled, and to all pharmacies and physicians in the state.

308 Sec. 10. Section 17b-274 of the general statutes is repealed and the
309 following is substituted in lieu thereof:

310 (a) The Commissioner of Social Services shall pay a pharmacist a
311 professional dispensing fee of fifty cents per prescription, in addition
312 to any other dispensing fee, for substituting a generically equivalent
313 drug product, in accordance with section 20-619, for the drug
314 prescribed by the licensed practitioner for a Medicaid recipient,
315 provided the substitution is not required by federal law or regulation.

316 (b) The Division of Criminal Justice shall periodically investigate
317 pharmacies to ensure that the state is not billed for a brand name drug
318 product when a less expensive generic substitute drug product is

319 dispensed to a Medicaid recipient. The Commissioner of Social
320 Services shall cooperate and provide information as requested by such
321 division.

322 (c) A licensed medical practitioner may specify in writing or by a
323 telephonic or electronic communication that there shall be no
324 substitution for the specified brand name drug product in any
325 prescription for a Medicaid, state-administered general assistance,
326 general assistance or ConnPACE recipient, provided (1) the
327 practitioner specifies the basis on which the brand name drug product
328 and dosage form is medically necessary in comparison to a chemically
329 equivalent generic drug product substitution, and (2) the phrase
330 "brand medically necessary" shall be in the practitioner's handwriting
331 on the prescription form or, if the prohibition was communicated by
332 telephonic communication, in the pharmacist's handwriting on such
333 form, and shall not be preprinted or stamped or initialed on such form.
334 If the practitioner specifies by telephonic communication that there
335 shall be no substitution for the specified brand name drug product in
336 any prescription for a Medicaid, state-administered general assistance,
337 general assistance or ConnPACE recipient, written certification in the
338 practitioner's handwriting bearing the phrase "brand medically
339 necessary" shall be sent to the dispensing pharmacy within ten days. A
340 pharmacist shall dispense a generically equivalent drug product for
341 any drug listed in accordance with the Code of Federal Regulations
342 Title 42 Part 447.332 for a drug prescribed for a Medicaid, state-
343 administered general assistance, general assistance or ConnPACE
344 recipient unless the phrase "brand medically necessary" is ordered in
345 accordance with this subsection. [and such pharmacist has received
346 approval to dispense the brand name drug product in accordance with
347 subsection (d) of this section.]

348 [(d) The Commissioner of Social Services shall establish a procedure
349 by which a pharmacist shall obtain approval from an independent
350 pharmacy consultant acting on behalf of the Department of Social

351 Services, under an administrative services only contract, whenever the
352 pharmacist dispenses a brand name drug product to a Medicaid, state-
353 administered general assistance, general assistance or ConnPACE
354 recipient and a chemically equivalent generic drug product
355 substitution is available, provided such procedure shall not require
356 approval for other than initial prescriptions for such drug product. If
357 such approval is not granted or denied within two hours of receipt by
358 the commissioner of the request for approval, it shall be deemed
359 granted. The pharmacist may appeal a denial of reimbursement to the
360 department based on the failure of such pharmacist to substitute a
361 generic drug product in accordance with this section.]

362 [(e)] (d) A licensed medical practitioner shall disclose to the
363 Department of Social Services, [or such consultant,] upon request, the
364 basis on which the brand name drug product and dosage form is
365 medically necessary in comparison to a chemically equivalent generic
366 drug product substitution. [The Commissioner of Social Services shall
367 establish a procedure by which such a practitioner may appeal a
368 determination that a chemically equivalent generic drug product
369 substitution is required for a Medicaid, state-administered general
370 assistance, general assistance or ConnPACE recipient.]

