S T A T E O F N E W Y O R K

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I N S E N A T E

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Introduced by Sens. HANNON, ALESI, BALL, BONACIC, DeFRANCISCO, FARLEY, FLANAGAN, FUSCHILLO, GALLIVAN, GOLDEN, GRIFFO, GRISANTI, JOHNSON, KLEIN, LANZA, LARKIN, LAVALLE, LIBOUS, LITTLE, MARCELLINO, MARTINS, MAZIARZ, McDONALD, NOZZOLIO, O'MARA, RANZENHOFER, RITCHIE, ROBACH, SALAND, SAVINO, SEWARD, SKELOS, VALESKY, YOUNG, ZELDIN -- read twice and ordered printed, and when printed to be committed to the Committee on Aging

AN ACT to amend the elder law, in relation to the program for elderly pharmaceutical insurance coverage; and to repeal certain provisions of such law relating thereto

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Paragraph (f) of subdivision 3 of section 242 of the elder law, as amended by section 3-d of part A of chapter 59 of the laws of 2011, is amended to read as follows:

(f) As a condition of CONTINUED eligibility for benefits under this title, IF a program participant IS ELIGIBLE FOR MEDICARE PART D DRUG COVERAGE UNDER SECTION 1860D OF THE FEDERAL SOCIAL SECURITY ACT, THE PARTICIPANT is required to [be enrolled] ENROLL in Medicare part D AT THE FIRST AVAILABLE ENROLLMENT PERIOD and to maintain such enrollment. THIS REQUIREMENT SHALL BE WAIVED IF SUCH ENROLLMENT WOULD RESULT IN SIGNIFICANT ADDITIONAL FINANCIAL LIABILITY BY THE PARTICIPANT, INCLUDING, BUT NOT LIMITED TO, INDIVIDUALS IN A MEDICARE ADVANTAGE PLAN WHOSE COST SHARING WOULD BE INCREASED, OR IF SUCH ENROLLMENT WOULD RESULT IN THE LOSS OF ANY HEALTH COVERAGE THROUGH A UNION OR EMPLOYER PLAN FOR THE PARTICIPANT, THE PARTICIPANT'S SPOUSE OR OTHER DEPENDENT. THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE PREMIUM ASSISTANCE FOR ALL PARTICIPANTS ENROLLED IN MEDICARE PART D AS FOLLOWS:

(I) FOR PARTICIPANTS WITH COMPREHENSIVE COVERAGE UNDER SECTION TWO HUNDRED FORTY-SEVEN OF THIS TITLE, 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

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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WHICH SUCH AGENCY ESTABLISHES UNDER ITS DE MINIMUS PREMIUM POLICY, EXCEPT THAT SUCH PAYMENTS MADE ON BEHALF OF PARTICIPANTS ENROLLED IN A MEDICARE ADVANTAGE PLAN MAY EXCEED THE LOW-INCOME BENCHMARK PREMIUM AMOUNT IF DETERMINED TO BE COST EFFECTIVE TO THE PROGRAM.

(II) FOR PARTICIPANTS WITH CATASTROPHIC COVERAGE UNDER SECTION TWO HUNDRED FORTY-EIGHT OF THIS TITLE, THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL CREDIT THE PARTICIPANT'S ANNUAL PERSONAL COVERED DRUG EXPENDITURE AMOUNT REQUIRED UNDER THIS TITLE BY AN AMOUNT EQUAL TO THE ANNUAL LOW-INCOME BENCHMARK PREMIUM AMOUNT ESTABLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, PRORATED FOR THE REMAINING PORTION OF THE PARTICIPANT'S ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM COVERAGE PERIOD. THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL, AT APPROPRIATE TIMES, NOTIFY PARTICIPANTS WITH CATASTROPHIC COVERAGE UNDER SECTION TWO HUNDRED FORTY-SEVEN OF THIS TITLE OF THEIR RIGHT TO COORDINATE THE ANNUAL COVERAGE PERIOD WITH THAT OF MEDICARE PART D, ALONG WITH THE POSSIBLE ADVANTAGES AND DISADVANTAGES OF DOING SO.

