



General Assembly

January Session, 2005

Bill No. 6687

LCO No. 3429

*03429 _____ *

Referred to Committee on Human Services

Introduced by:

REP. WARD, 86th Dist.

SEN. DELUCA, 32nd Dist.

**AN ACT CONCERNING THE GOVERNOR'S BUDGET
RECOMMENDATIONS WITH RESPECT TO THE IMPLEMENTATION
OF MEDICARE PART D.**

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

1 Section 1. (NEW) (*Effective July 1, 2005*) On and after the effective
2 date of the Medicare Part D program established pursuant to Public
3 Law 108-173, the Medicare Prescription Drug, Improvement, and
4 Modernization Act of 2003, no Medicaid prescription drug coverage
5 shall be provided to a Medicaid recipient eligible for Medicare Part D
6 for Medicare Part D Drugs, as defined in said act. Medicaid coverage
7 will be provided for prescription drugs that are not Medicare Part D
8 drugs, as defined in said act.

9 Sec. 2. Section 17b-490 of the general statutes is repealed and the
10 following is substituted in lieu thereof (*Effective July 1, 2005*):

11 As used in sections 17b-490 to 17b-498, inclusive:

12 (a) "Pharmacy" means a pharmacy licensed under section 20-594 or

13 a pharmacy located in a health care institution, as defined in
14 subsection (a) of section 19a-490, which elects to participate in the
15 program;

16 (b) "Prescription drugs" means (1) legend drugs, as defined in
17 section 20-571, (2) any other drugs which by state law or regulation
18 require the prescription of a licensed practitioner for dispensing,
19 except products prescribed for cosmetic purposes as specified in
20 regulations adopted pursuant to section 17b-494, and on and after
21 September 15, 1991, diet pills, smoking cessation gum, contraceptives,
22 multivitamin combinations, cough preparations and antihistamines,
23 and (3) insulin [,] and insulin syringes; [and insulin needles;]

24 (c) "Reasonable cost" means the cost of the prescription drug
25 determined in accordance with the formula adopted by the
26 Commissioner of Social Services in regulations for medical assistance
27 purposes plus a dispensing fee equal to the fee determined by said
28 commissioner for medical assistance purposes;

29 (d) "Resident" means a person legally domiciled within the state for
30 a period of not less than one hundred eighty-three days immediately
31 preceding the date of application for inclusion in the program. Mere
32 seasonal or temporary residences within the state, of whatever
33 duration, shall not constitute domicile;

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

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

38 (g) "Income" means adjusted gross income as determined for
39 purposes of the federal income tax plus any other income of such
40 person not included in such adjusted gross income minus Medicare
41 Part B premium payments. The amount of any Medicaid payments
42 made on behalf of such person or the spouse of such person shall not

43 constitute income;

44 (h) "Program" means the Connecticut [pharmaceutical assistance
45 contract to the elderly and the disabled program] Pharmaceutical
46 Assistance Contract to the Elderly and the Disabled Program otherwise
47 known as ConnPACE;

48 (i) "Pharmaceutical manufacturer" means any entity holding legal
49 title to or possession of a national drug code number issued by the
50 federal Food and Drug Administration;

51 (j) "Average manufacturer price" means the average price paid by a
52 wholesaler to a pharmaceutical manufacturer, after the deduction of
53 any customary prompt payment discounts, for a product distributed
54 for retail sale;

55 (k) "Assets" means a person's resources, as defined by Public Law
56 108-173, the Medicare Prescription Drug, Improvement, and
57 Modernization Act of 2003;

58 (l) "Low income subsidy" means a premium and cost-sharing
59 subsidy for low-income individuals, as defined by Public Law 108-173,
60 the Medicare Prescription Drug, Improvement, and Modernization Act
61 of 2003;

62 (m) "Medicare Part D covered prescription drugs" means drugs that
63 are included in Medicare Part D plan's formulary or are treated as
64 being included in a Medicare Part D plan's formulary, as defined by
65 Public Law 108-173, the Medicare Prescription Drug, Improvement
66 and Modernization Act of 2003;

67 (n) "Medicare Part D plan" means a Medicare Part D plan, as
68 defined by Public Law 108-173, the Medicare Prescription Drug,
69 Improvement, and Modernization Act of 2003;

70 (o) "Gap in standard Medicare Part D coverage" means a drug
71 obtained after a Medicare Part D beneficiary's initial coverage limit has

72 been exceeded but before the beneficiary's annual out-of-pocket
73 threshold has been met, as defined by Public Law 108-173, the
74 Medicare Prescription Drug, Improvement, and Modernization Act of
75 2003.