371 Sec. 11. (NEW) The Commissioner of Social Services shall submit an
372 application for a federal waiver for the purposes of conducting a
373 program to provide prescription drugs to persons who meet the
374 eligibility requirements under the ConnPACE Part B program
375 established in subsection (b) of section 17b-492 of the general statutes,
376 as amended by this act, at the Medicaid price which shall be the
377 average wholesale price reduced by twelve per cent or such other price
378 as may be calculated under the Medicaid program. The state shall pay
379 the pharmacist a participation incentive fee at a rate of not less than
380 one hundred fifty per cent of the Medicaid dispensing fee. The state
381 shall receive the applicable Medicaid rebate from the pharmaceutical
382 drug companies and shall apply the rebates to offset the costs of the

383 dispensing fee. The waiver shall include the full range of prescription
384 drugs provided under the current Medicaid program. There shall be
385 no asset limit for eligibility.

386 Sec. 12. (NEW) (a) There is established a Prescription Drug Fair
387 Pricing Review Board. The board shall consist of: (1) Three members
388 appointed by the speaker of the House of Representatives; (2) three
389 members appointed by the president pro tempore of the Senate; (3)
390 three members appointed by the minority leader of the House of
391 Representatives; (4) three members appointed by the minority leader
392 of the Senate; and (5) three members appointed by the Governor. Such
393 members may include, but need not be limited to, members of the
394 General Assembly, representatives of relevant state agencies,
395 pharmacists, physicians, representatives of health care providers who
396 are not physicians, representatives of disabled persons, senior citizens
397 and low income persons having no financial or other affiliation with
398 any health care provider, representatives of health care facilities,
399 representatives of health insurers and representatives of
400 pharmaceutical companies. The Department of Social Services shall
401 provide such staff as is necessary for the performance of the functions
402 and duties of the board.

403 (b) Not later than January 1, 2002, the board shall establish a
404 schedule of suggested fair manufacturer prices for all prescription
405 drugs sold through the ConnPACE Part A and Part B programs. In
406 establishing such schedule, the board shall consider (1) the prices
407 charged for prescription drugs in other countries, (2) the prices listed
408 on the federal supply schedule, (3) the prices charged to other
409 governmental agencies, health care facilities, health insurance
410 companies and other purchasers, and (4) such other comparable
411 information as the board deems relevant. The fair manufacturer price
412 of any prescription drug, as provided in such schedule, shall not
413 exceed the manufacturer price for such prescription drug as sold in
414 Canada or the price listed on the federal supply schedule. Not later

415 than January 1, 2002, the board shall establish a reasonable dispensing
416 fee for retail pharmacies applicable to sales through the ConnPACE
417 Part B program. Such fee shall be sufficient to encourage pharmacist
418 participation in the program provided such fee is not less than one
419 hundred fifty per cent of the Medicaid dispensing fee. Not later than
420 January 1, 2002, and annually thereafter, the board shall review such
421 schedule and dispensing fee and may revise such schedule and
422 dispensing fee as the board may determine to be appropriate.

423 (c) The Commissioner of Social Services shall distribute and post the
424 schedule of suggested fair manufacturer prices established under
425 subsection (b) of this section. The commissioner shall distribute such
426 schedule to all retail pharmacies in this state and shall post such
427 schedule on the Department of Social Services' Internet web site. The
428 commissioner may take any action necessary to implement the
429 provisions of this section including, but not limited to, issuing
430 subpoenas and collecting from any manufacturer, wholesaler or
431 retailer of prescription drugs sold in this state such information as the
432 commissioner deems necessary for the board to carry out its duties
433 under subsection (b) of this section.

434 (d) The board and the Commissioner of Social Services, in
435 consultation with the Commissioner of Consumer Protection, shall
436 submit a report to the General Assembly not later than January 1, 2002,
437 and annually thereafter, in accordance with section 11-4a of the general
438 statutes, concerning prescription drug prices in this state. Such report
439 shall include, but not be limited to: (1) The schedule of suggested fair
440 manufacturer prices established under subsection (b) of this section; (2)
441 the surveys of retail prices conducted pursuant to subsection (b) of this
442 section for the most commonly used prescription drugs in this state; (3)
443 a financial analysis of the effect of the requirements of this section on
444 prescription drug costs in this state, including the financial savings to
445 public and private health insurance programs and financial savings to
446 individual state residents and employers; and (4) such other findings

447 and recommendations as the board and the Commissioner of Social
448 Services deem appropriate.

