§ 240. Short title: Program for Elderly Pharmaceutical Insurance Coverage

This title shall be known and may be cited as the "program for elderly pharmaceutical insurance coverage".

§ 241. Definitions: Program for Elderly Pharmaceutical Insurance Coverage

For purposes of this title, the terms:

1. "Covered drug" shall mean a drug dispensed subject to a legally authorized prescription pursuant to section sixty-eight hundred ten of the education law, and insulin, an insulin syringe, or an insulin needle. Such term shall not include: (a) any drug determined by the commissioner of the federal food and drug administration to be ineffective or unsafe; (b) any drug dispensed in a package, or form of dosage or administration, as to which the commissioner of health finally determines in accordance with the provisions of section two hundred fifty-two of this title that a less expensive package, or form of dosage or administration, is available that is pharmaceutically equivalent and equivalent in its therapeutic effect for the general health characteristics of the eligible program participant population; (c) any device for the aid or correction of vision, or any drug, including vitamins, which is generally available without a physician's prescription; and (d) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food and drug administration. For the purpose of this title, except as otherwise provided in this section, a covered drug shall be dispensed in quantities no greater than a thirty day supply or one hundred units, whichever is greater. In the case of a drug dispensed in a form of administration other than a tablet or capsule, the maximum allowed quantity shall be a thirty day supply; the commissioner is authorized to approve exceptions to these limits for specific products following consideration of recommendations from pharmaceutical or medical experts regarding commonly packaged quantities, unusual forms of administration, length of treatment or cost effectiveness. In the case of a drug prescribed pursuant to section thirty-three hundred thirty-two of the public health law to treat one of the conditions that have been enumerated by the commissioner of health pursuant to regulation as warranting the prescribing of greater than a thirty day supply, such drug shall be dispensed in quantities not to exceed a three month supply.

2. "Provider pharmacy" shall mean a pharmacy registered in the state of New York pursuant to section sixty-eight hundred eight of the education law, a non-resident establishment registered pursuant to section sixty-eight hundred eight-b of the education law, or a pharmacy registered in a state bordering the state of New York when certified as necessary by the executive director pursuant to section two hundred fifty-three of this title, for which an agreement to provide pharmacy services for purposes of this program pursuant to section two hundred forty-nine of this title is in effect.

3. "Income" shall mean "household gross income" as defined in the real property tax circuit breaker credit program, pursuant to subparagraph (C) of paragraph one of subsection (e) of section six hundred six of the tax law, but only shall include the income of program applicants and spouses and shall exclude the income of other members of the household.

4. "Contractor" shall mean a private not-for-profit or proprietary corporation which has entered into a contractual arrangement with the state to carry out the provisions of section two hundred forty-three of this title.
5. "Resident" shall mean an individual legally domiciled within the state.

6. "Annual coverage period" shall mean the period of twelve consecutive calendar months for which an eligible program participant has met the application fee or deductible requirements, as the case may be, of sections two hundred forty-seven and two hundred forty-eight of this title.

7. "Program year" shall mean a year beginning on October first and ending the following September thirtieth.

8. "Medicare part D excluded drug classes" shall mean any drugs or classes of drugs, or their medical uses, which are described in section 1927(d)(2) or 1927(d)(3) of the federal social security act, with the exception of smoking cessation agents.

§ 242. Program Eligibility: Program for Elderly Pharmaceutical Insurance Coverage

1. Persons eligible for comprehensive coverage under section two hundred forty-seven of this title shall include:

   (a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand five, is less than or equal to twenty thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

   (b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person’s spouse beginning on or after January first, two thousand one, is less than or equal to twenty-six thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

2. Persons eligible for catastrophic coverage under section two hundred forty-eight of this title shall include:

   (a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand five, is more than twenty thousand and less than or equal to seventy-five thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

   (b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person’s spouse beginning on or after January first, two thousand one, is more than twenty-six thousand dollars and less than or equal to one hundred thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

3. (a) Eligibility for assistance under this title shall not be granted to any person who at the time an application is made is receiving medical assistance under section three hundred sixty-six of the social services law, or to any person receiving equivalent or better coverage from any other public or private third party payment source or insurance plan than those benefits provided for under this title.

   (b) An individual who is determined eligible for assistance under this title whose prescription costs are covered in part by any public or private plan may receive reduced assistance under this title. In such cases, benefits provided through this title shall be considered payments of last resort.
(c) The participant registration fee charged to eligible program participants for comprehensive coverage pursuant to section two hundred forty-seven of this title shall be waived for the portion of the annual coverage period that the participant is also enrolled as a full subsidy individual in a prescription drug or MA-PD plan under part D of title XVIII of the federal social security act.

(e) As a condition of eligibility for benefits under this title, if a program participant’s income indicates that the participant could be eligible for an income-related subsidy under section 1860D-14 of the federal social security act by either applying for such subsidy or by enrolling in a medicare savings program as a qualified medicare beneficiary (QMB), a specified low-income medicare beneficiary (SLMB), or a qualifying individual (QI), a program participant is required to provide, and to authorize the elderly pharmaceutical insurance coverage program to obtain, any information or documentation required to establish the participant's eligibility for such subsidy, and to authorize the elderly pharmaceutical insurance coverage program to apply on behalf of the participant for the subsidy or the medicare savings program. The elderly pharmaceutical insurance coverage program shall make a reasonable effort to notify the program participant of his or her need to provide any of the above required information. After a reasonable effort has been made to contact the participant, a participant shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the participant's coverage may be terminated.

