FIRST EXTRAORDINARY SESSION

[PERFECTED**]**

HOUSE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 3

91ST GENERAL ASSEMBLY

Taken up for Perfection September 10, 2001.

House Substitute for House Committee Substitute for House Bill No. 3 ordered Perfected and printed, as amended.

TED WEDEL, Chief Clerk

2382L.03P

AN ACT

To repeal sections 135.095, 208.010 and 208.151, RSMo, and to enact in lieu thereof ten new sections relating to a pharmaceutical investment program, with an emergency clause and penalty provision.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 135.095, 208.010 and 208.151, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 135.095, 208.010, 208.151, 208.550, 208.553, 208.556, 208.559, 208.562, 208.565 and 208.568, to read as follows:

135.095. For all tax years beginning on or after January 1, 1999, but before **[**January 1, 2005**] December 31, 2001**, a resident individual who has attained sixty-five years of age on or before the last day of the tax year shall be allowed, for the purpose of offsetting the cost of legend drugs, a maximum credit against the tax otherwise due pursuant to chapter 143, RSMo, not including sections 143.191 to 143.265, RSMo, of two hundred dollars. An individual shall be entitled to the maximum credit allowed by this section if the individual has a Missouri adjusted gross income of fifteen thousand dollars or less; provided that, no individual who receives full reimbursement for the cost of legend drugs from Medicare or Medicaid, or who is a resident of a local, state or federally funded facility shall qualify for the credit allowed pursuant to this section. If an individual's Missouri adjusted gross income is greater than fifteen thousand

EXPLANATION — Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

dollars, such individual shall be entitled to a credit equal to the greater of zero or the maximum credit allowed by this section reduced by two dollars for every hundred dollars such individual's income exceeds fifteen thousand dollars. The credit shall be claimed as prescribed by the director of the department of revenue. Such credit shall be considered an overpayment of tax and shall be refundable even if the amount of the credit exceeds an individual's tax liability.

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the division of family services to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 and 208.162 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the division of family services; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301 et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the division of family services may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such

resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the time of the investigation to an individual or on his or her behalf under the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of subsection 2 of this section shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the division of family services may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of:

(a) Prior to July 1, 2002, one thousand dollars or more; provided, however, that if such a person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed two thousand dollars;

(b) On July 1, 2002 and thereafter, two thousand five hundred dollars; provided, however, that if such person is married and living with a spouse, he or she, or they, individually or jointly, may own resources not to exceed four thousand five hundred dollars;

and provided further that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the division of family services, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife, if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the division of family services and as allowed by federal law or regulation, less encumbrances of record, exceeds one thousand dollars, excluding the home occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the division of family services to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270, RSMo, and any memorial, monument, marker, tombstone or letter

marking a burial space. If the beneficiary, as defined in chapter 436, RSMo, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest cancel or amend the contract so that any person will be entitled to a refund, such refund shall be paid to the state of Missouri up to the amount of public assistance benefits provided pursuant to this chapter with any remainder to be paid to those persons designated in chapter 436, RSMo.

5. In determining the total property owned pursuant to subdivision (5) of subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a et seq., the division of family services shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the division of family services of total countable resources owned by either or both spouses;

(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the

community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the consumer price index for all urban consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes, the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The division of family services shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

208.151. 1. For the purpose of paying medical assistance on behalf of needy persons and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

(1) All recipients of state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all

persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the division of family services, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All recipients of family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget

Reconciliation Act of 1989). The division of family services shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the division of family services shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The following children with family income which does not exceed two hundred percent of the federal poverty guideline for the applicable family size:

(a) Infants who have not attained one year of age with family income greater than one hundred eighty-five percent of the federal poverty guideline for the applicable family size;

(b) Children who have attained one year of age but have not attained six years of age with family income greater than one hundred thirty-three percent of the federal poverty guideline for the applicable family size; and

(c) Children who have attained six years of age but have not attained nineteen years of age with family income greater than one hundred percent of the federal poverty guideline for the applicable family size. Coverage under this subdivision shall be subject to the receipt of notification by the director of the department of social services and the revisor of statutes of approval from the secretary of the U.S. Department of Health and Human Services of applications for waivers of federal requirements necessary to promulgate regulations to implement this subdivision. The director of the department of social services shall apply for such waivers. The regulations may provide for a basic primary and preventive health care services package, not to include all medical services covered by section 208.152, and may also establish co-payment, coinsurance, deductible, or premium requirements for medical assistance under this subdivision. Eligibility for medical assistance under this subdivision shall be available only to those infants and children who do not have or have not been eligible for employer-subsidized health care insurance coverage for the six months prior to application for medical assistance. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The division of family services may establish a resource eligibility standard in assessing eligibility for persons under this subdivision. The division of medical services shall define the amount and scope of benefits which are available to individuals under this subdivision in accordance with the requirement of federal law and regulations. Coverage under this subdivision shall be subject to appropriation to provide services approved under the provisions of this subdivision;