449 Sec. 13. (NEW) (a) There is established a consumer advisory
450 committee that shall consist of: (1) Two members appointed by the
451 speaker of the House of Representatives; (2) two members appointed
452 by the president pro tempore of the Senate; (3) two members
453 appointed by the minority leader of the House of Representatives; (4)
454 two members appointed by the minority leader of the Senate; and (5)
455 two members appointed by the Governor. Such members shall be
456 appointed not later than October 1, 2001. The consumer advisory
457 committee shall review proposals for, and make recommendations to,
458 the Commissioner of Public Health concerning the award of grants
459 under this section. Said commissioner shall provide such staff as is
460 necessary for the performance of the functions and duties of the
461 consumer advisory committee.

462 (b) Not later than October 1, 2001, the Commissioner of Public
463 Health shall request proposals to award one or more grants to
464 community health centers, free health care clinics and other nonprofit
465 organizations to educate and assist state residents to purchase
466 prescription drugs at the lowest possible cost. Grants may be awarded
467 under this section for: (1) Identifying and organizing pharmacies,
468 clinics, physicians and other health care providers who can assist state
469 residents in the prescribing and purchasing of prescription drugs at
470 the lowest possible price; (2) assisting and organizing the
471 communications, prescriptions, purchasing, transportation and other
472 activities necessary for state residents to purchase prescription drugs;
473 and (3) any other proposal designed to educate state residents about
474 low cost prescription drug opportunities at the state or federal level or
475 to permit state residents to purchase prescription drugs at the lowest
476 possible price.

477 (c) The commissioner shall review proposals submitted under

478 subsection (a) of this section and, after the review and upon the
479 recommendation of the consumer advisory committee established
480 pursuant to subsection (a) of this section, may award one or more
481 grants under this section, provided: (1) All such proposals shall be
482 submitted to the commissioner not later than October 1, 2001; (2) any
483 proposal for which a grant is awarded shall be implemented not later
484 than December 31, 2001, and shall be approved for a duration of not
485 less than one year; and (3) such proposals shall ensure that any
486 prescription drug purchase transaction is approved by a retail
487 pharmacist in this state, who shall receive a fee for approval equal to
488 the Medicaid dispensing fee.

489 Sec. 14. (NEW) The Governor shall direct the appropriate state
490 officials to join the New England consortium for group purchases of
491 prescription drugs.

492 Sec. 15. (NEW) On March 31, 2002, and annually thereafter, any
493 manufacturer of prescription drugs which were sold in this state
494 during the preceding calendar year shall file a report with the
495 Commissioner of Consumer Protection. Such report shall disclose the
496 total amount of expenses for advertising and promotions of
497 prescription drugs in this state and in the United States for the
498 preceding calendar year. For purposes of this section, promotions
499 include free samples, media events, gifts, trips, conferences or meals.
500 The annual report shall list expenses for promotions by such categories
501 and such other categories as the manufacturer may determine. Within
502 thirty days of receipt of such report, the Commissioner of Consumer
503 Protection shall file such report with the joint standing committees of
504 the General Assembly having cognizance of matters relating to public
505 health and human services and the Prescription Drug Fair Pricing
506 Review Board. The Prescription Drug Fair Pricing Review Board shall
507 prescribe the form for such report for use by such manufacturers.

508 Sec. 16. This act shall take effect from its passage.

HS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Significant Cost

Affected Agencies: Departments of Social Services, Public Health, Consumer Protection; Office of Legislative Management, Office of the State Comptroller

Municipal Impact: None

Explanation

State Impact:

This bill makes various changes regarding pharmaceutical benefit programs administered by the Department of Social Services (DSS) and related issues. These changes and their associated fiscal impacts are as follows:

CONNPACE PART A

Change Income Limits

The Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE) Program's income limits would be increased to 300 percent of the federal poverty limit, effective upon passage. These income limits are currently set at \$15,100 (single) and \$18,100 (married), and are indexed upward each January 1st in accordance with the prior year's social security cost of living

adjustment (COLA). The new limits would initially be set at \$25,800 (single) and \$34,800 (married).