(f) As a condition of eligibility for benefits under this title, a program participant is required to be enrolled in Medicare part D and to maintain such enrollment. For unmarried participants with individual annual income less than or equal to twenty-three thousand dollars and married participants with joint annual income less than or equal to twenty-nine thousand dollars, the elderly pharmaceutical insurance coverage program shall pay for the portion of the part D monthly premium that is the responsibility of the participant. Such payment shall be limited to the low-income benchmark premium amount established by the federal centers for medicare and medicaid services and any other amount which such agency establishes under its de minimus premium policy.

(h) The elderly pharmaceutical insurance coverage program is authorized to represent program participants under this title with respect to their Medicare part D coverage.

4. As a condition of eligibility for benefits under this title, participants must be enrolled in medicare part D and maintain such enrollment. For persons who meet the eligibility requirements to participate in the elderly pharmaceutical insurance coverage program, the program will pay for a drug covered by the person’s medicare part D plan or a drug in a medicare part D excluded drug class, as defined in subdivision eight of section two hundred forty-one of this title, provided that such drug is a covered drug, as defined in subdivision one of section two hundred forty-one of this title, and that the participant complies with the point of sale co-payment requirements set forth in sections two hundred forty-seven and two hundred forty-eight of this title. No payment shall be made for medicare part D plan deductibles.


1. The commissioner of health shall, subject to the approval of the director of the budget, enter into a contract with one or more contractors to assist in carrying out the provisions of this title. Such contractual arrangements shall be made subject to a competitive process pursuant to the state finance law and shall ensure that state payments for the contractor's necessary and legitimate expenses for the administration of
this program are limited to the amount specified in advance, and that such payments shall not exceed the amount appropriated therefor in any fiscal year. The commissioner shall review the contract pricing provisions to assure that the level of contract payments are in the best interest of the state, giving consideration to the total level of participant enrollment achieved, the volume of claims processed, and such other factors as may be relevant in order to contain state expenditures. In the event that the commissioner determines that the contract payment provisions do not protect the interest of the state, the commissioner shall initiate contract negotiations for the purpose of modifying contract payments and/or scope requirements.

2. The responsibilities of the contractor or contractors shall include, but need not be limited to:

(a) providing for a method of determining, on an annual basis and upon their application therefor, the eligibility of persons pursuant to section two hundred forty-two of this title within a reasonable period of time, including alternative methods for such determination of eligibility, such as through the mail or home visits, where reasonable and/or necessary, and for notifying applicants of such eligibility determinations;

(b) notifying each eligible program participant in writing upon the commencement of the annual coverage period of such participant's cost-sharing responsibilities pursuant to section two hundred forty-seven of this title. The contractor shall also notify each eligible program participant of any adjustment of the co-payment schedule by mail no less than thirty days prior to the effective date of such adjustments and shall inform such eligible program participants of the date such adjustments shall take effect;

(c) issuing an identification card to each eligible program participant;

(d) processing of claims for reimbursement to participating provider pharmacies pursuant to section two hundred fifty of this title;

(e) performing or causing to be performed utilization reviews for such purposes as may be required by the commissioner of health;

(f) conducting audits and surveys of participating provider pharmacies as specified pursuant to the terms and conditions of the contract; and

(g) coordinating coverage with insurance companies and other public and private organizations offering such coverage for those eligible program participants having partial coverage for covered drugs through third-party sources, and providing for recoupment of any duplicate reimbursement paid by the state on behalf of such eligible program participants.

3. The contractor or contractors shall be required to provide such reports as may be deemed necessary by the commissioner of health and shall maintain files in a manner and format approved by the commissioner.

4. The contractor or contractors may contract with private not-for-profit or proprietary corporations, or with entities of local government within the state of New York, to perform such obligations of the contractor or contractors as the commissioner of health shall permit.

§ 244. Powers of the commissioner of health: Program for Elderly Pharmaceutical Insurance Coverage

The powers of the commissioner of health in administering the elderly pharmaceutical insurance coverage program shall include but not be limited to the following:
1. subject to the approval of the director of the budget, promulgating program regulations pursuant to section two hundred forty-six of this title;

2. determining the annual schedule of cost-sharing responsibilities of eligible program participants pursuant to section two hundred forty-seven of this title;

3. entering into contracts pursuant to section two hundred forty-three of this title;

4. implementing alternative program improvements for the efficient and effective operation of the program in accordance with the provisions of this title;

5. establishing or contracting for a therapeutic drug monitoring program, for the purpose of monitoring therapeutic drug use by eligible program participants in an effort to prevent the incorrect or unnecessary consumption of such therapeutic drugs; and

6. monitor the provision of services pursuant to contractual arrangements entered into pursuant to section two hundred forty-three of this title and examine and review all documents and other information to assure compliance with all provisions of this article whether such documents or other information are under the control of a contractor or a participating provider pharmacy.

§ 246. Regulations: Program for Elderly Pharmaceutical Insurance Coverage

Program regulations shall:

1. Provide for a process of determining and redetermining eligibility for participation in this program including provisions for submission of proof of income, age, and residency and information on existing complete or partial coverage of prescription drug expenses under a third party assistance or insurance plan;

2. Provide for a fair hearing process pursuant to an agreement with the department of health for individuals and participating provider pharmacies to appeal determinations or actions of the contractors;

3. Establish procedures for the state to recover the value of benefits or payments made under this title, if any, that were based on applications or claims submitted in violation of any provision of this title; and

4. Establish procedures to ensure that all information obtained on persons pursuant to paragraph (a) of subdivision two of section two hundred forty-three of this title shall remain confidential and shall not be disclosed to persons or agencies other than those entitled to such information because such disclosure is necessary for the proper administration of the program established pursuant to this title.

