Article - Insurance

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§14–512. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2016 PER CHAPTER 84 OF 2014 //

(a) The Program shall:

(1) provide a prescription drug benefit subsidy, as determined by the Board, that may pay all or some of the deductibles, coinsurance payments, premiums, and copayments under the federal Medicare Part D Pharmaceutical Assistance Program for enrollees of the Program; and

(2) provide the subsidy to the maximum number of individuals eligible for enrollment in the Program, subject to the moneys available in the segregated account under § 14–504 of this subtitle.

(b) The Program may limit payment of any subsidy by paying the subsidy only on behalf of eligible individuals enrolled in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan that coordinates with the Program in accordance with federal requirements.

(c) The Program:

(1) may annually provide an additional subsidy, up to the full amount of the Medicare Part D Prescription Drug Plan premium, for individuals who qualify for a partial federal low–income subsidy; and

(2) shall annually provide an additional subsidy up to the full amount of the Medicare Part D coverage gap, subject to the availability of:

(i) funds provided under § 14–106.2 of this title; and

(ii) any other funds available for this purpose.

(d) The Program shall maintain a waiting list of individuals who meet the eligibility requirements for the Program but who are not served by the Program due to funding limitations.

(e) The Board shall determine annually:

(1) the number of individuals to be enrolled in the Program;

(2) the amount of subsidy to be provided under subsections (a) and (c)(2) of this section; and

(3) the amount of any additional subsidy provided under subsection (c)(1)

of this section.

(f) On or before January 1 of each year, the Board, in accordance with § 2–1246 of the State Government Article, shall report to the General Assembly on:

(1) the number of individuals on the waiting list for the Program; and

(2) to the extent that the Board is able to collect the information:

(i) the number of enrollees with out–of–pocket prescription drug costs that exceed $2,250, broken down for each fiscal quarter; and

(ii) the total annual out–of–pocket prescription drug costs for enrollees.

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