76 Sec. 3. Subsection (a) of section 17b-491 of the general statutes is
77 repealed and the following is substituted in lieu thereof (*Effective July*
78 *1, 2005*):

79 (a) There shall be a "Connecticut Pharmaceutical Assistance
80 Contract to the Elderly and the Disabled Program" which shall be
81 within the Department of Social Services. The program shall consist of
82 payments by the state to pharmacies for the reasonable cost of
83 prescription drugs dispensed to eligible persons minus a copayment
84 charge. The pharmacy shall collect the copayment charge from the
85 eligible person at the time of each purchase of prescription drugs, and
86 shall not waive, discount or rebate in whole or in part such amount.
87 [Except for a replacement prescription dispensed pursuant to section
88 17b-492, the] The copayment for each prescription shall be [as follows:]
89 sixteen dollars and twenty-five cents.

90 [(1) Sixteen dollars and twenty-five cents if the participant is (A) not
91 married and has an annual income of less than twenty thousand three
92 hundred dollars, or (B) married and has an annual income that, when
93 combined with the participant's spouse, is less than twenty-seven
94 thousand five hundred dollars.

95 (2) Upon the granting of a federal waiver to expand the program in
96 accordance with section 17b-492, the copayment shall be twenty
97 dollars for a participant who is (A) not married and has an annual
98 income that equals or exceeds twenty thousand three hundred dollars,
99 or (B) married and has an annual income that, when combined with
100 the participant's spouse, equals or exceeds twenty-seven thousand five
101 hundred dollars.]

102 Sec. 4. Section 17b-492 of the general statutes is repealed and the

103 following is substituted in lieu thereof (*Effective July 1, 2005*):

104 (a) Eligibility for participation in the program shall be limited to any
105 resident (1) who is sixty-five years of age or older or who is disabled,
106 (2) whose current annual income at the time of application or
107 redetermination, if unmarried, is less than twenty thousand eight
108 hundred dollars or whose annual income, if married, when combined
109 with that of the resident's spouse is less than twenty-eight thousand
110 one hundred dollars, (3) who is not insured under a policy which
111 provides full or partial coverage for prescription drugs once a
112 deductible is met, except for a Medicare prescription drug discount
113 card endorsed by the Secretary of Health and Human Services in
114 accordance with Public Law 108-173, the Medicare Prescription Drug,
115 Improvement, and Modernization Act of 2003, [once a deductible
116 amount is met] or coverage under Medicare Part D pursuant to said
117 act, and (4) on and after September 15, 1991, who pays an annual
118 thirty-dollar registration fee to the Department of Social Services.
119 [Effective January 1, 2002, the commissioner shall commence accepting
120 applications from individuals who will become eligible to participate
121 in the program as of April 1, 2002.] On January 1, 1998, and annually
122 thereafter, the commissioner shall increase the income limits
123 established under this subsection over those of the previous fiscal year
124 to reflect the annual inflation adjustment in Social Security income, if
125 any. Each such adjustment shall be determined to the nearest one
126 hundred dollars.