§ 247. Cost-sharing responsibilities of eligible program participants for comprehensive coverage: Program for Elderly Pharmaceutical Insurance Coverage

1. Registration fee. Eligible individuals meeting the registration fee requirements of this section may purchase prescribed covered drugs for an amount specified by subdivision three of this section, subject to the limits on point of sale co-payments specified by subdivision four of this section.

2. Registration fee schedule. Eligible individuals electing to meet the requirements of this subdivision shall pay a quarterly registration fee in a manner and form determined by the executive director; at the option of the participant, the registration fee may be paid annually in a lump sum upon the beginning of the annual coverage period. No eligible individual electing to meet the requirements of this subdivision shall have his participation in the program lapse by virtue of non-payment of the applicable registration fee unless the
Contractor has provided notification of the amount and due date thereof, and more than thirty days have elapsed since the due date of the individual's registration fee. The registration fee to be charged to eligible program participants for comprehensive coverage under this option shall be in accordance with the following schedule:

(a) Quarterly registration fees for unmarried individual program participants: individual income of $5,000 or less $2.00 individual income of $5,001 to $6,000 $2.00 individual income of $6,001 to $7,000 $4.00 individual income of $7,001 to $8,000 $5.50 individual income of $8,001 to $9,000 $7.00 individual income of $9,001 to $10,000 $9.00 individual income of $10,001 to $11,000 $10.00 individual income of $11,001 to $12,000 $11.50 individual income of $12,001 to $13,000 $13.50 individual income of $13,001 to $14,000 $15.00 individual income of $14,001 to $15,000 $20.00 individual income of $15,001 to $16,000 $27.50 individual income of $16,001 to $17,000 $35.00 individual income of $17,001 to $18,000 $42.50 individual income of $18,001 to $19,000 $50.00 individual income of $19,001 to $20,000 $57.50

(b) Quarterly registration fees for each married individual program participant: joint income of $5,000 or less $2.00 joint income of $5,001 to $6,000 $2.00 joint income of $6,001 to $7,000 $3.00 joint income of $7,001 to $8,000 $4.00 joint income of $8,001 to $9,000 $5.00 joint income of $9,001 to $10,000 $6.00 joint income of $10,001 to $11,000 $7.00 joint income of $11,001 to $12,000 $8.00 joint income of $12,001 to $13,000 $9.00 joint income of $13,001 to $14,000 $10.00 joint income of $14,001 to $15,000 $10.00 joint income of $15,001 to $16,000 $21.00 joint income of $16,001 to $17,000 $26.50 joint income of $17,001 to $18,000 $31.50 joint income of $18,001 to $19,000 $37.50 joint income of $19,001 to $20,000 $43.00 joint income of $20,001 to $21,000 $48.50 joint income of $21,001 to $22,000 $54.00 joint income of $22,001 to $23,000 $59.50 joint income of $23,001 to $24,000 $65.00 joint income of $24,001 to $25,000 $68.75 joint income of $25,001 to $26,000 $75.00

(c) In the event that the state expenditures per participant meeting the requirements of this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, exceed such expenditures in the previous program year by a minimum of ten percent, the annual registration fees set forth in this subdivision may, unless otherwise provided by law, be increased, pro-rata, for the subsequent program year, provided that such increase shall not exceed seven and one-half percent of the prior year registration fees as may have been adjusted in accordance with this paragraph.

(d) In the event that the state expenditures per such participant, incurred pursuant to this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, are less than such expenditures in the previous program year by a minimum of ten percent, the annual registration fees set forth in this subdivision may, unless otherwise provided by law, be decreased, pro-rata, for the subsequent program year, provided that such decrease shall not exceed seven and one-half percent of the prior year registration fees as may have been adjusted in accordance with this paragraph.

(e) The determination to adjust annual registration fees set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments and changes in the consumer price index. The frequency of such adjustments shall not exceed once in any program year and such adjustments shall not become effective for individual program participants prior to the first day of the next annual coverage period for each participant.
3. Point of sale co-payment. (a) Upon satisfaction of the registration fee pursuant to this section an eligible program participant must pay a point of sale co-payment as set forth in paragraph (b) of this subdivision at the time of each purchase of a covered drug prescribed for such individual. Such co-payment shall not be waived or reduced in whole or in part subject to the limits provided by subdivision four of this section.

(b) The point of sale co-payment amounts which are to be charged eligible program participants shall be in accordance with the following schedule: For each prescription of covered drugs costing $15.00 or less.....$3.00 For each prescription of covered drugs costing $15.01 to $35.00...$7.00 For each prescription of covered drugs costing $35.01 to $55.00..$15.00 For each prescription of covered drugs costing $55.01 or more....$20.00

(c) For the purposes of the foregoing schedule of point of sale co-payments, "costing" shall mean the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with section two hundred fifty of this title plus the point of sale co-payment, calculated as of the date of sale.

4. Limits on point of sale co-payments. During each annual coverage period no point of sale co-payment as set forth in subdivision three of this section shall be required to be made for the remainder of such period by any eligible program participant who has already incurred co-payments in excess of the limits set forth in the following schedule:

(a) Limits on co-payments by unmarried individual eligible program participants: individual income of $5,000 or less no more than $340 individual income of $5,001 to $6,000 no more than $408 individual income of $6,001 to $7,000 no more than $476 individual income of $7,001 to $8,000 no more than $544 individual income of $8,001 to $9,000 no more than $612 individual income of $9,001 to $10,000 no more than $700 individual income of $10,001 to $11,000 no more than $790 individual income of $11,001 to $12,000 no more than $896 individual income of $12,001 to $13,000 no more than $996 individual income of $13,001 to $14,000 no more than $1,094 individual income of $14,001 to $15,000 no more than $1,192 individual income of $15,001 to $16,000 no more than $1,290 individual income of $16,001 to $17,000 no more than $1,388 individual income of $17,001 to $18,000 no more than $1,486 individual income of $18,001 to $19,000 no more than $1,584 individual income of $19,001 to $20,000 no more than $1,682