The bill also allows married applicants to apply under the single enrollee's income limit. While the bill does not state how a married couple's income is to be divided for purposes of determining ConnPACE eligibility, if fifty percent of their joint income is attributed to one applicant, this would have the effect of increasing the income limits for married persons to \$51,600.

It is estimated that these policy changes would result in an increase in the number of ConnPACE enrollees by approximately 33,000 persons. FY 02 costs associated with supporting their drug purchases cannot be accommodated within DSS's budget, as provided within sHB 6668 (the Appropriations Act, as favorably reported by the Appropriations Committee). The Committee Report includes FY 02 funding of \$58,085,086 and an earmarking of \$20 million from the FY 01 General Fund surplus to allow for increasing the ConnPACE Program's income limits to 250 percent of the federal poverty level, which will add approximately 16,600 persons to the program.

Other ConnPACE Part A Changes

Further, the bill allows a person to deduct from their income any verifiable medical or prescription expenses incurred during the twelve-month period preceding the date of application. The number of persons made eligible due to this policy change cannot be determined at this time. However, it is anticipated that DSS will incur both significant administrative costs, in the course of reviewing applicant's documented expenses, and program costs to support the purchase of an indeterminate number of additional prescriptions. Any resulting costs would be partially offset by the applicant's payment of a \$25 annual fee and collection of manufacturer rebates of approximately nineteen percent of the value of drugs purchased by these individuals. No funding has been included within sHB 6668 for

this purpose.

Finally, the bill modifies current law, which requires the Commissioner of Social Services to adjust the ConnPACE income limits annually in accordance with the social security COLA by instead requiring that the income limits be adjusted according to the higher of the social security COLA or the change in the federal poverty level. To the extent that this increases future income limits above those that would otherwise be set, potentially significant future costs will ensue.

CONNPACE PART B

A significant cost will be incurred by DSS to establish the ConnPACE Part B program. This cost will be associated with additional administrative staff and data processing systems changes needed to develop this new benefit. It should be noted that while the Governor's Recommended FY 02 - FY 03 Biennial Budget included an earmarking of \$2.4 million from the FY 01 General Fund surplus to support these startup costs, these dollars were not included in sHB 6668.

ELIMINATION OF PRIOR AUTHORIZATION & STRICT GENERIC SUBSTITUTION REQUIREMENTS FOR MEDICAID/ SAGA/CONNPACE

The bill repeals DSS's authority to implement a prior authorization procedure for high cost drugs under the Medicaid, ConnPACE and State Administered General Assistance (SAGA) programs. A significant cost will result from the elimination of prior authorization. sHB 6668 assumes savings of \$2.4 million in FY 02 and \$2.9 million in FY 03 from this procedure.

It also repeals DSS's ability to pre-approve any non-generic prescriptions under the Medicaid, ConnPACE and SAGA programs. This will also result in significant costs to the state. sHB 6668 assumes

savings of \$2.7 million in FY 02 and \$2.9 million in FY 03 from this procedure.

PRESCRIPTION DRUG FAIR PRICING REVIEW BOARD / CONSUMER ADVISORY COMMITTEE

To the extent that the members of the General Assembly are appointed to the Prescription Drug Fair Pricing Review Board or the Consumer Advisory Committee, the Office of Legislative Management may incur a minimal cost. A total cost of less than \$2,500 annually may result from mileage reimbursement to legislators due to traveling to and from board/committee meetings. Legislators are currently reimbursed 30 cents per mile. Considering that legislators may be traveling to the Capitol on other legislative business, any additional cost due to an increased number of reimbursed trips could be handled within the anticipated budgetary resources of the department.

An indeterminate significant cost will be incurred by the Department of Public Health to the extent that it enters into contracts with nonprofit organizations to educate and assist residents about purchasing prescription drugs at the lowest possible cost. The bill requires bids for "one or more grants" to be solicited. No funding has been included within sHB 6668 for these grants, which would be anticipated to be significant in dollar magnitude.