127 (b) (1) Payment for a prescription under the program shall be made
128 only if no other plan of insurance or assistance is available to an
129 eligible person for such prescription at the time of dispensing, except
130 for benefits received from an endorsed Medicare prescription drug
131 discount card or benefits provided under Medicare Part D. The
132 pharmacy shall make reasonable efforts to ascertain the existence of
133 other insurance or assistance, including the subsidy provided by an
134 endorsed Medicare prescription drug discount card or benefits
135 provided under Medicare Part D. A Medicare prescription drug

136 discount card beneficiary shall be responsible for the payment of any
137 Medicare prescription drug discount card coinsurance requirements,
138 provided such requirements do not exceed the ConnPACE program
139 copayment requirements. If a Medicare prescription drug discount
140 card beneficiary's coinsurance requirements exceed the ConnPACE
141 copayment requirements, the Department of Social Services shall make
142 payment to the pharmacy to cover costs in excess of the ConnPACE
143 copayment amount. If the cost to such beneficiary exceeds the
144 remaining available Medicare prescription drug discount card subsidy,
145 the beneficiary shall not be responsible for any payment in excess of
146 the amount of the ConnPACE program copayment requirement. In
147 such cases, the Department of Social Services shall make payment to
148 the pharmacy to cover costs in excess of the ConnPACE copayment
149 amount.

150 (2) A Medicare Part D beneficiary shall be responsible for the
151 payment of Medicare Part D copayments, coinsurance and deductible
152 requirements for Medicare Part D covered prescription drugs, as
153 defined in Public Law 108-173, the Medicare Prescription Drug,
154 Improvement, and Modernization Act of 2003, to the extent such
155 requirements do not exceed the ConnPACE program copayment
156 requirements. The Department of Social Services shall pay Medicare
157 Part D monthly beneficiary premiums on behalf of the beneficiary. If a
158 Medicare Part D beneficiary's out-of-pocket copayment, coinsurance or
159 deductible requirements exceed the ConnPACE copayment
160 requirements, the department shall make payment to the pharmacy to
161 cover costs in excess of the ConnPACE copayment amount. The
162 department shall be responsible for payment of a Medicare Part D
163 covered prescription drug, including a drug obtained during the gap
164 in standard Medicare Part D coverage, at the lowest price established
165 by the Medicare Part D plan for a preferred drug in the same
166 therapeutic class and category that is dispensed by a preferred
167 pharmacy, with the client responsible for any cost differential beyond
168 the department's payment. To the extent permitted under said act,
169 payment may be made by the department for a prescription at the

170 lower of the price that would be paid under the ConnPACE program
171 or the negotiated price established by the beneficiary's Medicare Part D
172 plan pursuant to Public Law 108-173, the Medicare Prescription Drug,
173 Improvement, and Modernization Act of 2003. Payment shall be made
174 under the ConnPACE program for prescription drugs that are not
175 Medicare Part D drugs, as defined in said act.

176 [(2)] (3) Payment for a replacement prescription under the program
177 shall be made only if the eligible person signs a statement, on such
178 form as the commissioner prescribes and subject to penalty under
179 section 17b-497, that the prescription drug is lost or was stolen or
180 destroyed and the person has made a good faith effort to recover the
181 prescription drug, except that payment for a replacement prescription
182 shall not be made on behalf of a person more than twice in a calendar
183 year. [No copayment shall be required for such replacement
184 prescription.]

185 (c) Any eligible resident who (1) is insured under a policy, including
186 an endorsed Medicare prescription drug discount card, which
187 provides full or partial coverage for prescription drugs, and (2) expects
188 to exhaust such coverage, may apply to participate in the program
189 prior to the exhaustion of such coverage. Such application shall be
190 valid for the applicable income year. To be included in the program, on
191 or after the date the applicant exhausts such coverage, the applicant or
192 the applicant's designee shall notify the department that such coverage
193 is exhausted and, if required by the department, shall submit evidence
194 of exhaustion of coverage. Not later than ten days after an eligible
195 resident submits such evidence, such resident shall be included in the
196 program. The program shall, except for those beneficiaries with an
197 endorsed Medicare prescription drug discount card, (A) cover
198 prescriptions that are not covered by any other plan of insurance or
199 assistance available to the eligible resident and that meet the
200 requirements of this chapter, and (B) retroactively cover such
201 prescriptions filled after or concurrently with the exhaustion of such
202 coverage. Nothing in this subsection shall be construed to prevent a

203 resident from applying to participate in the program as otherwise
204 permitted by this chapter and regulations adopted pursuant to this
205 chapter.

