AN ACT concerning aging.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by changing Section 4 as follows:

(320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

Sec. 4. Amount of Grant.

(a) In general. Any individual 65 years or older or any individual who will become 65 years old during the calendar year in which a claim is filed, and any surviving spouse of such a claimant, who at the time of death received or was entitled to receive a grant pursuant to this Section, which surviving spouse will become 65 years of age within the 24 months immediately following the death of such claimant and which surviving spouse but for his or her age is otherwise qualified to receive a grant pursuant to this Section, and any disabled person whose annual household income is less than $14,000 for grant years before the 1998 grant year, less than $16,000 for the 1998 and 1999 grant years, and less than (i) $21,218 for a household containing one person, (ii) $28,480 for a household containing 2 persons, or (iii) $35,740 for a household containing 3 or more persons for the 2000 grant year

and thereafter and whose household is liable for payment of property taxes accrued or has paid rent constituting property taxes accrued and is domiciled in this State at the time he or she files his or her claim is entitled to claim a grant under this Act. With respect to claims filed by individuals who will become 65 years old during the calendar year in which a claim is filed, the amount of any grant to which that household is entitled shall be an amount equal to 1/12 of the amount to which the claimant would otherwise be entitled as provided in this Section, multiplied by the number of months in which the claimant was 65 in the calendar year in which the claim is filed.

(b) Limitation. Except as otherwise provided in subsections (a) and (f) of this Section, the maximum amount of grant which a claimant is entitled to claim is the amount by which the property taxes accrued which were paid or payable during the last preceding tax year or rent constituting property taxes accrued upon the claimant's residence for the last preceding taxable year exceeds 3 1/2% of the claimant's household income for that year but in no event is the grant to exceed (i) $700 less 4.5% of household income for that year for those with a household income of $14,000 or less or (ii) $70 if household income for that year is more than $14,000.

(c) Public aid recipients. If household income in one or more months during a year includes cash assistance in excess of $55 per month from the Department of Healthcare and Family

Services or the Department of Human Services (acting as successor to the Department of Public Aid under the Department of Human Services Act) which was determined under regulations of that Department on a measure of need that included an allowance for actual rent or property taxes paid by the recipient of that assistance, the amount of grant to which that household is entitled, except as otherwise provided in subsection (a), shall be the product of (1) the maximum amount computed as specified in subsection (b) of this Section and (2) the ratio of the number of months in which household income did not include such cash assistance over $55 to the number twelve. If household income did not include such cash assistance over $55 for any months during the year, the amount of the grant to which the household is entitled shall be the maximum amount computed as specified in subsection (b) of this Section. For purposes of this paragraph (c), "cash assistance" does not include any amount received under the federal Supplemental Security Income (SSI) program.

(d) Joint ownership. If title to the residence is held jointly by the claimant with a person who is not a member of his or her household, the amount of property taxes accrued used in computing the amount of grant to which he or she is entitled shall be the same percentage of property taxes accrued as is the percentage of ownership held by the claimant in the residence.

(e) More than one residence. If a claimant has occupied

more than one residence in the taxable year, he or she may claim only one residence for any part of a month. In the case of property taxes accrued, he or she shall prorate 1/12 of the total property taxes accrued on his or her residence to each month that he or she owned and occupied that residence; and, in the case of rent constituting property taxes accrued, shall prorate each month's rent payments to the residence actually occupied during that month.

(f) There is hereby established a program of pharmaceutical assistance to the aged and disabled which shall be administered by the Department in accordance with this Act, to consist of payments to authorized pharmacies, on behalf of beneficiaries of the program, for the reasonable costs of covered prescription drugs. Each beneficiary who pays $5 for an identification card shall pay no additional prescription costs. Each beneficiary who pays $25 for an identification card shall pay $3 per prescription. In addition, after a beneficiary receives $2,000 in benefits during a State fiscal year, that beneficiary shall also be charged 20% of the cost of each prescription for which payments are made by the program during the remainder of the fiscal year. To become a beneficiary under this program a person must: (1) be (i) 65 years of age or older, or (ii) the surviving spouse of such a claimant, who at the time of death received or was entitled to receive benefits pursuant to this subsection, which surviving spouse will become 65 years of age within the 24 months immediately following the