(b) Limits on co-payments by each married individual eligible program participant: joint income of $5,000 or less no more than $291 joint income of $5,001 to $6,000 no more than $342 joint income of $6,001 to $7,000 no more than $399 joint income of $7,001 to $8,000 no more than $456 joint income of $8,001 to $9,000 no more than $513 joint income of $9,001 to $10,000 no more than $570 joint income of $10,001 to $11,000 no more than $622 joint income of $11,001 to $12,000 no more than $684 joint income of $12,001 to $13,000 no more than $746 joint income of $13,001 to $14,000 no more than $808 joint income of $14,001 to $15,000 no more than $870 joint income of $15,001 to $16,000 no more than $932 joint income of $16,001 to $17,000 no more than $994 joint income of $17,001 to $18,000 no more than $1,056 joint income of $18,001 to $19,000 no more than $1,118 joint income of $19,001 to $20,000 no more than $1,180 joint income of $20,001 to $21,000 no more than $1,242 joint income of $21,001 to $22,000 no more than $1,304 joint income of $22,001 to $23,000 no more than $1,366 joint income of $23,001 to $24,000 no more than $1,428 joint income of $24,001 to $25,000 no more than $1,490 joint income of $25,001 to $26,000 no more than $1,552

(c) Effective October first, nineteen hundred eighty-eight, the limits on point of sale co-payments as set forth in this subdivision may be adjusted by the panel on the anniversary date of each program participant’s annual coverage period, and such adjustment shall be in effect for the duration of that annual coverage period. Any such annual adjustment shall be made using a percentage adjustment factor which shall not exceed one-half...
of the difference between the year-to-year percentage increase in the consumer price index for all urban consumers, as published by the United States Department of Labor, and, if larger, the year-to-year percentage increase in the aggregate average cost of covered drugs purchased under this title, which year-to-year percentage increase in such cost shall be determined by comparison of such cost in the same month of each of the appropriate successive years; provided, however, that for any such adjustment based wholly on experience in the program year commencing October first, nineteen hundred eighty-seven, the year-to-year percentage increase in such cost shall be determined by comparison of such cost in each of two months no less than five months apart and within such program year, which comparison shall be annualized. Such percentage adjustment factor shall be the same as that used to determine any similar annual adjustment for the same annual coverage periods pursuant to the provisions of subdivision four of section two hundred forty-eight of this title.

(d) Such annual adjustments shall be calculated by multiplying the percentage adjustment factor by (1) ten percent and applying the resulting percentage to the upper income limitation of each income level for unmarried individuals contained in this subdivision, and by (2) seven and one-half percent and applying the resulting percentage to the upper income limitation of each income level for married individuals contained in this subdivision; each result of such calculations, minus any applicable registration fee increases made pursuant to subdivision two of this section and plus the result of applying the percentage adjustment factor to the sum of any such annual adjustments applicable thereto for any prior annual coverage period, shall be the amount by which the limit on co-payments for each such income level may be adjusted, and such amount shall be in addition to any such amount or amounts applicable to prior annual coverage periods.

(e) The determination to adjust the limits on point of sale co-payments set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments.

§ 248. Cost-sharing responsibilities of eligible program participants for catastrophic coverage: Program for Elderly Pharmaceutical Insurance Coverage

Cost-sharing responsibilities of eligible program participants for catastrophic coverage. 1. Deductible. Eligible individuals meeting the deductible requirements of this section may purchase prescribed covered drugs for an amount specified by subdivision three of this section, subject to the limits on point of sale co-payments specified by subdivision four of this section.

2. Deductible schedule. Eligible individuals electing to meet the requirements of this subdivision shall incur an amount of personal covered drug expenditures during any annual coverage period which are not reimbursed by any other public or private third party payment source or insurance plan, and shall be deemed to have met their deductible requirements for the remainder of such annual coverage period. The amount of personal covered drug expenditures to be incurred by eligible program participants for catastrophic coverage under this option shall be in accordance with the following schedule:

(a) Annual personal covered drug expenditures for unmarried individual eligible program participants:
- Individual income of $20,001 to $21,000: $530
- Individual income of $21,001 to $22,000: $550
- Individual income of $22,001 to $23,000: $580
- Individual income of $23,001 to $24,000: $720
- Individual income of $24,001 to $25,000: $750
- Individual income of $25,001 to $26,000: $780
- Individual income of $26,001 to $27,000: $810
- Individual income of $27,001 to $28,000: $840
- Individual income of $28,001 to $29,000: $870
- Individual income of $29,001 to $30,000: $900
- Individual income of $30,001 to $31,000: $930
- Individual income of $31,001 to
$32,000 $960 individual income of $32,001 to $33,000 $1,160 individual income of $33,001 to $34,000 $1,190 individual income of $34,001 to $35,000 $1,230 individual income of $35,001 to $36,000 $1,260 individual income of $36,001 to $37,000 $1,290 individual income of $37,001 to $38,000 $1,320 individual income of $38,001 to $39,000 $1,350 individual income of $39,001 to $40,000 $1,380 individual income of $40,001 to $41,000 $1,410 individual income of $41,001 to $42,000 $1,440 individual income of $42,001 to $43,000 $1,470 individual income of $43,001 to $44,000 $1,500 individual income of $44,001 to $45,000 $1,530 individual income of $45,001 to $46,000 $1,560 individual income of $46,001 to $47,000 $1,590 individual income of $47,001 to $48,000 $1,620 individual income of $48,001 to $49,000 $1,650 individual income of $49,001 to $50,000 $1,680 individual income of $50,001 to $51,000 $1,710 individual income of $51,001 to $52,000 $1,740 individual income of $52,001 to $53,000 $1,770 individual income of $53,001 to $54,000 $1,800 individual income of $54,001 to $55,000 $1,830 individual income of $55,001 to $56,000 $1,860 individual income of $56,001 to $57,000 $1,890 individual income of $57,001 to $58,000 $1,920 individual income of $58,001 to $59,000 $1,950 individual income of $59,001 to $60,000 $1,980 individual income of $60,001 to $61,000 $2,010 individual income of $61,001 to $62,000 $2,040 individual income of $62,001 to $63,000 $2,070 individual income of $63,001 to $64,000 $2,100 individual income of $64,001 to $65,000 $2,130 individual income of $65,001 to $66,000 $2,160 individual income of $66,001 to $67,000 $2,190 individual income of $67,001 to $68,000 $2,220 individual income of $68,001 to $69,000 $2,250 individual income of $69,001 to $70,000 $2,280 individual income of $70,001 to $71,000 $2,310 individual income of $71,001 to $72,000 $2,340 individual income of $72,001 to $73,000 $2,370 individual income of $73,001 to $74,000 $2,400 individual income of $74,001 to $75,000 $2,430