206 (d) (1) As a condition of eligibility for participation in the
207 ConnPACE program, a resident with an income at or below one
208 hundred thirty-five per cent of the federal poverty level, who is
209 Medicare Part A or Part B eligible, shall obtain annually an endorsed
210 Medicare prescription drug discount card designated by the
211 Commissioner of Social Services for use in conjunction with the
212 ConnPACE program. The commissioner shall be the authorized
213 representative of such resident for the purpose of enrolling a resident
214 in the transitional assistance program of Public Law 108-173, the
215 Medicare Prescription Drug, Improvement, and Modernization Act of
216 2003. As the authorized representative for this purpose, the
217 commissioner may sign required forms and enroll such resident in an
218 endorsed Medicare prescription drug discount card on [his or her] the
219 resident's behalf. Such resident shall have the opportunity to select an
220 endorsed Medicare prescription drug discount card designated by the
221 commissioner for use in conjunction with the ConnPACE program,
222 and shall be notified of such opportunity by the commissioner. In the
223 event that such resident does not select an endorsed Medicare
224 prescription drug discount card designated by the commissioner for
225 use in conjunction with the ConnPACE program within a reasonable
226 period of time, as determined by the commissioner, the department
227 shall enroll the resident in an endorsed Medicare prescription drug
228 discount card designated by the commissioner. The provisions of this
229 subdivision shall remain in effect until the effective date of the
230 Medicare Part D program pursuant to Public Law 108-173, the
231 Medicare Prescription Drug, Improvement, and Modernization Act of
232 2003.

233 (2) The commissioner may require, as a condition of eligibility for
234 participation in the ConnPACE program, that a resident with an
235 income above one hundred thirty-five per cent of the federal poverty

236 level, who is Medicare Part A or Part B eligible, obtain an endorsed
237 Medicare prescription drug discount card designated by the
238 commissioner for use in conjunction with the ConnPACE program if
239 obtaining such discount card is determined by the commissioner to be
240 cost-effective to the state. In such an event, the commissioner may
241 provide payment for any Medicare prescription drug discount card
242 enrollment fees. The provisions of this subdivision shall remain in
243 effect until the effective date of the Medicare Part D program pursuant
244 to Public Law 108-173, the Medicare Prescription Drug, Improvement,
245 and Modernization Act of 2003.

246 (e) On and after the effective date of the Medicare Part D program
247 pursuant to Public Law 108-173, the Medicare Prescription Drug,
248 Improvement, and Modernization Act of 2003, enrollment in the
249 Medicare Part D program, for individuals eligible for such program in
250 accordance with said act, shall be a condition of eligibility for the
251 ConnPACE program. The ConnPACE program shall cover the
252 financial costs of Medicare Part D participation for ConnPACE
253 recipients enrolled in Medicare Part D in accordance with subsection
254 (b) of this section. Effective July 1, 2005, a ConnPACE recipient shall, as
255 a condition of eligibility, provide information regarding the recipient's
256 assets and income, as defined by said act, and that of the recipient's
257 spouse, provided said spouse resides in the same household, as
258 required by the Department of Social Services in order to determine
259 the extent of benefits for which the recipient is eligible under Medicare
260 Part D.

261 (f) The Commissioner of Social Services shall be the authorized
262 representative of a ConnPACE applicant or recipient for the purpose of
263 submitting an application to the Social Security Administration to
264 obtain the low income subsidy benefit provided under Public Law 108-
265 173, the Medicare Prescription Drug, Improvement, and
266 Modernization Act of 2003. As the authorized representative for this
267 purpose, the commissioner may also sign required forms and enroll
268 the applicant or recipient in a Medicare Part D plan on the applicant or

269 recipient's behalf. The applicant or recipient shall have the opportunity
270 to select a Medicare Part D plan and shall be notified of such
271 opportunity by the commissioner. In the event that such applicant or
272 recipient does not select a Medicare Part D plan within a reasonable
273 period of time, as determined by the commissioner, the department
274 shall enroll the applicant or recipient in a Medicare Part D plan
275 designated by the commissioner in accordance with said act.