S 2. Subdivision 6 of section 241 of the elder law, as amended by section 2 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

6. "Annual coverage period" shall mean the period of twelve consecutive calendar months for which an eligible program participant has met the [requirements of section two hundred forty-two] APPLICATION FEE OR DEDUCTIBLE REQUIREMENTS, AS THE CASE MAY BE, OF SECTIONS TWO HUNDRED FORTY-SEVEN AND TWO HUNDRED FORTY-EIGHT of this title.

S 3. Subdivisions 8 and 9 of section 241 of the elder law are REPEALED.

S 4. Subdivision 1 of section 242 of the elder law, as amended by section 3 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

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[, who is enrolled in Medicare part D,] 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 [thirty-five] 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[, who is enrolled in Medicare part D,] 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 [fifty] TWENTY-SIX thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

S 5. Section 242 of the elder law is amended by adding a new subdivision 2 to read as follows:

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 ONE, IS MORE THAN TWENTY THOUSAND AND LESS THAN OR EQUAL TO THIRTY-FIVE THOUSAND DOLLARS. AFTER THE INITIAL DETERMINATION OF ELIGI-

BILITY, 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 FIFTY THOUSAND DOLLARS. AFTER THE INITIAL DETERMINATION OF ELIGIBILITY, EACH ELIGIBLE INDIVIDUAL MUST BE REDETERMINED ELIGIBLE AT LEAST EVERY TWENTY-FOUR MONTHS.

S 6. Paragraph (c) of subdivision 3 of section 242 of the elder law is REPEALED and a new paragraph (c) is added to read as follows:

(C)(1) THE FACT THAT SOME OF AN INDIVIDUAL'S PRESCRIPTION DRUG EXPENSES ARE PAID OR REIMBURSABLE UNDER THE PROVISIONS OF THE MEDICARE PROGRAM SHALL NOT DISQUALIFY AN INDIVIDUAL, IF HE OR SHE IS OTHERWISE ELIGIBLE, FROM RECEIVING ASSISTANCE UNDER THIS TITLE. IN SUCH CASES, THE STATE SHALL PAY THE PORTION OF THE COST OF THOSE PRESCRIPTIONS FOR QUALIFIED DRUGS FOR WHICH NO PAYMENT OR REIMBURSEMENT IS MADE BY THE MEDICARE PROGRAM OR ANY FEDERALLY FUNDED PRESCRIPTION DRUG BENEFIT, LESS THE PARTICIPANT'S CO-PAYMENT REQUIRED ON THE AMOUNT NOT PAID BY THE MEDICARE PROGRAM.

(2) COVERAGE UNDER THIS PARAGRAPH SHALL BE AVAILABLE ONLY AFTER THE PARTICIPANT HAS FIRST EXHAUSTED THE FIRST TWO LEVELS OF APPEAL AVAILABLE UNDER PART D OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT (FN1) AND THE APPEAL HAS BEEN DENIED. DURING THE COVERAGE DETERMINATION AND APPEAL PERIOD, THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE UP TO A NINETY DAY SUPPLY OF THE PRESCRIBED MEDICATION, OR SUCH LESSER SUPPLY AS SPECIFIED ON THE PRESCRIPTION, IF: (I) THE PHARMACIST NOTIFIES THE PRESCRIBER THAT THE PARTICIPANT'S MEDICARE PART D PLAN AND THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM HAVE DENIED PAYMENT FOR THE PRESCRIBED MEDICATION AND THAT IF THE PRESCRIBER DOES NOT CHOOSE TO CHANGE THE PRESCRIPTION TO A DRUG THAT IS COVERED BY THE PARTICIPANT'S MEDICARE PART D PLAN, A MEDICARE PART D APPEAL MUST BE PURSUED; AND (II) THE PRESCRIBER NOTIFIES THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM OF THE PRESCRIBER'S INTENT TO PROVIDE NECESSARY INFORMATION AND COOPERATION IN THE PURSUIT OF THE MEDICARE PART D APPEAL. IN INSTANCES WHERE THE PHARMACIST IS UNABLE TO IMMEDIATELY REACH THE PRESCRIBER, THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL, UPON THE REQUEST OF THE PHARMACIST, AUTHORIZE A THREE DAY EMERGENCY SUPPLY OF THE PRESCRIBED MEDICATION. THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL AUTHORIZE SUCH ADDITIONAL NINETY DAY SUPPLIES OF THE PRESCRIBED MEDICATION, OR SUCH LESSER SUPPLY AS SPECIFIED ON THE PRESCRIPTION, AND SUCH ADDITIONAL THREE DAY EMERGENCY SUPPLIES AS REQUIRED TO ENSURE COVERAGE OF THE PRESCRIBED MEDICATION DURING THE PENDENCY OF THE MEDICARE PART D APPEAL.