death of such claimant and which surviving spouse but for his or her age is otherwise qualified to receive benefits pursuant to this subsection, or (iii) disabled, and (2) be domiciled in this State at the time he or she files his or her claim, and (3) have a maximum household income of less than $14,000 for grant years before the 1998 grant year, less than $16,000 for the 1998 and 1999 grant years, and less than (i) $21,218 for a household containing one person, (ii) $28,480 for a household containing 2 persons, or (iii) $35,740 for a household containing 3 more persons for the 2000 grant year and thereafter. In addition, each eligible person must (1) obtain an identification card from the Department, (2) at the time the card is obtained, sign a statement assigning to the State of Illinois benefits which may be otherwise claimed under any private insurance plans, and (3) present the identification card to the dispensing pharmacist.

The Department may adopt rules specifying participation requirements for the pharmaceutical assistance program, including copayment amounts, identification card fees, expenditure limits, and the benefit threshold after which a 20% charge is imposed on the cost of each prescription, to be in effect on and after July 1, 2004. Notwithstanding any other provision of this paragraph, however, the Department may not increase the identification card fee above the amount in effect on May 1, 2003 without the express consent of the General Assembly. To the extent practicable, those requirements shall

be commensurate with the requirements provided in rules adopted by the Department of Healthcare and Family Services to implement the pharmacy assistance program under Section 5-5.12a of the Illinois Public Aid Code.

Whenever a generic equivalent for a covered prescription drug is available, the Department shall reimburse only for the reasonable costs of the generic equivalent, less the co-pay established in this Section, unless (i) the covered prescription drug contains one or more ingredients defined as a narrow therapeutic index drug at 21 CFR 320.33, (ii) the prescriber indicates on the face of the prescription "brand medically necessary", and (iii) the prescriber specifies that a substitution is not permitted. When issuing an oral prescription for covered prescription medication described in item (i) of this paragraph, the prescriber shall stipulate "brand medically necessary" and that a substitution is not permitted. If the covered prescription drug and its authorizing prescription do not meet the criteria listed above, the beneficiary may purchase the non-generic equivalent of the covered prescription drug by paying the difference between the generic cost and the non-generic cost plus the beneficiary co-pay.

Any person otherwise eligible for pharmaceutical assistance under this Act whose covered drugs are covered by any public program for assistance in purchasing any covered prescription drugs shall be ineligible for assistance under

this Act to the extent such costs are covered by such other plan.

The fee to be charged by the Department for the identification card shall be equal to $5 per coverage year for persons below the official poverty line as defined by the United States Department of Health and Human Services and $25 per coverage year for all other persons.

In the event that 2 or more persons are eligible for any benefit under this Act, and are members of the same household, (1) each such person shall be entitled to participate in the pharmaceutical assistance program, provided that he or she meets all other requirements imposed by this subsection and (2) each participating household member contributes the fee required for that person by the preceding paragraph for the purpose of obtaining an identification card.

The provisions of this subsection (f), other than this paragraph, are inoperative after December 31, 2005. Beneficiaries who received benefits under the program established by this subsection (f) are not entitled, at the termination of the program, to any refund of the identification card fee paid under this subsection.

(g) Effective January 1, 2006, there is hereby established a program of pharmaceutical assistance to the aged and disabled, entitled the Illinois Seniors and Disabled Drug Coverage Program, which shall be administered by the Department of Healthcare and Family Services and the Department on Aging

in accordance with this subsection, to consist of coverage of specified prescription drugs on behalf of beneficiaries of the program as set forth in this subsection. The program under this subsection replaces and supersedes the program established under subsection (f), which shall end at midnight on December 31, 2005.