(b) Annual personal covered drug expenditures for each married individual eligible program participant: joint income of $26,001 to $27,000 $650 joint income of $27,001 to $28,000 $675 joint income of $28,001 to $29,000 $700 joint income of $29,001 to $30,000 $725 joint income of $30,001 to $31,000 $900 joint income of $31,001 to $32,000 $930 joint income of $32,001 to $33,000 $960 joint income of $33,001 to $34,000 $990 joint income of $34,001 to $35,000 $1,020 joint income of $35,001 to $36,000 $1,050 joint income of $36,001 to $37,000 $1,080 joint income of $37,001 to $38,000 $1,110 joint income of $38,001 to $39,000 $1,140 joint income of $39,001 to $40,000 $1,170 joint income of $40,001 to $41,000 $1,200 joint income of $41,001 to $42,000 $1,230 joint income of $42,001 to $43,000 $1,260 joint income of $43,001 to $44,000 $1,290 joint income of $44,001 to $45,000 $1,320 joint income of $45,001 to $46,000 $1,350 joint income of $46,001 to $47,000 $1,380 joint income of $47,001 to $48,000 $1,410 joint income of $48,001 to $49,000 $1,440 joint income of $49,001 to $50,000 $1,470 joint income of $50,001 to $51,000 $1,500 joint income of $51,001 to $52,000 $1,530 joint income of $52,001 to $53,000 $1,560 joint income of $53,001 to $54,000 $1,590 joint income of $54,001 to $55,000 $1,620 joint income of $55,001 to $56,000 $1,650 joint income of $56,001 to $57,000 $1,680 joint income of $57,001 to $58,000 $1,710 joint income of $58,001 to $59,000 $1,740 joint income of $59,001 to $60,000 $1,770 joint income of $60,001 to $61,000 $1,800 joint income of $61,001 to $62,000 $1,830 joint income of $62,001 to $63,000 $1,860 joint income of $63,001 to $64,000 $1,890 joint income of $64,001 to $65,000 $1,920 joint income of $65,001 to $66,000 $1,950 joint income of $66,001 to $67,000 $1,980 joint income of $67,001 to $68,000 $2,010 joint income of $68,001 to $69,000 $2,040 joint income of $69,001 to $70,000 $2,070 joint income of $70,001 to $71,000 $2,100 joint income of $71,001 to $72,000 $2,130 joint income of $72,001 to $73,000 $2,160 joint income of $73,001 to $74,000 $2,190 joint income of $74,001 to $75,000 $2,220 joint income of $75,001 to $76,000 $2,250 joint income of $76,001 to $77,000 $2,280 joint income of $77,001 to $78,000 $2,310 joint income of $78,001 to $79,000 $2,340 joint income of $79,001 to $80,000 $2,370 joint income of $80,001 to $81,000 $2,400 joint income of $81,001 to $82,000 $2,430
$82,000 $2,675 joint income of $82,001 to $83,000 $2,705 joint income of $83,001 to $84,000 $2,735 joint income of $84,001 to $85,000 $2,765 joint income of $85,001 to $86,000 $2,795 joint income of $86,001 to $87,000 $2,825 joint income of $87,001 to $88,000 $2,855 joint income of $88,001 to $89,000 $2,885 joint income of $89,001 to $90,000 $2,915 joint income of $90,001 to $91,000 $2,945 joint income of $91,001 to $92,000 $2,975 joint income of $92,001 to $93,000 $3,005 joint income of $93,001 to $94,000 $3,035 joint income of $94,001 to $95,000 $3,065 joint income of $95,001 to $96,000 $3,095 joint income of $96,001 to $97,000 $3,125 joint income of $97,001 to $98,000 $3,155 joint income of $98,001 to $99,000 $3,185 joint income of $99,001 to $100,000 $3,215

(c) In the event that the state expenditures per participant electing to meet the deductible requirements of this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, exceed such expenditures in the previous program year by a minimum of ten percent, the annual personal covered drug expenditures set forth in this subdivision may, unless otherwise provided by law, be increased, pro-rata, for the subsequent program year, provided that such increase shall not exceed eight percent of the prior year personal covered drug expenditures as may have been adjusted in accordance with this paragraph.