PARTICIPATION IN NEW ENGLAND CONSORTIUM

The bill appears to require the state to join Maine, Vermont and New Hampshire in their efforts to provide group purchasing for prescription drugs. These states have pursued plans to create a regional prescription drug purchasing pool, having as its goal the provision of coverage to Medicaid and Medicare beneficiaries, state employees, retirees and their dependents, those without access to pharmaceutical coverage and others. They have also solicited contract bids from pharmaceutical benefits managers to oversee such a

purchasing pool. Connecticut has entered multi-year agreements with insurers for coverage of persons under various state-funded health plans. The potential ramifications for these agreements of participating in an initiative of this type are uncertain at this time.

MANUFACTURER REPORTING TO DEPARTMENT OF CONSUMER PROTECTION

The bill requires manufacturers of prescription drugs sold in the state to file a report with the Department of Consumer Protection (DCP) on a form prescribed by the Prescription Drug Fair Pricing Board. The department must then file such reports with the General Assembly. There is no cost to DCP to receive and forward these reports. Additionally, it is anticipated that DSS will be able to provide staff support to the Prescription Drug Fair Pricing Board and develop the needed forms within the agency's anticipated budgetary resources.

OLR Bill Analysis

sHB 5607

AN ACT ESTABLISHING A COMPREHENSIVE AFFORDABLE PRESCRIPTION DRUG PROGRAM.

SUMMARY:

This bill expands eligibility for the state's existing pharmacy assistance program for the elderly and also disabled and offers prescription discounts to people who do not qualify for that program. Specifically, it:

1. creates a Part B component in the Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE) program, and calls the existing program Part A;
2. increases the income limits in Part A and for both parts requires automatic increases in the income limits using the higher of two inflation indices;
3. allows applicants for either part, beginning July 1, 2001, to (a) deduct catastrophic drug and other medical expenses from income in eligibility determinations and (b) apply using the income limits for a single person when they are married;
4. directs the Department of Social Services (DSS) commissioner to apply for a federal waiver to run the Part B program, which allows enrollees to purchase drugs at the price the state pays under the Medicaid program;
5. removes DSS' authority to require prior authorization in its prescription drug assistance programs;
6. establishes a 15-member prescription drug fair pricing review board;

7. establishes a grant program for educating consumers on the purchase of drugs at the lowest possible price and a 10-member consumer advisory committee for it;
8. requires the governor to direct the appropriate state officials to join Maine, New Hampshire, and Vermont in the New England consortium for group purchases of prescription drugs; and
9. on March 31, 2002, and annually thereafter, requires drug manufacturers whose drugs are sold in the state to file a report with the commissioner of the Department of Consumer Protection (DCP) that discloses their expenses for advertising and promoting drugs sold here and elsewhere in the country.

EFFECTIVE DATE: Upon passage

CONNPACE—PARTS A AND B

Income Limits

The bill increases the income limits in Part A from \$15,100 and \$18,100, for single and married applicants, respectively, to 300% of the federal poverty level (FPL) (currently \$25,800 and \$34,800, when rounded to the nearest \$100). For Part B applicants, there is no income limit for people aged 65 and over and people with disabilities. For younger Part B applicants, the income limit is also 300% of the FPL.

Under current law, ConnPACE income limits increase each January 1, based on Social Security cost-of-living adjustments. The bill requires indexing for both Parts A and B. The adjustments must be the higher of the percentage increase in Social Security benefits or the FPL, and the remitting income limits must be rounded to the nearest \$100.

Catastrophic Medical Spend-Down

The bill permits applicants for Part A or Part B to have verifiable medical and prescription drug costs from the previous 12 months deducted from income in an eligibility determination. Applicants who use the deduction in Part A must be able to document these costs for DSS' review; no such documentation is explicitly required for Part B

applicants.

Married Applicants Applying as Single Individuals

Starting July 1, 2001, the bill gives married applicants in Part A an option to apply for benefits using the income limits for single applicants; no such provision exists for Part B applicants.