To become a beneficiary under the program established under this subsection, a person must:

(1) be (i) 65 years of age or older or (ii) disabled; and

(2) be domiciled in this State; and

(3) enroll with a qualified Medicare Part D Prescription Drug Plan if eligible and apply for all available subsidies under Medicare Part D; and

(4) have a maximum household income of (i) less than $21,218 for a household containing one person, (ii) less than $28,480 for a household containing 2 persons, or (iii) less than $35,740 for a household containing 3 or more persons. If any income eligibility limit set forth in items (i) through (iii) is less than 200% of the Federal Poverty Level for any year, the income eligibility limit for that year for households of that size shall be income equal to or less than 200% of the Federal Poverty Level.

All individuals enrolled as of December 31, 2005, in the pharmaceutical assistance program operated pursuant to subsection (f) of this Section and all individuals enrolled as

of December 31, 2005, in the SeniorCare Medicaid waiver program operated pursuant to Section 5-5.12a of the Illinois Public Aid Code shall be automatically enrolled in the program established by this subsection for the first year of operation without the need for further application, except that they must apply for Medicare Part D and the Low Income Subsidy under Medicare Part D. A person enrolled in the pharmaceutical assistance program operated pursuant to subsection (f) of this Section as of December 31, 2005, shall not lose eligibility in future years due only to the fact that they have not reached the age of 65.

To the extent permitted by federal law, the Department may act as an authorized representative of a beneficiary in order to enroll the beneficiary in a Medicare Part D Prescription Drug Plan if the beneficiary has failed to choose a plan and, where possible, to enroll beneficiaries in the low-income subsidy program under Medicare Part D or assist them in enrolling in that program.

Beneficiaries under the program established under this subsection shall be divided into the following 5 eligibility groups:

(A) Eligibility Group 1 shall consist of beneficiaries who are not eligible for Medicare Part D coverage and who are:

(i) disabled and under age 65; or

(ii) age 65 or older, with incomes over 200% of the Federal Poverty Level; or

(iii) age 65 or older, with incomes at or below 200% of the Federal Poverty Level and not eligible for federally funded means-tested benefits due to immigration status.

(B) Eligibility Group 2 shall consist of beneficiaries otherwise described in Eligibility Group 1 but who are eligible for Medicare Part D coverage.

(C) Eligibility Group 3 shall consist of beneficiaries age 65 or older, with incomes at or below 200% of the Federal Poverty Level, who are not barred from receiving federally funded means-tested benefits due to immigration status and are eligible for Medicare Part D coverage.

(D) Eligibility Group 4 shall consist of beneficiaries age 65 or older, with incomes at or below 200% of the Federal Poverty Level, who are not barred from receiving federally funded means-tested benefits due to immigration status and are not eligible for Medicare Part D coverage.

If the State applies and receives federal approval for a waiver under Title XIX of the Social Security Act, persons in Eligibility Group 4 shall continue to receive benefits through the approved waiver, and Eligibility Group 4 may be expanded to include disabled persons under age 65 with incomes under 200% of the Federal Poverty Level who are not eligible for Medicare and who are not barred from receiving federally funded means-tested benefits due to immigration status.

(E) On and after January 1, 2007, Eligibility Group 5 shall consist of beneficiaries who are otherwise described in Eligibility Groups 2 and 3 who ~~Group 1 but are eligible for Medicare Part D and~~ have a diagnosis of HIV or AIDS.

The program established under this subsection shall cover the cost of covered prescription drugs in excess of the beneficiary cost-sharing amounts set forth in this paragraph that are not covered by Medicare. In 2006, beneficiaries shall pay a co-payment of $2 for each prescription of a generic drug and $5 for each prescription of a brand-name drug. In future years, beneficiaries shall pay co-payments equal to the co-payments required under Medicare Part D for "other low-income subsidy eligible individuals" pursuant to 42 CFR 423.782(b). For individuals in Eligibility Groups 1, 2, 3, and 4, once the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs, the beneficiary shall pay 20% of the cost of each prescription in addition to the co-payments set forth in this paragraph. For individuals in Eligibility Group 5, once the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs, the beneficiary shall pay 20% of the cost of each prescription in addition to the co-payments set forth in this paragraph unless the drug is included in the formulary of the Illinois AIDS Drug Assistance Program operated by the Illinois Department of Public Health. If the drug is included in the

formulary of the Illinois AIDS Drug Assistance Program, individuals in Eligibility Group 5 shall continue to pay the co-payments set forth in this paragraph after the program established under this subsection and Medicare combined have paid $1,750 in a year for covered prescription drugs.