(d) In the event that the state expenditures per such participant, incurred pursuant to this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, are less than such expenditures in the previous program year by a minimum of ten percent, the annual personal covered drug expenditures set forth in this subdivision may, unless otherwise provided by law, be decreased, pro-rata, for the subsequent program year, provided that such decrease shall not exceed eight percent of the prior year personal covered drug expenditures as may have been adjusted in accordance with this paragraph.

(e) The determination to adjust annual personal covered drug expenditures set forth in this subdivision, shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments and changes in the consumer price index. The frequency of such adjustments shall not exceed once in any twelve month period and such adjustments shall not become effective for individual program participants prior to the first day of the next annual coverage period for each participant.

3. Point of sale co-payment. (a) Upon satisfaction of the deductible requirements pursuant to subdivision two of this section, an eligible program participant shall pay a point of sale co-payment as set forth in paragraph (b) of this subdivision at the time of each purchase of a covered drug prescribed for such individual. Such co-payment shall not be waived or reduced in whole or in part, subject to the limits provided by subdivision four of this section.

(b) The point of sale co-payment amounts which are to be charged eligible program participants shall be in accordance with the following schedule: For each prescription of covered drugs costing $15.00 or less $3.00 For each prescription of covered drugs costing $15.01 to $35.00 $7.00 For each prescription of covered drugs costing $35.01 to $55.00 $15.00 For each prescription of covered drugs costing $55.01 or more $20.00

(c) For the purposes of the foregoing schedule of point of sale co-payments, "costing" shall mean the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with section two hundred fifty of this title plus the point of sale co-payment, calculated as of the date of sale.
4. Annual limits on point of sale co-payments. During each annual coverage period, no point of sale co-payments as set forth in subdivision three of this section shall be required to be made for the remainder of such period by any eligible program participant meeting the personal covered drug expenditure requirements of subdivision two of this section in excess of the limits set forth in the following schedule:

(a) Limits on co-payments by unmarried individual eligible program participants: individual income of $20,001 to $21,000 no more than $1,050 individual income of $21,001 to $22,000 no more than $1,100 individual income of $22,001 to $23,000 no more than $1,150 individual income of $23,001 to $24,000 no more than $1,200 individual income of $24,001 to $25,000 no more than $1,250 individual income of $25,001 to $26,000 no more than $1,300 individual income of $26,001 to $27,000 no more than $1,350 individual income of $27,001 to $28,000 no more than $1,400 individual income of $28,001 to $29,000 no more than $1,450 individual income of $29,001 to $30,000 no more than $1,500 individual income of $30,001 to $31,000 no more than $1,550 individual income of $31,001 to $32,000 no more than $1,600 individual income of $32,001 to $33,000 no more than $1,650 individual income of $33,001 to $34,000 no more than $1,700 individual income of $34,001 to $35,000 no more than $1,750

(b) Limits on co-payments by each married individual eligible program participant: joint income of $26,001 to $27,000 no more than $1,080 joint income of $27,001 to $28,000 no more than $1,120 joint income of $28,001 to $29,000 no more than $1,160 joint income of $29,001 to $30,000 no more than $1,200 joint income of $30,001 to $31,000 no more than $1,240 joint income of $31,001 to $32,000 no more than $1,280 joint income of $32,001 to $33,000 no more than $1,320 joint income of $33,001 to $34,000 no more than $1,360 joint income of $34,001 to $35,000 no more than $1,400 joint income of $35,001 to $36,000 no more than $1,440 joint income of $36,001 to $37,000 no more than $1,480 joint income of $37,001 to $38,000 no more than $1,520 joint income of $38,001 to $39,000 no more than $1,560 joint income of $39,001 to $40,000 no more than $1,600 joint income of $40,001 to $41,000 no more than $1,640 joint income of $41,001 to $42,000 no more than $1,680 joint income of $42,001 to $43,000 no more than $1,720 joint income of $43,001 to $44,000 no more than $1,760 joint income of $44,001 to $45,000 no more than $1,800 joint income of $45,001 to $46,000 no more than $1,840 joint income of $46,001 to $47,000 no more than $1,880 joint income of $47,001 to $48,000 no more than $1,920 joint income of $48,001 to $49,000 no more than $1,960 joint income of $49,001 to $100,000 no more than $2,000

(c) Effective October first, nineteen hundred eighty-eight, the limits on point of sale co-payments as set forth in this subdivision may be adjusted by the commissioner on the anniversary date of each program participant’s annual coverage period, and such adjustment shall be in effect for the duration of that annual coverage period. Any such annual adjustment shall be made using a percentage adjustment factor which shall not exceed one-half of the difference between the year-to-year percentage increase in the consumer price index for all urban consumers, as published by the United States department of labor, and, if larger, the year-to-year percentage increase in the aggregate average cost of covered drugs purchased under this title, which year-to-year percentage increase in such cost shall be determined by comparison of such cost in the same month of each of the appropriate successive years; provided, however, that for any such adjustment based wholly on experience in the program year commencing October first, nineteen hundred eighty-seven, the year-to-year percentage increase in such cost shall be determined by comparison of such cost in each of two months no less than five months apart and within such program year, which comparison shall be annualized. Such percentage adjustment factor shall be the same as that used to determine any similar annual adjustment for the same annual coverage periods pursuant to the provisions of subdivision four of section two hundred forty-seven of this title. Such annual adjustments shall be calculated by multiplying the percentage adjustment
factor by (1) ten percent and applying the resulting percentage to the upper income limitation of each income level for unmarried individuals contained in this subdivision, and by (2) seven and one-half percent and applying the resulting percentage to the upper income limitation of each income level for married individuals contained in this subdivision; each result of such calculations, minus any applicable deductible increases made pursuant to subdivision two of this section and plus the result of applying the percentage adjustment factor to the sum of any such annual adjustments applicable thereto for any prior annual coverage period, shall be the amount by which the limit on co-payments for each such income level may be adjusted, and such amount shall be in addition to any such amount or amounts applicable to prior annual coverage periods.