Part B—Unique Provisions and Those Similar to Part A

Under the bill, enrollees in Part B can purchase prescription drugs at the average wholesale price, reduced by 12%, or some other price that would be calculated under Medicaid.

DSS pays a participation incentive fee to pharmacists for each Part B prescription they fill. The fee must be at least 150% of the Medicaid dispensing fee (\$4.10), or \$6.15. Applicants do not have to pass an asset test, which is already the case in Part A. (In Part A, enrollees pay a \$12 co-payment for each prescription and DSS reimburses the pharmacy using the Medicaid formula.)

Currently in the Medicaid program, DSS pays pharmacists, in addition to the \$4.10 dispensing fee (1) the average wholesale price, less 12% (2) the Health Care Financing Administration's (HCFA) federal upper limit, or (3) the usual and customary charge for every drug purchased by program enrollees. The 12% discount applies to brand-name drugs and generic drugs that are not included on the HCFA list.

Applicants for Part B cannot be eligible for Part A or have any other insurance available to them. But if they expect to exhaust their coverage, they can get assistance once this occurs and can apply before hand. This already applies to Part A enrollees.

Enrollees must pay a \$25 annual registration fee, as is already the case in Part A.

The bill applies to Part B other existing Part A provisions, such as (1) requiring pharmacists to dispense generics, unless physicians indicate otherwise; (2) contracting with a fiscal intermediary to administer the program; and (3) a six-month residency requirement. It extends the

appeal rights in ConnPACE to Part B. It also widens the target of the DSS ConnPACE educational outreach program to include physicians.

Waiver for Part B—New Drug Rebates

The bill directs the DSS commissioner to apply for a federal waiver to conduct the Part B program. By expanding the reach of Medicaid to include Part B enrollees, the bill requires drug manufacturers to provide additional rebates to the state. (It appears that the state would be leveraging only the rebates and not full Medicaid coverage for enrollees. Federal law generally requires only manufacturers to have rebate agreements with states as a condition of receiving Medicaid payments for most of their drugs (42 USC § 1396r-8). These rebates must be used to offset the costs of the bill's participation incentive fee (see BACKGROUND). The waiver must include the full range of drugs available under Medicaid.

The bill makes participation by drug manufacturers in one part of the program contingent on their participation in the other. States law requires manufacturers to give the state a rebate for each of their drugs purchased by ConnPACE Part A recipients.

PRIOR AUTHORIZATION REPEAL

The bill eliminates the requirement that the DSS commissioner establish a prior authorization plan for drugs purchased by Medicaid, State-Administered General Assistance (SAGA), general assistance, or ConnPACE enrollees. Under current law, prior authorization is required for (1) first-time prescriptions costing \$500 or more for a 30-day supply (2) early refills, and (3) first time prescriptions for which a brand-name has been prescribed and a generic is available.

PRESCRIPTION DRUG FAIR PRICING REVIEW BOARD

The governor, the House speaker, Senate president pro tempore, and House and Senate majority leaders appoints three of the 15 board members. They can choose members from the legislature; relevant state agencies; pharmacists; physicians; representatives of health care providers who are not physicians; representatives of people with disabilities, senior citizens, and low-income individuals who have no

financial or other affiliation with any health care provider; and representatives of health care facilities, health insurers, and pharmaceutical companies.

By January 1, 2002, the board must establish a schedule of suggested fair manufacturer prices for all prescriptions sold through ConnPACE Parts A and B. It must consider (1) prices charged for prescription drugs in other countries; (2) prices listed on the federal supply schedule; (3) prices charged to other government agencies, health care facilities, health insurance companies, and other purchasers; and (4) other comparable information that it deems relevant. The fair suggested manufacturer price cannot exceed either the manufacturer price for drugs sold in Canada or the price listed in the federal supply schedule. The DSS commissioner must distribute the schedule to all retail pharmacies in the state and she must post it on the department's website.

By that date, the board must also establish a reasonable dispensing fee for retail pharmacies participating in ConnPACE, Part B. (This would presumably be the same as the pharmacist incentive fee established elsewhere in the bill.) The fee must be high enough to encourage pharmacist participation and must be the same or higher than the incentive fee (\$6.15) that the bill establishes.