276 [(e)] (g) The Commissioner of Social Services may adopt regulations,
277 in accordance with the provisions of chapter 54, to implement the
278 provisions of subsection (c) of this section. Such regulations may
279 provide for the electronic transmission of relevant coverage
280 information between a pharmacist and the department or between an
281 insurer and the department in order to expedite applications and
282 notice. The commissioner may implement the policies and procedures
283 necessary to carry out the provisions of this section while in the
284 process of adopting such policies and procedures in regulation form,
285 provided notice of intent to adopt the regulations is published not later
286 than twenty days after the date of implementation. Such policies and
287 procedures shall be valid until the time the final regulations are
288 adopted.

289 Sec. 5. Section 17b-280 of the general statutes is repealed and the
290 following is substituted in lieu thereof (*Effective July 1, 2005*):

291 (a) The state shall reimburse for all legend drugs provided under
292 the Medicaid, state-administered general assistance, ConnPACE and
293 Connecticut AIDS drug assistance programs at the rate established by
294 the [Health Care Finance Administration] Centers for Medicare and
295 Medicaid Services as the federal [acquisition cost] upper limit, or, if no
296 such rate is established, the commissioner shall establish and
297 periodically revise the estimated acquisition cost in accordance with
298 federal regulations. The commissioner shall also establish a
299 professional fee of three dollars and fifteen cents for each prescription
300 to be paid to licensed pharmacies for dispensing drugs to Medicaid,

301 ConnPACE and Connecticut AIDS drug assistance recipients in
302 accordance with federal regulations; and on and after September 4,
303 1991, payment for legend and nonlegend drugs provided to Medicaid
304 recipients shall be based upon the actual package size dispensed.
305 Effective October 1, 1991, reimbursement for over-the-counter drugs
306 for such recipients shall be limited to those over-the-counter drugs and
307 products published in the Connecticut Formulary, or the cross
308 reference list, issued by the commissioner. The cost of all over-the-
309 counter drugs and products provided to residents of nursing facilities,
310 chronic disease hospitals, and intermediate care facilities for the
311 mentally retarded shall be included in the facilities' per diem rate.
312 Notwithstanding the provisions of this subsection, no dispensing fee
313 shall be issued for a prescription drug dispensed to a ConnPACE or
314 Medicaid recipient who is a Medicare Part D beneficiary when the
315 prescription drug is a Medicare Part D drug, as defined in Public Law
316 108-173, the Medicare Prescription Drug, Improvement, and
317 Modernization Act of 2003.

318 (b) The Department of Social Services may provide an enhanced
319 dispensing fee to a pharmacy enrolled in the federal Office of
320 Pharmacy Affairs Section 340B drug discount program established
321 pursuant to 42 USC 256b or a pharmacy under contract to provide
322 services under said program.

323 Sec. 6. Section 17b-264 of the general statutes is repealed and the
324 following is substituted in lieu thereof (*Effective July 1, 2005*):

325 All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive,
326 17b-79 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are
327 extended to the medical assistance program except such provisions as
328 are inconsistent with federal law and regulations governing Title XIX
329 of the Social Security Amendments of 1965 and sections 17b-260 to 17b-
330 262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to [17b-362]
331 17b-361, inclusive.

332 Sec. 7. Subsection (a) of section 17b-266 of the general statutes is

333 repealed and the following is substituted in lieu thereof (*Effective July*
334 *1, 2005*):

335 (a) The Commissioner of Social Services may, when [he] the
336 commissioner finds it to be in the public interest, fund part or all of the
337 cost of benefits to any recipient under sections 17b-260 to 17b-262,
338 inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to [17b-362] 17b-361,
339 inclusive, 17b-289 to 17b-303, inclusive, and section 16 of public act 97-
340 1 of the October 29 special session*, through the purchase of insurance
341 from any organization authorized to do a health insurance business in
342 this state or from any organization specified in subsection (b) of this
343 section.