(d) The determination to adjust the limits on point of sale co-payments set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participant to support such adjustments.

§ 249. Participating provider pharmacies: Program for Elderly Pharmaceutical Insurance Coverage

1. The state shall offer an opportunity to participate in this program to all provider pharmacies as defined in section two hundred forty-one of this title, provided, however, that the participation of pharmacies registered in the state pursuant to section sixty-eight hundred eight-b of the education law shall be limited to state assistance provided under this title for prescription drugs covered by a program participant’s medicare drug plan.

2. To participate in this program, a pharmacy shall be required to enter into a provider agreement and shall abide by such terms and conditions as shall be prescribed in the agreement, including the release of financial information for the purpose of program audits and surveys.

§ 250. Reimbursement to participating provider pharmacies: Program for Elderly Pharmaceutical Insurance Coverage

1. The amount of reimbursement which shall be paid by the state to a participating provider pharmacy for any covered drug filled or refilled for any eligible program participant shall be equal to the allowed amount defined as follows, minus the point of sale co-payment as required by sections two hundred forty-seven and two hundred forty-eight of this title:

(a) Multiple source covered drugs. Except for brand name drugs that are required by the prescriber to be dispensed as written, the allowed amount for a multiple source covered drug shall equal the lower of:

(1) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase, or

(2) The upper limit, if any, set by the centers for medicare and medicaid services for such multiple source drug, or

(3) Average wholesale price discounted by twenty-five percent, or

(4) The maximum allowable cost, if any, established by the commissioner of health pursuant to paragraph (e) of subdivision nine of section three hundred sixty-seven-a of the social services law.

Plus a dispensing fee for drugs reimbursed pursuant to subparagraphs two, three, and four of this paragraph, as defined in paragraph (c) of this subdivision.
(b) Other covered drugs. The allowed amount for brand name drugs required by the prescriber to be dispensed as written and for covered drugs other than multiple source drugs shall be determined by applying the lower of:

1. Average wholesale price discounted by sixteen and twenty-five one hundredths percent, plus a dispensing fee as defined in paragraph (c) of this subdivision, or

2. The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase.

(c) As required by paragraphs (a) and (b) of this subdivision, a dispensing fee of four dollars fifty cents will apply to generic drugs and a dispensing fee of three dollars fifty cents will apply to brand name drugs.

2. For purposes of determining the amount of reimbursement which shall be paid to a participating provider pharmacy, the commissioner of health shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug that participating provider pharmacies buy most frequently. Using the result of this survey, the contractor shall update every thirty days the list of average wholesale prices upon which such reimbursement is determined using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is dispensed.

3. (a) Notwithstanding any inconsistent provision of law, the program for elderly pharmaceutical insurance coverage shall reimburse for covered drugs which are dispensed under the program by a provider pharmacy only pursuant to the terms of a rebate agreement between the program and the manufacturer (as defined under section 1927 of the federal social security act) of such covered drugs; provided, however, that:

1. any agreement between the program and a manufacturer entered into before August first, nineteen ninety-one, shall be deemed to have been entered into on April first, nineteen ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen ninety-one, such agreement shall not be effective until April first, nineteen ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen ninety-one; and

2. the program may reimburse for any covered drugs pursuant to subdivisions one and two of this section, for which a rebate agreement does not exist and which are determined by the commissioner to be essential to the health of persons participating in the program; and likely to provide effective therapy or diagnosis for a disease not adequately treated or diagnosed by any other covered drug.

(b) The rebate agreement between such manufacturer and the program for elderly pharmaceutical insurance coverage shall utilize for covered drugs the identical formula used to determine the rebate for federal financial participation for drugs, pursuant to section 1927(c) of the federal social security act, to determine the amount of the rebate pursuant to this subdivision.

(c) The amount of rebate pursuant to paragraph (b) of this subdivision shall be calculated by multiplying the required rebate formulas by the total number of units of each dosage form and strength dispensed. The rebate agreement shall also provide for periodic payment of the rebate, provision of information to the program, audits, verification of data, damages to the program for any delay or non-production of necessary data by the manufacturer and for the confidentiality of information.
(d) The program in providing utilization data to a manufacturer (as provided for under section 1927 (b) of the federal social security act) shall provide such data by zip code, if requested, for the top three hundred most commonly used drugs by volume covered under a rebate agreement.

(e) Any funds collected pursuant to any rebate agreements entered into with a manufacturer pursuant to this subdivision, shall be deposited into the elderly pharmaceutical insurance coverage program premium account.

4. Notwithstanding any other provision of law, entities which offer insurance coverage for provision of and/or reimbursement for pharmaceutical expenses, including but not limited to, entities licensed/certified pursuant to article thirty-two, forty-two, forty-three or forty-four of the insurance law (employees welfare funds) or article forty-four of the public health law, shall participate in a benefit recovery program with the elderly pharmaceutical insurance coverage (EPIC) program which includes, but is not limited to, a semi-annual match of EPIC's file of enrollees against the entity's file of insured to identify individuals enrolled in both plans with claims paid within the twenty-four months preceding the date the entity receives the match request information from EPIC. Such entity shall indicate if pharmaceutical coverage is available from the entity for the insured persons, list the copayment or other payment obligations of the insured persons applicable to the pharmaceutical coverage, and (after receiving necessary claim information from EPIC) list the amounts which the entity would have paid for the pharmaceutical claims for those identified individuals and the entity shall reimburse EPIC for pharmaceutical expenses paid by EPIC that are covered under the contract between the entity and its insured in only those instances where the entity has not already made payment of the claim. Reimbursement of the net amount payable (after rebates and discounts) that would have been paid under the coverage issued by the entity will be made by the entity to EPIC within sixty days of receipt from EPIC of the standard data in electronic format necessary for the entity to adjudicate the claim and if the standard data is provided to the entity by EPIC in paper format payment by the entity shall be made within one hundred eighty days. After completing at least one match process with EPIC in electronic format, an entity shall be entitled to elect a monthly or bi-monthly match process rather than a semi-annual match process.