The board must review both the price schedule and dispensing fee each year, beginning January 1, 2002. (But the bill also requires the establishment of the schedule and dispensing fee by that date).

DSS must provide the staff needed to perform the board's duties and functions. The bill authorizes the commissioner to take any action necessary to implement the bill's drug pricing and dispensing fee provisions, including issuing subpoenas and collecting information she thinks the board needs from drug manufacturers, wholesalers, or retailers that sell drugs in Connecticut.

The board and DSS commissioner, in consultation with the DCP commissioner, must report to the General Assembly by January 1, 2002, and annually thereafter. At a minimum, the report must include: (1) the pricing schedule; (2) surveys of retail drug prices for the most commonly prescribed drugs in the state; (3) a financial analysis of the

effect of the bill's pricing requirements (presumably what the effects would be if the state were to mandate the fair manufacturer price) on drug costs in the state, including the savings to public and private health insurance programs, state residents, and employers; and (4) any other findings and recommendations deemed appropriate.

DRUG PURCHASING EDUCATION GRANT AND ADVISORY COMMITTEE

By October 1, 2001, the bill requires the Department of Public Health (DPH) commissioner to request proposals to award one or more grants to community health centers, free health care clinics, and other nonprofit organizations to educate and help state residents buy drugs at the lowest possible cost.

The grants can be awarded for (1) identifying and organizing pharmacies, clinics, physicians, and other health care providers who can assist residents in the prescribing and purchasing prescription drugs at the lowest possible price; (2) assisting and organizing the communications, prescriptions, purchasing, transportation, and other activities needed to enable such purchases to occur; and (3) any other proposal designed to (a) educate residents about low cost prescription drug opportunities at the state or federal level or (b) permit them to purchase prescriptions at the lowest possible price.

The bill creates a consumer advisory committee consisting of 10 people, two each appointed by the House speaker, Senate president pro tempore, and House and Senate majority leaders and the governor. Appointments must be made by October 1, 2001. The DPH commissioner must provide necessary staff to the committee.

The committee must review the proposals and make recommendations to the commissioner of the Department of Public Health (DPH) concerning the awarding of the grants. The commissioner must also review the proposals. Once he reviews the proposals and has the committee's recommendations, he can award the grants.

The proposals are awarded only if (1) they are submitted by October 1, 2001, (2) can be implemented by December 31, 2001 and are to last for at least one year, and (3) the grantee can ensure that any prescription

drug purchase is approved by a retail pharmacist in the state, who gets paid an approval fee equal to the Medicaid dispensing fee (\$4.10).

DRUG MANUFACTURER REPORTING OF ADVERTISING AND PROMOTIONAL COSTS

The bill requires an annual report of manufacturer advertising and promotional expenses during the previous calendar year. Promotions include free samples, media events, gifts, trips, and conferences or meals. Manufacturers must list expenses for promotions by these or other categories they determine.

The DCP commissioner must, within 30 days of receiving the report, file it with the Public Health and Human Services committees and the Prescription Drug Fair Pricing Review Board. The board must prescribe the form for the report.

BACKGROUND

Related Law: ConnPace B Plan

Section 29 of PA 00-2, June special session, required the DSS Commissioner to come up with a cost-neutral plan for administering a ConnPace Part B program. DSS submitted the plan in February 2001. The plan assumes the state would receive additional manufacturer rebates, which would be used to pay (1) pharmacist a participation incentive fee and (2) for administrative costs. Although the ongoing program would be expected to be cost-neutral, the plan estimate start-up costs, which rise as the program's income limits are raised, the act requires DSS to run the program only after the committees of cognizance agree that cost-neutrality has been met. To date, the committees have not approved the plan.

Related Bill

SSB 1120, favorably reported on April 10, 2001, for ConnPace to 250% of the FPL (2) allows for increases the income limits deductions of prescription drug expenses, and (3) requires the DSS commission to apply for a federal waiver to get Medicaid to pay for one-half of ConnPace costs.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 9 Nay 7