For beneficiaries eligible for Medicare Part D coverage, the program established under this subsection shall pay 100% of the premiums charged by a qualified Medicare Part D Prescription Drug Plan for Medicare Part D basic prescription drug coverage, not including any late enrollment penalties. Qualified Medicare Part D Prescription Drug Plans may be limited by the Department of Healthcare and Family Services to those plans that sign a coordination agreement with the Department.

Notwithstanding Section 3.15, for purposes of the program established under this subsection, the term "covered prescription drug" has the following meanings:

For Eligibility Group 1, "covered prescription drug" means: (1) any cardiovascular agent or drug; (2) any insulin or other prescription drug used in the treatment of diabetes, including syringe and needles used to administer the insulin; (3) any prescription drug used in the treatment of arthritis; (4) any prescription drug used in the treatment of cancer; (5) any prescription drug used in the treatment of Alzheimer's disease; (6) any prescription drug used in the treatment of Parkinson's disease; (7) any

prescription drug used in the treatment of glaucoma; (8) any prescription drug used in the treatment of lung disease and smoking-related illnesses; (9) any prescription drug used in the treatment of osteoporosis; and (10) any prescription drug used in the treatment of multiple sclerosis. The Department may add additional therapeutic classes by rule. The Department may adopt a preferred drug list within any of the classes of drugs described in items (1) through (10) of this paragraph. The specific drugs or therapeutic classes of covered prescription drugs shall be indicated by rule.

For Eligibility Group 2, "covered prescription drug" means those drugs covered for Eligibility Group 1 that are also covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

For Eligibility Group 3, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

For Eligibility Group 4, "covered prescription drug" means those drugs covered by the Medical Assistance Program under Article V of the Illinois Public Aid Code.

For Eligibility Group 5, <u>for individuals otherwise described in Eligibility Group 2,</u> "covered prescription drug" means: (1) those drugs covered for Eligibility Group <u>2</u> ~~1~~ that are also covered by the Medicare Part D

Prescription Drug Plan in which the beneficiary is enrolled; and (2) those drugs included in the formulary of the Illinois AIDS Drug Assistance Program operated by the Illinois Department of Public Health that are also covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled. For Eligibility Group 5, for individuals otherwise described in Eligibility Group 3, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

An individual in Eligibility Group 1, 2, 3, ~~or~~ 4, or 5 may opt to receive a $25 monthly payment in lieu of the direct coverage described in this subsection.

Any person otherwise eligible for pharmaceutical assistance under this subsection whose covered drugs are covered by any public program is ineligible for assistance under this subsection to the extent that the cost of those drugs is covered by the other program.

The Department of Healthcare and Family Services shall establish by rule the methods by which it will provide for the coverage called for in this subsection. Those methods may include direct reimbursement to pharmacies or the payment of a capitated amount to Medicare Part D Prescription Drug Plans.

For a pharmacy to be reimbursed under the program established under this subsection, it must comply with rules adopted by the Department of Healthcare and Family Services

regarding coordination of benefits with Medicare Part D Prescription Drug Plans. A pharmacy may not charge a Medicare-enrolled beneficiary of the program established under this subsection more for a covered prescription drug than the appropriate Medicare cost-sharing less any payment from or on behalf of the Department of Healthcare and Family Services.

The Department of Healthcare and Family Services or the Department on Aging, as appropriate, may adopt rules regarding applications, counting of income, proof of Medicare status, mandatory generic policies, and pharmacy reimbursement rates and any other rules necessary for the cost-efficient operation of the program established under this subsection.

(Source: P.A. 93-130, eff. 7-10-03; 94-86, eff. 1-1-06; 94-909, eff. 6-23-06.)

Section 99. Effective date. This Act takes effect upon becoming law.