344 Sec. 8. Subsection (a) of section 17b-267 of the general statutes is
345 repealed and the following is substituted in lieu thereof (*Effective July*
346 *1, 2005*):

347 (a) If any group or association of providers of medical assistance
348 services wishes to have payments as provided for under sections 17b-
349 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
350 [17b-362] 17b-361, inclusive, to such providers made through a
351 national, state or other public or private agency or organization and
352 nominates such agency or organization for this purpose, the
353 Commissioner of Social Services is authorized to enter into an
354 agreement with such agency or organization providing for the
355 determination by such agency or organization, subject to such review
356 by the Commissioner of Social Services as may be provided for by the
357 agreement, of the payments required to be made to such providers at
358 the rates set by the hospital cost commission, and for the making of
359 such payments by such agency or organization to such providers. Such
360 agreement may also include provision for the agency or organization
361 to do all or any part of the following: With respect to the providers of
362 services which are to receive payments through it, (1) to serve as a
363 center for, and to communicate to providers, any information or
364 instructions furnished to it by the Commissioner of Social Services, and

365 to serve as a channel of communication from providers to the
366 Commissioner of Social Services; (2) to make such audits of the records
367 of providers as may be necessary to insure that proper payments are
368 made under this section; and (3) to perform such other functions as are
369 necessary to carry out the provisions of sections 17b-267 to 17b-271,
370 inclusive.

371 Sec. 9. Section 17b-272 of the general statutes is repealed and the
372 following is substituted in lieu thereof (*Effective July 1, 2005*):

373 Effective July 1, 1998, the Commissioner of Social Services shall
374 permit patients residing in nursing homes, chronic disease hospitals
375 and state humane institutions who are medical assistance recipients
376 under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285,
377 inclusive, and 17b-357 to [17b-362] 17b-361, inclusive, to have a
378 monthly personal fund allowance of fifty dollars. Effective July 1, 1999,
379 the commissioner shall increase such allowance annually to reflect the
380 annual inflation adjustment in Social Security income, if any.

381 Sec. 10. Section 53a-290 of the general statutes is repealed and the
382 following is substituted in lieu thereof (*Effective July 1, 2005*):

383 A person commits vendor fraud when, with intent to defraud and
384 acting on such person's own behalf or on behalf of an entity, such
385 person provides goods or services to a beneficiary under sections 17b-
386 22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, 17b-180a,
387 17b-183, 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive,
388 17b-357 to [17b-362] 17b-361, inclusive, 17b-600 to 17b-604, inclusive,
389 17b-749, 17b-807 and 17b-808 or provides services to a recipient under
390 Title XIX of the Social Security Act, as amended, and, (1) presents for
391 payment any false claim for goods or services performed; (2) accepts
392 payment for goods or services performed, which exceeds either the
393 amounts due for goods or services performed, or the amounts
394 authorized by law for the cost of such goods or services; (3) solicits to
395 perform services for or sell goods to any such beneficiary, knowing
396 that such beneficiary is not in need of such goods or services; (4) sells

397 goods to or performs services for any such beneficiary without prior
 398 authorization by the Department of Social Services, when prior
 399 authorization is required by said department for the buying of such
 400 goods or the performance of any service; or (5) accepts from any
 401 person or source other than the state an additional compensation in
 402 excess of the amount authorized by law.

403 Sec. 11. Sections 17b-274b and 17b-362 of the general statutes are
 404 repealed. (*Effective July 1, 2005*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	New section
Sec. 2	<i>July 1, 2005</i>	17b-490
Sec. 3	<i>July 1, 2005</i>	17b-491(a)
Sec. 4	<i>July 1, 2005</i>	17b-492
Sec. 5	<i>July 1, 2005</i>	17b-280
Sec. 6	<i>July 1, 2005</i>	17b-264
Sec. 7	<i>July 1, 2005</i>	17b-266(a)
Sec. 8	<i>July 1, 2005</i>	17b-267(a)
Sec. 9	<i>July 1, 2005</i>	17b-272
Sec. 10	<i>July 1, 2005</i>	53a-290
Sec. 11	<i>July 1, 2005</i>	17b-274b and 17b-362 repealed

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]