(16) The division of family services shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The division of medical services shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder except that the scope of benefits shall include case management services;

(17) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(18) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the division of family services shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(19) Pregnant women and children eligible for medical assistance pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for medical assistance benefits be required to apply for aid to families with dependent children. The division of family services shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for medical assistance. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for medical assistance benefits under subdivision (12), (13) or (14) shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the division of family services for assessing eligibility under this chapter shall be as simple as practicable;

(20) Subject to appropriations necessary to recruit and train such staff, the division of

family services shall provide one or more full-time, permanent case workers to process applications for medical assistance at the site of a health care provider, if the health care provider requests the placement of such case workers and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment, of such case workers. The division may provide a health care provider with a part-time or temporary case worker at the site of a health care provider if the health care provider requests the placement of such a case worker and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such a case worker. The division may seek to employ such case workers who are otherwise qualified for such positions and who are current or former welfare recipients. The division may consider training such current or former welfare recipients as case workers for this program;

(21) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(22) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

(23) By January 1, 1988, the department of social services and the department of health

and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

(24) All recipients who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(25) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits, under the eligibility standards in effect December 31, 1973**[**, or those supplemental security income recipients who would be determined eligible for general relief benefits under the eligibility standards in effect December 31, 1973, except income; or less restrictive standards as established by rule of the division of family services**]; except that, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a (r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level on July 1, 2002**. If federal law or regulation authorizes the division of family services to, by rule, exclude the income or resources of a parent or parents of a person under the age of eighteen and such exclusion of income or resources can be limited to such parent or parents, then notwithstanding the provisions of section 208.010:

(a) The division may by rule exclude such income or resources in determining such person's eligibility for permanent and total disability benefits; and

(b) Eligibility standards for permanent and total disability benefits shall not be limited by age;

(26) Within thirty days of the effective date of an initial appropriation authorizing medical assistance on behalf of "medically needy" individuals for whom federal reimbursement is available under 42 U.S.C. 1396a (a)(10)(c), the department of social services shall submit an amendment to the Medicaid state plan to provide medical assistance on behalf of, at a minimum, an individual described in subclause (I) or (II) of clause 42 U.S.C. 1396a (a)(10)(C)(ii);

(27) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. No rule or portion of a rule promulgated under the authority of this chapter shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months

immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule the scope of medical assistance coverage to be granted to such families.

4. For purposes of section 1902(1), (10) of Title XIX of the federal Social Security Act, as amended, any individual who, for the month of August, 1972, was eligible for or was receiving aid or assistance pursuant to the provisions of Titles I, X, XIV, or Part A of Title IV of such act and who, for such month, was entitled to monthly insurance benefits under Title II of such act, shall be deemed to be eligible for such aid or assistance for such month thereafter prior to October, 1974, if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under Title II of such act resulting from enactment of Public Law 92-336 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended, not been applicable to such individual.

5. When any individual has been determined to be eligible for medical assistance, such medical assistance will be made available to him for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

208.550. As used in sections 208.550 to 208.568, the following terms mean:

(1) "Commission", the commission for the pharmaceutical investment program for seniors established in section 208.553;

(2) "Division", the division of aging within the department of health and senior services;

(3) "Household income", the amount of income as defined in section 135.010, RSMo. For purposes of this section, household income shall be the household income of

the applicant for the previous calendar year;

(4) "Medicaid", the program for medical assistance established pursuant to Title XIX of the federal Social Security Act and administered by the department of social services;

(5) "Missouri resident", an individual who establishes residence for a period of twelve months in a settled or permanent home or domicile within the state of Missouri with the intention of remaining in this state. An individual is a resident of this state until the individual establishes a permanent residence outside this state;

(6) "Program", the pharmaceutical investment program for seniors (PIPS) established in section 208.556;

(7) "Third-party administrator", a private party contracted to administer the pharmaceutical investment program for seniors established in section 208.556, with duties that may include, but shall not be limited to, devising applications, enrolling members, administration of prescription drug benefits, and implementation of cost-control measures, including such programs as disease management programs, early refill edits, a fraud and abuse detection system, and auditing programs.