5. Notwithstanding any other provision of law, the commissioner of health shall maximize the coordination of benefits for persons enrolled under Title XVIII of the federal social security act (medicare) and enrolled under this title in order to facilitate medicare payment of claims. The commissioner of health may select an independent contractor, through a request-for-proposal process, to implement a centralized coordination of benefits system under this subdivision for individuals qualified in both the elderly pharmaceutical insurance coverage (EPIC) program and medicare programs who receive medications or other covered products from a pharmacy provider currently enrolled in the elderly pharmaceutical insurance coverage (EPIC) program.

6. The EPIC program shall be the payor of last resort for individuals qualified in both the EPIC program and title XVIII of the federal social security act (Medicare).

§ 251. Penalties for fraud and abuse: Program for Elderly Pharmaceutical Insurance Coverage

1. Any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain any benefit under this title to which he or she is not entitled, shall be guilty of a class A misdemeanor.
2. Any person who, having made application to receive any benefit under this title for the use and benefit of another and having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person, shall be guilty of a class A misdemeanor.

3. Any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under this title, shall be guilty of a class A misdemeanor.

§ 252. Procedures for determinations relating to package, or form of dosage or administration, of certain drugs: Program for Elderly Pharmaceutical Insurance Coverage

Procedures for determinations relating to package, or form of dosage or administration, of certain drugs. 1. If the department of health makes an initial determination that a particular package, or form of dosage or administration, of a drug shall be excluded in accordance with the provisions of paragraph (b) of subdivision one of section two hundred forty-one of this title, the executive department shall notify the manufacturer of such drug product that the executive department intends to seek the exclusion of such package, or form of dosage or administration, from the program and shall provide such manufacturer with the reasons therefor together with the facts which the department relies upon to support its initial determination. The manufacturer shall have fifteen days after receiving such exclusion notice to notify the executive department of an intent to appeal the decision. If the manufacturer fails to notify the executive department of an intent to appeal within the time specified in this section, the commissioner of health shall forthwith determine whether the package, or form of dosage or administration, shall be excluded from the program. If the manufacturer notifies the executive department of an intent to appeal, the manufacturer shall submit to the executive department within forty-five days of receiving such exclusion notice, the basis of the manufacturer's appeal. Within fifteen days of receiving such submission from the manufacturer, the executive department shall provide to the manufacturer any additional facts concerning the drug product that the department relies upon to support its initial determination. Within ten days of receiving such facts, the manufacturer may submit additional facts concerning the drug package, or form of dosage or administration. Based on the facts submitted pursuant to this section, the commissioner of health shall make a final determination, in accordance with the standard set forth in paragraph (b) of subdivision one of section two hundred forty-one of this title, as to whether the package, or form of dosage or administration, of the drug product shall constitute a covered drug for the purposes of this article. A determination to exclude the drug package, or form of dosage or administration, shall be subject to judicial review pursuant to article seventy-eight of the civil practice law and rules.

2. The commissioner of health shall establish by regulation an appropriate process allowing drug packages, or forms of dosage or administration, finally determined under this section not to be covered drugs for the purposes of this title to be dispensed to program participants for whom such drug packages, or forms of dosage or administration, are medically indicated as certified to by a physician treating such participant. Any such drug package, or form of dosage or administration, so certified as medically indicated for a specific participant in accordance with such regulations shall be a covered drug for the purpose of this title.

Utilization of out-of-state provider pharmacies; necessity and convenience. 1. In counties having a population of seventy-five thousand or less that are in proximity to the state boundary and which are determined by the commissioner of health to be not adequately served by provider pharmacies registered in New York, and in Fishers Island in the town of Southold, Suffolk county, the commissioner may approve as provider pharmacies, pharmacies located in New Jersey, Connecticut, Vermont, Pennsylvania or Massachusetts. Such approvals shall be made after (a) consideration of the convenience and necessity of New York residents in the rural areas served by such pharmacies, (b) consideration of the quality of service of such pharmacies and the standing of such pharmacies with the governmental board or agency of the state in which such pharmacy is located, (c) the commissioner shall give all licensed pharmacies within the county notice of his or her intention to approve such out-of-state provider pharmacies, and (d) the commissioner has held a public hearing at which he or she has determined factually that the licensed pharmacies within such county are not adequately serving as provider pharmacies.

2. The commissioner of health shall investigate and determine whether certification shall be granted within ninety days of the filing of an application for certification by the governing body of any city, town or village, within a county determined by the commissioner to be not adequately served by provider pharmacies registered in New York pursuant to subdivision one of this section, claiming to be lacking adequate pharmaceutical service.

3. Every certification granted pursuant to this section shall expire not more than five years after the date of issuance.

§ 254. Cost of living adjustment: Program for Elderly Pharmaceutical Insurance Coverage

1. Within amounts appropriated, the commissioner of health shall adjust the program eligibility standards set forth in subdivision two of section two hundred forty-two of this title to account for increases in the cost of living.

2. The commissioner shall further adjust individual and joint income categories set forth in subdivisions two and four of section two hundred forty-eight of this title to conform to the adjustments made pursuant to subdivision one of this section.