(3) 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.

S 7. Subdivision 3 of section 242 of the elder law is amended by adding a new paragraph (d) to read as follows:

(D) THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM IS AUTHORIZED TO APPLY FOR TRANSITIONAL ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM WITH A SPECIFIC DRUG DISCOUNT CARD

UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT ON BEHALF OF APPLICANTS AND ELIGIBLE PROGRAM PARTICIPANTS UNDER THIS TITLE. THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE APPLICANTS AND ELIGIBLE PROGRAM PARTICIPANTS WITH PRIOR WRITTEN NOTICE OF, AND THE OPPORTUNITY TO DECLINE, SUCH AUTOMATIC ENROLLMENT.

S 8. Paragraph (e) of subdivision 3 of section 242 of the elder law, as amended by section 3-d of part A of chapter 59 of the laws of 2011, is amended to read as follows:

(e) As a condition of CONTINUED 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.

S 9. Subdivision 3 of section 242 of the elder law is amended by adding a new paragraph (g) to read as follows:

(G) THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM IS AUTHORIZED AND DIRECTED TO CONDUCT AN ENROLLMENT PROGRAM TO FACILITATE, IN AS PROMPT AND STREAMLINED A FASHION AS POSSIBLE, THE ENROLLMENT INTO MEDICARE PART D OF PROGRAM PARTICIPANTS WHO ARE REQUIRED BY THE PROVISIONS OF THIS SECTION TO ENROLL IN PART D. PROVIDED, HOWEVER, THAT A PARTICIPANT SHALL NOT BE PREVENTED FROM RECEIVING HIS OR HER DRUGS IMMEDIATELY AT THE PHARMACY UNDER THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM AS A RESULT OF SUCH PARTICIPANT'S ENROLLMENT IN MEDICARE PART D.

S 10. Paragraph (h) of subdivision 3 of section 242 of the elder law, as amended by section 3-f of part A of chapter 59 of the laws of 2011, is amended to read as follows:

(h) [The] IN ORDER TO MAXIMIZE PRESCRIPTION DRUG COVERAGE UNDER MEDICARE PART D, THE elderly pharmaceutical insurance coverage program is authorized to represent program participants under this title [with respect to their Medicare part D] IN THE PURSUIT OF SUCH coverage. SUCH REPRESENTATION SHALL NOT RESULT IN ANY ADDITIONAL FINANCIAL LIABILITY ON BEHALF OF SUCH PROGRAM PARTICIPANTS AND SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING ACTIONS:

(I) APPLICATION FOR THE PREMIUM AND COST-SHARING SUBSIDIES ON BEHALF OF ELIGIBLE PROGRAM PARTICIPANTS;

(II) ENROLLMENT IN A PRESCRIPTION DRUG PLAN OR MA-PD PLAN; THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE PROGRAM PARTICIPANTS WITH PRIOR WRITTEN NOTICE OF, AND THE OPPORTUNITY TO DECLINE SUCH FACILITATED ENROLLMENT SUBJECT, HOWEVER, TO THE PROVISIONS OF PARAGRAPH (F) OF THIS SUBDIVISION;

(III) PURSUIT OF APPEALS, GRIEVANCES, OR COVERAGE DETERMINATIONS.

S 11. Section 243 of the elder law, as amended by section 3-g of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 243. Pharmaceutical insurance contract. 1. The [commissioner of health] ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL, ESTABLISHED PURSUANT TO SECTION TWO HUNDRED FORTY-FOUR OF THIS TITLE 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] PANEL shall, AT EACH OF ITS REGULARLY SCHEDULED MEETINGS, 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] PANEL determines that the contract payment provisions do not protect the interest of the state, the [commissioner] EXECUTIVE DIRECTOR 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] SECTIONS two hundred forty-seven AND TWO HUNDRED FORTY-EIGHT 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 WHO IS ELIGIBLE TO PURCHASE PRESCRIBED COVERED DRUGS FOR AN AMOUNT SPECIFIED PURSUANT TO SUBDIVISION THREE OF SECTION TWO HUNDRED FORTY-SEVEN OR SUBDIVISION THREE OF SECTION TWO HUNDRED FORTY-EIGHT OF THIS TITLE. THE DATES OF THE ANNUAL COVERAGE PERIOD SHALL BE IMPRINTED ON THE CARD. WHEN AN ELIGIBLE PROGRAM PARTICIPANT MEETS THE ANNUAL LIMITS ON POINT OF SALE CO-PAYMENTS SET FORTH IN SUBDIVISION FOUR OF SECTION TWO HUNDRED FORTY-SEVEN OR SUBDIVISION FOUR OF SECTION TWO HUNDRED FORTY-EIGHT OF THIS TITLE, EITHER NEW IDENTIFICATION CARDS SHALL BE ISSUED TO SUCH PARTICIPANT INDICATING WAIVER OF SUCH CO-PAYMENT REQUIREMENTS FOR THE REMAINDER OF THE ANNUAL COVERAGE PERIOD OR THE CONTRACTOR SHALL DEVELOP AND IMPLEMENT AN ALTERNATIVE METHOD TO PERMIT THE PURCHASE OF COVERED DRUGS WITHOUT A CO-PAYMENT REQUIREMENT;

(d) DEVELOPING AND IMPLEMENTING THE SYSTEM FOR THOSE INDIVIDUALS ELECTING THE DEDUCTIBLE OPTION TO RECORD THEIR PERSONAL COVERED DRUG EXPENDITURES IN ACCORDANCE WITH SUBDIVISION THREE OF SECTION TWO HUNDRED

FORTY-EIGHT OF THIS TITLE. SUCH RECORDKEEPING SYSTEM SHALL BE PROVIDED TO EACH SUCH PARTICIPANT AT A NOMINAL CHARGE WHICH SHALL BE SUBJECT TO THE APPROVAL OF THE PANEL. THE CONTRACTOR SHALL ALSO REIMBURSE PARTICIPANTS FOR PERSONAL COVERED DRUG EXPENDITURES MADE IN EXCESS OF THEIR DEDUCTIBLE REQUIREMENTS, LESS THE CO-PAYMENTS REQUIRED BY SUBDIVISION FOUR OF SECTION TWO HUNDRED FORTY-EIGHT OF THIS TITLE, MADE PRIOR TO THEIR RECEIPT OF AN IDENTIFICATION CARD ISSUED IN ACCORDANCE WITH PARAGRAPH (C) OF THIS SUBDIVISION;

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

[(e)] (F) performing or causing to be performed utilization reviews for such purposes as may be required by the [commissioner of health] ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL;

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

[(g)] (H) 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] ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL and shall maintain files in a manner and format approved by the [commissioner] EXECUTIVE DIRECTOR.

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] ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL shall permit.

S 12. Section 244 of the elder law is REPEALED and a new section 244 is added to read as follows:

S 244. ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL. 1. THERE IS HEREBY ESTABLISHED WITHIN THE EXECUTIVE DEPARTMENT, A PANEL TO BE KNOWN AS THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL HEREINBEFORE OR HEREINAFTER REFERRED TO AS THE PANEL.

2. THE PANEL SHALL CONSIST OF THE COMMISSIONERS OF THE DEPARTMENTS OF EDUCATION AND HEALTH, THE SUPERINTENDENT OF FINANCIAL SERVICES, AND THE DIRECTORS OF THE OFFICE FOR THE AGING AND THE DIVISION OF BUDGET. EACH PANEL MEMBER MAY DESIGNATE AN OFFICER OF HIS OR HER RESPECTIVE DEPARTMENT, OFFICE, OR DIVISION TO REPRESENT AND EXERCISE ALL THE POWERS OF SUCH PANEL MEMBER AS THE CASE MAY BE AT ALL MEETINGS OF THE PANEL FROM WHICH SUCH PANEL MEMBER MAY BE ABSENT.

3. THE DIRECTOR OF THE OFFICE FOR THE AGING AND THE COMMISSIONER OF HEALTH SHALL SERVE AS CO-CHAIRS OF THE PANEL.

4. THE PANEL SHALL MEET AT SUCH TIMES AS MAY BE REQUESTED BY THE CO-CHAIRS, PROVIDED THAT THE PANEL SHALL MEET AT LEAST FOUR TIMES A YEAR.

5. THE PANEL SHALL:

(A) SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET, PROMULGATE PROGRAM REGULATIONS PURSUANT TO SECTION TWO HUNDRED FORTY-SIX OF THIS TITLE;

(B) DETERMINE THE ANNUAL SCHEDULE OF COST-SHARING RESPONSIBILITIES OF ELIGIBLE PROGRAM PARTICIPANTS PURSUANT TO SECTIONS TWO HUNDRED FORTY-SEVEN AND TWO HUNDRED FORTY-EIGHT OF THIS TITLE;

(C) ENTER INTO CONTRACTS PURSUANT TO SECTION TWO HUNDRED FORTY-THREE OF THIS TITLE;

(D) RECOMMEND AND IMPLEMENT ALTERNATIVE PROGRAM IMPROVEMENTS FOR THE EFFICIENT AND EFFECTIVE OPERATION OF THE PROGRAM IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE;

(E) ESTABLISH OR CONTRACT FOR A THERAPEUTIC DRUG MONITORING PROGRAM. SUCH PROGRAM SHALL MONITOR THERAPEUTIC DRUG USE OF ELIGIBLE PROGRAM PARTICIPANTS IN AN EFFORT TO PREVENT THE INCORRECT OR UNNECESSARY CONSUMPTION OF SUCH THERAPEUTIC DRUGS;

(F) DEVELOP AND IMPLEMENT, IN COOPERATION WITH AREA OFFICES FOR THE AGING, AN OUTREACH PROGRAM TO INFORM THE ELDERLY OF BENEFITS THEY MAY BE ENTITLED TO PURSUANT TO THIS TITLE, AND TO MAKE AVAILABLE INFORMATION CONCERNING THE PROGRAM FOR ELDERLY PHARMACEUTICAL INSURANCE COVERAGE AND BENEFITS TO WHICH THEY MAY BE ENTITLED THROUGH A PRESCRIPTION DRUG COVERAGE PROGRAM FUNDED BY THE FEDERAL GOVERNMENT;

(G) PREPARE AN ANNUAL REPORT AND SUBMIT SUCH REPORT TO THE GOVERNOR AND THE LEGISLATURE NO LATER THAN THE FIRST DAY OF JANUARY OF EACH YEAR. THE PANEL SHOULD INCLUDE IN THE REPORT A SUMMARY OF THE ADMINISTRATIVE COST CONTAINMENT INITIATIVES COMPLETED DURING THE YEAR. SUCH REPORT SHALL, AT A MINIMUM, CONTAIN ANNUAL STATISTICAL INFORMATION REGARDING THE NUMBER OF PERSONS ENROLLED IN THE PROGRAM BY MARITAL STATUS AND INCOME LEVEL, THE TOTAL AND PER CAPITA NUMBER OF PRESCRIPTIONS FILLED AND TOTAL STATE REIMBURSEMENT AND PARTICIPANT CO-PAYMENT EXPENDITURES, BY INCOME LEVELS, THE TOTAL NUMBERS OF PRESCRIPTIONS FILLED WITH GENERIC DRUGS, BRAND NAME DRUGS AND SOLE SOURCE DRUGS, THE AUTHORIZATION AND SUBSTITUTION RATE FOR THE TOTAL NUMBERS OF PRESCRIPTIONS FILLED WITH GENERIC, BRAND NAME AND SOLE SOURCE DRUGS, THE DISTRIBUTION OF THE TOP THREE HUNDRED MOST COMMONLY USED DRUGS BY VOLUME AND COST, A DISTRIBUTION OF ALL PRESCRIPTIONS BY VOLUME AND PRICE, THE ANNUAL PERCENTAGE INCREASE IN THE COST OF THESE DRUGS, NUMBERS OF PARTICIPATING PROVIDER PHARMACIES, RECIPIENTS AND PAYMENTS BY COUNTY, THE AMOUNT OF COST RECOVERIES FOR THE PERIOD COVERED IN THE REPORT, PROJECTIONS OF PROGRAM COSTS FOR THE FOLLOWING TWO YEARS, AND AN EVALUATION OF THE PERFORMANCE OF THE PROGRAM CONTRACTOR OR CONTRACTORS AND OF THE COST EFFECTIVENESS OF ALL OUTREACH EFFORTS;

(H) PREPARE AN EVALUATION REPORT ON THE EXPERIENCE OF THE PROGRAM FOR THE GOVERNOR AND THE LEGISLATURE NO LATER THAN NOVEMBER FIRST, NINETEEN HUNDRED NINETY-FIVE. SUCH REPORT SHOULD INCLUDE THE RECOMMENDATIONS OF THE PANEL CONCERNING THE CONTINUATION OF THE PROGRAM BEYOND ITS EXPIRATION;

(I) ESTABLISH POLICIES AND PROCEDURES TO ALLOW INDIVIDUALS WHO PARTICIPATE IN THE CATASTROPHIC DEDUCTIBLE PLAN ON DECEMBER THIRTY-FIRST, TWO THOUSAND TO CONTINUE TO RECEIVE BENEFITS UNDER THE PROVISIONS OF SECTION TWO HUNDRED FORTY-EIGHT OF THIS TITLE IN EFFECT ON DECEMBER THIRTY-FIRST, TWO THOUSAND, IF AND FOR AS LONG AS THE ENROLLEE SO CHOOSES;

(J) FACILITATE IMPLEMENTATION OF AN EXPANDED ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM ON JANUARY FIRST, TWO THOUSAND ONE, BY COMMENCING NO LATER THAN OCTOBER FIRST, TWO THOUSAND, OUTREACH ACTIVITIES, INCLUDING BUT NOT LIMITED TO THE DISSEMINATION OF INFORMATION TO LOCAL GOVERNMENTS AND SENIOR CITIZEN PROVIDER ADVOCACY GROUPS REGARDING SUCH EXPANDED PROGRAM. THE PANEL SHALL MAKE APPLICATIONS AVAILABLE FOR

THE EXPANDED ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM ON OCTOBER FIRST, TWO THOUSAND; AND

(K) ENTER INTO AN AGREEMENT WITH ONE OR MORE SPONSORS OF A DRUG DISCOUNT CARD PROGRAM OR A PRESCRIPTION DRUG PLAN AUTHORIZED UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, TO SERVE AS AN ENDORSED EPIC DRUG DISCOUNT CARD PROGRAM OR PRESCRIPTION DRUG PLAN FOR THE PURPOSES OF EFFECTIVE COORDINATION OF BENEFITS.

6. THE PANEL MEMBERS SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES AS PANEL MEMBERS.

7. THERE SHALL BE AN ADVISORY COMMITTEE TO THE PANEL COMPRISED OF TWELVE PERSONS. FOUR MEMBERS SHALL BE APPOINTED BY THE GOVERNOR, THREE MEMBERS SHALL BE APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE, ONE MEMBER SHALL BE APPOINTED BY THE MINORITY LEADER OF THE SENATE, THREE MEMBERS SHALL BE APPOINTED BY THE SPEAKER OF THE ASSEMBLY AND ONE MEMBER SHALL BE APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY. THE COMMITTEE MEMBERS SHALL BE REPRESENTATIVES OF CONSUMERS, PHARMACISTS, PHARMACEUTICAL DRUG MANUFACTURERS AND PHARMACEUTICAL WHOLESALERS. NO LESS THAN FIFTY PERCENT OF THE COMMITTEE MEMBERSHIP SHALL REPRESENT THE CONSUMERS. THE EXECUTIVE DIRECTOR SHALL CONSULT THE ADVISORY COMMITTEE AND CONSIDER ITS RECOMMENDATIONS CONCERNING THE IMPLEMENTATION OF THIS PROGRAM AND THE POLICIES GOVERNING THE CONTINUED OPERATION OF THIS PROGRAM. COMMITTEE MEMBERS SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES BUT SHALL BE ALLOWED THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES.

S 13. The section heading of section 247 of the elder law, as amended by section 3-i of part A of chapter 59 of the laws of 2011, is amended to read as follows:

Cost-sharing responsibilities of eligible program participants FOR COMPREHENSIVE COVERAGE.

S 14. Subdivision 1 of section 247 of the elder law is REPEALED and a new subdivision 1 is added to read as follows:

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.

S 15. Subdivision 2 of section 247 of the elder law, as renumbered by section 3-k of part A of chapter 59 of the laws of 2011, is renumbered subdivision 3 and two new subdivisions 2 and 4 are added to read as follows:

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 REGISTRATION FEE 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.

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 $720
INDIVIDUAL INCOME OF $11,001 TO $12,000	NO MORE THAN $827
INDIVIDUAL INCOME OF $12,001 TO $13,000	NO MORE THAN $896
INDIVIDUAL INCOME OF $13,001 TO $14,000	NO MORE THAN $964
INDIVIDUAL INCOME OF $14,001 TO $15,000	NO MORE THAN $1,016
INDIVIDUAL INCOME OF $15,001 TO $16,000	NO MORE THAN $1,034
INDIVIDUAL INCOME OF $16,001 TO $17,000	NO MORE THAN $1,052
INDIVIDUAL INCOME OF $17,001 TO $18,000	NO MORE THAN $1,070
INDIVIDUAL INCOME OF $18,001 TO $19,000	NO MORE THAN $1,088
INDIVIDUAL INCOME OF $19,001 TO $20,000	NO MORE THAN $1,160

(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 $641
JOINT INCOME OF $12,001 TO $13,000	NO MORE THAN $660
JOINT INCOME OF $13,001 TO $14,000	NO MORE THAN $684
JOINT INCOME OF $14,001 TO $15,000	NO MORE THAN $710
JOINT INCOME OF $15,001 TO $16,000	NO MORE THAN $826
JOINT INCOME OF $16,001 TO $17,000	NO MORE THAN $877
JOINT INCOME OF $17,001 TO $18,000	NO MORE THAN $928
JOINT INCOME OF $18,001 TO $19,000	NO MORE THAN $980
JOINT INCOME OF $19,001 TO $20,000	NO MORE THAN $990
JOINT INCOME OF $20,001 TO $21,000	NO MORE THAN $1,008
JOINT INCOME OF $21,001 TO $22,000	NO MORE THAN $1,026
JOINT INCOME OF $22,001 TO $23,000	NO MORE THAN $1,044

JOINT INCOME OF $23,001 TO $24,000 NO MORE THAN $1,062
JOINT INCOME OF $24,001 TO $25,000 NO MORE THAN $1,080
JOINT INCOME OF $25,001 TO $26,000 NO MORE THAN $1,150

(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.

S 16. Paragraph (a) of subdivision 3 of section 247 of the elder law, as amended by section 3-k of part A of chapter 59 of the laws of 2011, such subdivision as renumbered by section fifteen of this act, is amended to read as follows:

(a) [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 [that is described in paragraph (c) of subdivision three of section two hundred forty-two of this title]. 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.

S 17. The elder law is amended by adding a new section 248 to read as follows:

S 248. 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

(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	$1,575

JOINT INCOME OF $46,001 TO $47,000	$1,610
JOINT INCOME OF $47,001 TO $48,000	$1,645
JOINT INCOME OF $48,001 TO $49,000	$1,680
JOINT INCOME OF $49,001 TO $50,000	$1,715

(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 $50,000	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 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-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.

S 18. Section 250 of the elder law, as amended by section 3-m of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 250. Reimbursement to participating provider pharmacies. 1. The amount of reimbursement which shall be paid by the state to a participating provider pharmacy [filling or refilling a prescription for a drug that is described in paragraph (c) of subdivision three of section two hundred forty-two of this title] 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 [section] 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] PANEL 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 HUNDRED NINETY-ONE, SHALL BE DEEMED TO HAVE BEEN ENTERED INTO ON APRIL FIRST, NINETEEN HUNDRED NINETY-ONE; AND PROVIDED FURTHER, THAT IF A MANUFACTURER HAS NOT ENTERED INTO AN AGREEMENT WITH THE DEPARTMENT BEFORE AUGUST FIRST, NINETEEN HUNDRED NINETY-ONE, SUCH AGREEMENT SHALL NOT BE EFFECTIVE UNTIL APRIL FIRST, NINETEEN HUNDRED NINETY-TWO, UNLESS SUCH AGREEMENT PROVIDES THAT REBATES WILL BE RETROACTIVELY CALCULATED AS IF THE AGREEMENT HAD BEEN IN EFFECT ON APRIL FIRST, NINETEEN HUNDRED 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 ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PANEL 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; AND WHICH ARE RECOMMENDED FOR REIMBURSEMENT BY THE PANEL AND APPROVED BY THE COMMISSIONER OF HEALTH.

(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.

[4.] 5. Notwithstanding any other provision of law, the [commissioner of health] PANEL 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] PANEL 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.

[5.] 6. (A) 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). FOR SUCH INDIVIDUALS, NO REIMBURSEMENT SHALL BE AVAILABLE UNDER EPIC FOR COVERED DRUG EXPENSES EXCEPT:

(I) WHERE A PRESCRIPTION DRUG PLAN AUTHORIZED BY PART D OF THE FEDERAL SOCIAL SECURITY ACT (REFERRED TO IN THIS SUBDIVISION AS A MEDICARE PART D PLAN) HAS APPROVED COVERAGE AND EPIC HAS AN OBLIGATION UNDER THIS TITLE TO PAY A PORTION OF THE PARTICIPANT'S COST-SHARING RESPONSIBILITY UNDER MEDICARE PART D; OR

(II) WHERE THE PROVIDER PHARMACY HAS CERTIFIED THAT A MEDICARE PART D PLAN HAS DENIED COVERAGE.

(B) IF THE PROVIDER PHARMACY CERTIFIES AS SET FORTH IN SUBPARAGRAPH (II) OF PARAGRAPH (A) OF THIS SUBDIVISION, THE EPIC PROGRAM SHALL PAY FOR THE DRUG AS THE PRIMARY PAYOR UPON A SHOWING OF COMPLIANCE WITH THE NOTIFICATION AND APPEAL PROVISIONS OF SUBPARAGRAPH TWO OF PARAGRAPH (C) OF SUBDIVISION THREE OF SECTION TWO HUNDRED FORTY-TWO OF THIS TITLE.

S 19. Section 254 of the elder law, as amended by section 3-n of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 254. Cost of living adjustment. 1. Within amounts appropriated, the [commissioner of health] PANEL shall adjust the program eligibility standards set forth in subdivision [one] TWO of section two hundred forty-two of this title to account for increases in the cost of living.

2. THE PANEL 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.

S 20. This act shall take effect April 1, 2012; provided, however, that if this act shall not have become a law on or before April 1, 2012, this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2012.