208.553. 1. There is hereby established the "Commission for the Pharmaceutical Investment Program for Seniors" within the division of aging in the department of health and senior services to govern the operation of the pharmaceutical investment program for seniors established in section 208.556. The commission shall consist of the following eleven members:

(1) The lieutenant governor, who shall act as chair in his or her capacity as advocate for the elderly;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate;

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives;

(4) The director of the division of medical services in the department of social services;

(5) The director of the division of aging in the department of health and senior services; and

(6) The following four members appointed by the governor with the advice and

consent of the senate:

(a) A pharmacist;

(b) A physician specializing in the treatment of seniors;

(c) A representative from a senior advocacy group; and

(d) A representative from an area agency on aging.

The initial members of the commission appointed by the governor shall serve the following terms: two shall serve for two years and two shall serve three years. Thereafter, each appointment shall be for a term of three years. If for any reason a vacancy occurs, the governor, with the advice and consent of the senate, shall appoint a new member to fill the unexpired term. Members are eligible for reappointment.

2. The commission may employ an executive director and such professional, clerical, and research personnel as may be necessary to assist in the performance of the commission's duties.

3. The commission:

(1) May establish guidelines, policies, and procedures necessary to establish the pharmaceutical investment program for seniors;

(2) Shall hold quarterly meetings within fifteen days of the submission of each quarterly report required in subsection 13 of section 208.556, and other meetings as deemed necessary to make recommendations to the division for appropriate cost-control measures;

(3) May establish guidelines and collect information and data to promote and facilitate the program;

(4) May, after implementation of the program, evaluate and make recommendations to the governor and general assembly regarding the creation of a senior prescription drug benefit available to seniors who are not eligible for the program due to income that does not meet the program requirements.

4. The members of the commission shall receive no compensation for their service on the commission, but shall be reimbursed for ordinary and necessary expenses incurred in the performance of their duties as a member of the commission.

208.556. 1. There is hereby established the "Pharmaceutical Investment Program for Seniors" within the division of aging in the department of health and senior services to help defray the costs of prescription drugs for elderly Missouri residents. The program shall be governed by the commission for the pharmaceutical investment program for seniors established in section 208.553. The division shall provide technical assistance to the commission for the administration and implementation of the program. The commission

shall solicit requests for proposals from private contractors for the third-party administration of the program; except that the Commission shall either administer the rebate program established in Section 208.565 or contract with the Division of Medical Services for the rebate program established in Section 208.565.

2. Administration of the program shall include, but not be limited to, devising program applications, enrolling participants, administration of prescription drug benefits, and implementation of cost-control measures, including such strategies as disease management programs, early refill edits, and fraud and abuse detection system, and auditing programs. The commission shall select a responsive, cost-effective bid from the request for proposals; however, if no responsive, cost-effective bids are received, the program shall be administered collaboratively by the department of health and senior services and the department of social services.

3. Any Missouri resident who is sixty-five years of age or older, who has not had access to employer-subsidized health care insurance that offers a pharmacy benefit for six months prior to application, who is not currently ineligible pursuant to subsection 4 of this section, and who has a household income at or below seventeen thousand dollars for an individual or twenty-three thousand dollars for a married couple is eligible to participate in the program. Any person who has retired and received employer-sponsored health insurance while employed, but whose employer does not offer health insurance coverage to retirees shall not be subject to the six-month uninsured requirement.

4. Any person who is receiving Medicaid benefits shall not be eligible to participate in the program. The pharmaceutical investment program for seniors is a payer of last resort. If a senior has coverage for pharmaceutical benefits through a health benefit plan, as defined in section 376.1350, RSMo, including a Medicare supplement or Medicare+Choice plan, or through a self-funded employee benefit plan, the pharmaceutical investment program for seniors shall pay only for eligible costs not provided by such coverage. Individuals who have benefits with an actuarial value greater than or equal to the benefits in the program are not eligible for the program.

5. Applicants for the program shall submit an annual application to the division, or the division's designee, that attests to the age, residence, any third-party health insurance coverage, and annual household income for an individual or couple, if married. The third-party administrator shall prescribe the form of the application for enrollment in the program, which shall be approved by the division. The commission shall develop and implement a means test by which applicants must demonstrate that they meet the income requirements of the program. Each enrollee with an annual household income at or below twelve thousand dollars for an individual or seventeen thousand dollars for a

married couple shall pay an annual twenty-five dollar enrollment fee and each enrollee with a household income between twelve thousand one dollars and seventeen thousand dollars for an individual or between seventeen thousand one dollars and twenty-three thousand dollars for a married couple shall pay an annual thirty-five dollar enrollment fee to offset the administrative costs of the program.

6. Nothing in this section shall be construed as requiring an applicant to accept Medicaid benefits in lieu of participation in this program.

7. The following annual deductibles shall apply to enrollees in the program:

(1) For an individual with a household income at or below twelve thousand dollars, the deductible shall be two hundred fifty dollars;

(2) For a married couple with a household income at or below seventeen thousand dollars, the deductible shall be two hundred fifty dollars for each person;

(3) For an individual with a household income between twelve thousand one dollars and seventeen thousand dollars, the deductible shall be five hundred dollars; and

(4) For a married couple with a household income between seventeen thousand one dollars and twenty-three thousand dollars, the deductible shall be five hundred dollars for each person.

8. For prescription drugs, enrollees shall pay a forty percent coinsurance. The division may implement a higher coinsurance at the recommendation of the commission. Such coinsurance may be adjusted annually by the general assembly through the appropriation process and shall be used to reduce the state's cost for the program.

9. The total annual expenditures for each enrollee in this program may be up to but shall not exceed five thousand dollars.

10. In providing program benefits, the department may enter into a contract with a private individual, corporation or agency to implement the program.

11. The division shall utilize area agencies on aging, senior citizens centers, and other senior focused entities to provide outreach, enrollment referral assistance, and education services to potentially eligible seniors for the pharmaceutical investment program for seniors. The division and third-party administrators shall be responsible for informing eligible seniors on the availability of and providing information about pharmaceutical company benefits which may be applicable.

12. The commission shall submit quarterly reports to the governor, the senate appropriations committee, the house of representatives budget committee, the speaker of the house of representatives, the president pro tem of the senate, and the division that include:

(1) Quantified data as to the number of program applicants;

(2) An estimate of whether the current rate of expenditures will exceed the existing appropriation for the program in the current fiscal year; and

(3) Information regarding the commission's recommendations for changes to coinsurance, deductibles, and benefit caps for enrollees in the program.

13. The program established in this section is not an entitlement. Benefits shall be limited to the level supported by the moneys explicitly appropriated pursuant to this section. If in any fiscal year the commission projects that the total cost of the program will exceed the amount currently appropriated for the program, the commission shall direct the third-party administrator to implement cost-control measures to reduce the projected cost. Such cost-control measures may include, but are not limited to, increasing the enrollment fees in subsection 5 of this section, the deductibles in subsection 6 of this section, and the coinsurance outlined in subsection 9 of this section. The pharmaceutical investment program for seniors is a payer of last resort. If the federal government establishes a pharmaceutical assistance program that covers program eligible seniors under Medicare or another program, the pharmaceutical insurance program for seniors shall cover only eligible costs not covered by the federal program.

14. The commission may promulgate rules to implement the provisions of sections 208.550 to 208.568. No rule or portion of a rule promulgated pursuant to the authority of sections 208.550 to 208.568 shall become effective unless it has been promulgated pursuant to chapter 536, RSMo.

15. Any person who knowingly makes any false statements, falsifies or permits to be falsified any records, or engages in conduct in an attempt to defraud the program is guilty of a misdemeanor and shall forfeit all rights to which he or she may be entitled hereunder.

208.559. 1. The pharmaceutical investment program for seniors shall be operational no later than July 1, 2002. A second initial enrollment period shall be held from November 1, 2002, through December 15, 2002, to allow persons who did not enroll during the April through May 2002 enrollment period to enroll with the program for calendar year 2003. Current enrollees in the program shall not be required to reenroll during the second initial enrollment period for calendar year 2003. The division shall accept applications for enrollment during an initial open enrollment period from April 1, 2002, through May 30, 2002. Beginning with the enrollment period for calendar year 2004, open enrollment periods for the program shall be held from November first through December fifteenth of the calendar year immediately preceding the calendar year for which participation is sought.

2. A person may apply for participation in the program outside the enrollment

periods listed in subsection 1 of this section within thirty days of such person attaining the age or income eligibility requirements of the program established in section 208.556.

208.562. 1. Generic prescription drugs shall be used for the program when available. An enrollee may receive a name brand drug when a generic drug is available only if both the physician and enrollee request that the name brand drug be dispensed and the enrollee pays the coinsurance on the generic drug plus the difference in cost between the name brand drug and the generic drug.

2. Pharmacies participating in the pharmaceutical investment program for seniors shall be reimbursed based on the following formula:

(1) For generic prescription drugs, the average wholesale price minus twenty percent, plus a four dollar and nine cent dispensing fee; and

(2) For name brand prescription drugs, the average wholesale price minus ten and forty-three one hundredths percent, plus a four dollar and nine cent dispensing fee.

208.565. 1. As used in sections 208.565, the following terms mean:

(a) "Direct seller", any person, partnership, corporation, institution or entity engaged in the selling of pharmaceutical products directly to consumers in this state;

(b) "Distributor", a private entity under contract with the original labeler or holder of the national code number to manufacture, package or market the covered prescription drug;

(c) "FDA", the Food and Drug Administration of the Public Health Services of the Department of Health and Human Services;

(d) "Manufacturer", shall include:

(1) An entity which is engaged in any of the following:

a. The production, preparation, propagation, compounding, conversion or processing of prescription drug products:

(i) Directly or indirectly by extraction from substances of natural origin;

(ii) Independently by means of chemical synthesis; or

(iii) By a combination of extraction and chemical synthesis;

b. The packaging, repackaging, labeling or relabeling, or distribution of prescription drug products;

(b) The entity holding legal title to or possession of the national drug code number for the covered prescription drug;

(c) The term does not include a wholesale distributor of drugs, drugstore chain organization or retail pharmacy licensed by the state;

(e) "Unit", a drug unit in the lowest identifiable amount, such as tablet or capsule for solid dosage forms, milliliter for liquid forms and gram for ointments or creams. The

manufacturer shall specify the unit for each dosage form and strength of each covered prescription drug in accordance with the instructions developed by the Center for Medicare and Medicaid Services (CMS) for purposes of the Federal Medicaid Rebate Program under section 1927 of Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. section 301 et seq.);

(f) “Wholesaler", any person, partnership, corporation, institution or entity to which the manufacturer sells the covered prescription drug, including a pharmacy or chain of pharmacies.

(g) “National drug code number", the identifying drug number maintained by the FDA. The complete eleven-digit number must include the labeler code, product code and package size code;

(h) "New drug", a covered prescription drug approved as a new drug under section 201(p) of the Federal Food, Drug, and Cosmetic Act (52 Stat. 1040, 21 U.S.C. S 321(p));

2. The division shall issue a certificate of participation to pharmaceutical manufacturers participating in the PIPS. A pharmaceutical manufacturer may apply for participation in the program with an application form prescribed by the commission. A certificate of participation shall remain in effect for an initial period of not less than one year and shall be automatically renewed unless terminated by either the manufacturer or the state with sixty days notification.

3. The division shall negotiate with participating manufacturers for the amount of rebates. The rebate amount for each unit dispensed of brand name drug shall be no less than fifteen percent of the average manufacturers' price as defined pursuant to 42 U.S.C. 1396r-8(k)(1). No other discounts shall apply. The rebate amount for each unit dispensed of generic drug shall be no less than eleven percent. No other discounts shall apply. In order to receive a certificate of participation a manufacturer or distributor participating in the PIPS shall provide the division of aging the average manufacturers' price for their contracted products. The following shall apply to the providing of average manufacturers' price information to the division of aging:

(1) Any manufacturer or distributor with an agreement under this section that knowingly provides false information is subject to a civil penalty in an amount not to exceed one hundred thousand dollars for each provision of false information. Such penalties shall be in addition to other penalties as prescribed by law;

(2) Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers pursuant to this subsection or under an agreement with the division pursuant to section 208.565 is confidential and shall not be disclosed by the division or any other state agency or contractor therein in any form which discloses the

identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler, except to permit the state auditor to review the information provided and the division of medical services for rebate administration.

4. All rebates received through the program shall be used toward refunding the program. If a pharmaceutical manufacturer refuses to participate in the rebate program, such refusal shall not affect the manufacturer's status under the current Medicaid program.

5. Any prescription drug of a manufacturer that does not participate in the program shall not be paid for by the program.

208.568. 1. There is hereby created in the state treasury the "Pharmaceutical Investment Program for Seniors Fund", which shall consist of all moneys deposited in the fund pursuant to sections 208.550 to 208.565 and all moneys which may be appropriated to it by the general assembly, from federal or other sources.

2. The state treasurer shall administer the fund and credit all interest to the fund and the moneys in the fund shall be used solely by the commission for the pharmaceutical investment program for seniors and the division of aging for the implementation of the pharmaceutical investment program for seniors established in sections 208.550 to 208.565.

3. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, moneys in the fund shall not revert to the credit of the general revenue fund at the end of the biennium.

Section B. Because immediate action is necessary to ensure the timely provision of prescription drugs to the elderly, section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and section A of this act shall be in full force and effect upon its passage and approval.