

June 5, 1987

SUBJECT: INSURANCE

WITHDRAWN

Circular Letter No. 9 (1987)

TO: ALL FRATERNAL BENEFIT SOCIETIES AND INSURERS LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE IN NEW YORK STATE, INCLUDING ARTICLE 43 CORPORATIONS, AND CORPORATIONS WITH CERTIFICATES OF AUTHORITY UNDER

ARTICLE 44 OF THE PUBLIC HEALTH LAW

RE: NEW YORK STATE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM (EPIC)  
(CHAPTER 913 OF THE LAWS OF 1986)

As you may know, New York State has developed a program to subsidize the prescription drug purchases of needy elderly New York State residents who do not already have adequate prescription drug coverage. The program is called the New York State Elderly Pharmaceutical Insurance Coverage Program (EPIC). Under the EPIC legislation, an applicant is not eligible for benefits if he/she is receiving equivalent or better drug coverage from any other public or private third party payment source or insurance plan than those benefits provided for under EPIC.

This letter is a request for your assistance in facilitating the determination of this aspect of program eligibility. Please complete the enclosed survey for your in-force individual and group health insurance plans delivered in New York State which provide coverage for prescription drugs as well as for those self-insured programs you administer which pay for drugs. The information elicited by the survey is intended to assist the EPIC staff in determining the level of drug coverage identified by an applicant on an application for EPIC coverage. Policies or programs providing coverage for drugs furnished only when hospital confined, when surgery is performed on an outpatient basis and/or for emergency medical services need not be reported.

The survey includes naming of a company representative who may be contacted by EPIC staff in those instances where additional information regarding the level of drug coverage is needed to determine eligibility for EPIC. If you have no coverage for prescription drugs currently in force and do not administer a program which pays for drugs, please so indicate on the survey and return it with the name of the carrier and the name, address and telephone number of the person completing the survey.

We appreciate your cooperation and request that you respond as soon as possible. Please call Kevin B. WeMett of EPIC at (518)474-8841 if you have any questions.

Please address your response to:

EPIC Program

c/o Mr. Kevin B. WeMett

Empire State Plaza - Corning Tower - Rm. 2001

Albany, New York 12237

Very truly yours

[SIGNATURE]

JAMES P. CORCORAN

Superintendent of Insurance

INSURED PROGRAMS

NAME OF CARRIER

NEW YORK STATE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM COMPARATIVE STUDY

EPIC Coverage

Range of Options

Written by Carrier

Components

Comparative Components

I. Co-Payment Responsibility:

I. Co-payment Responsibility:\*

Insured will be responsible for co-pay ranging between \$ 3 to \$ 15 depending upon the cost of the prescription. (Co-pay averages 40% of medication cost.)

II. Annual Co-Pay Maximum:

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Insured annual responsibility for co-pay will not exceed between \$ 300 and \$ 1,088 depending upon income level.

\*Please provide the range of co-payments, deductibles and annual coverage limitations by type of coverage (i.e. major medical, programs providing coverage only for prescription drugs, etc.) written by the company in New York. Also, for

each type of coverage identified, please provide the name of the group policyholder or any distinct policy form number or plan name of those programs at the lowest end of the range of coverage. For example, a company which writes both major medical insurance and prescription drug programs should, for the first item relating to Co-payment Responsibility, separately identify the range of ea-payments. (e.g. from 0% to 25%) applicable to the prescription drug coverage component of its in-force major medical programs as well as the range of co-payments (e.g. from no co-pay to an \$ 8 co-pay per prescription) for its in-force drug programs. The name of the group policyholder or separate identifying policy form number or plan name of the major medical program(s) with a 25%. co-pay and of the prescription drug program(s) with an \$ 8 co-pay should also be identified under I. above.

III. Annual Deductible:

III. