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HOUSE BILL NO. 1469

Offered January 8, 2003

Prefiled December 4, 2002

A BILL to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 15, consisting of sections numbered 32.1-366 through 32.1-370, relating to the Virginia Insurance Plan for Seniors (VIPS).

Patrons—Purkey and Baskerville

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 15, consisting of sections numbered 32.1-366 through 32.1-370, as follows:

CHAPTER 15.

VIRGINIA INSURANCE PLAN FOR SENIORS.

§ 32.1-366. Definitions.

"Board" means the Board of Medical Assistance Services.

"Department" means the Department of Medical Assistance Services.

"Eligible person" means a person eligible for the Virginia Insurance Plan for Seniors (VIPS) pursuant to § 32.1-367.

"Prescription drugs" means drugs and supplies that have been approved as safe and effective by the Federal Food and Drug Administration or that are otherwise legally marketed in the United States, including items related to diabetes management if not covered by Medicare, that a physician has deemed medically necessary for the diagnosis and treatment of the patient. Prescription drugs covered under this chapter shall be limited and subject to the provisions of § 32.1-368 and the rules and regulations adopted pursuant thereto.

"Plan" means the Virginia Insurance Plan for Seniors.

§ 32.1-367. Eligibility.

To be eligible for payment assistance for prescription drugs a person shall:

1. Be a U.S. citizen or a lawfully admitted alien;

2. Be a resident of the Commonwealth;

3. Be aged 65 or older;

4. Be dually eligible for Medicare and Medicaid but whose limited assistance or coverage does not include any pharmacy benefit;

5. Not be enrolled in a Medicare health maintenance organization, a Medicare supplemental policy, or other third party payor plan that provides a pharmacy benefit; and

6. Request to be enrolled in the plan.

§ 32.1-368. Plan established; administration; limitations; manufacturer rebate requirement.

A. There is hereby established the Virginia Insurance Plan for Seniors (VIPS). The Plan shall be administered by the Department, which may contract with third-party administrators to provide administrative services for the Plan. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, payments, financial oversight and reporting and such other services necessary for the administration of the Plan.

B. Payment assistance shall not exceed 80 dollars per month to assist each eligible person in the purchase of prescription drugs. Benefits unused during any month shall remain available to the eligible person and may be carried over from one fiscal year to the next.

C. The Department shall restrict prescription drugs covered under the Plan to those manufactured by pharmaceutical companies that agree to provide manufacturer rebates. The product's manufacturer shall provide a rebate to the Commonwealth equal to the rebate required by the Medicaid program and make the drug product available to the Plan for the best price that the manufacturer makes the drug product available in the Medicaid program.

D. Eligible persons shall be required to make a co-payment of 10 percent of the acquisition cost, subject to the regulations adopted pursuant to clause 3 of § 32.1-369.

E. The Department shall establish guidelines for maximum dosing units or supply of prescription drugs.

F. No system of administration shall make a direct cash payment to any eligible person.

G. The Department shall require a mandatory point-of-sale claims submission within 14 days unless extenuating circumstances, as defined by the Department, exist.

H. The Plan shall allow any licensed pharmacist in the Commonwealth to participate in the Plan so long as the pharmacist is willing to abide by the terms and conditions the Board establishes.

I. Payment amounts to pharmacists for providing prescription drugs shall be reasonable to cover the costs of the items, including the cost of the product and all costs of dispensing the product, but shall not be less than Medicaid reimbursement.

J. The Plan shall not vary pharmacist payment amounts based on the size of the entity dispensing the prescription, and shall not vary beneficiary cost-sharing amounts based on the source of dispensing or method of distribution of the prescription.

K. The Plan shall require the use of approved generic prescription drugs. If eligible persons elect to take a brand-named prescription drug for which an approved generic prescription drug is available, the eligible person shall pay the price difference between the brand-named prescription drug and the approved generic prescription drug, in addition to the co-payment.

§ 32.1-369. Regulations of the Board.

The Board shall adopt regulations as are necessary to implement the Plan in a cost-effective manner and to ensure that the Plan is the payor of last resort for prescription drugs. The regulations shall (i) establish a limited-time enrollment period; (ii) provide for any fees and co-payments collected to be maintained by the Plan and not revert to the general fund; (iii) establish guidelines for co-payments and provisions to waive co-payments in cases of severe hardship; (iv) establish terms and conditions for licensed pharmacist participation; and (v) establish reasonable procedures and criteria for determining participant eligibility.

§ 32.1-370. Pharmacist duty to collect.

A pharmacist shall not dispense or provide a covered prescription drug to an eligible person until the eligible person makes the required co-payment, unless such co-payment is waived by regulation.

2. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

3. That this act shall take effect on July 1, 2004; however, the Plan created by this act shall not be implemented until the earlier of (i) 90 days following the adoption of regulations by the Board of Medical Assistance Services as set forth in § 32.1-369 or (ii) July 1, 2005.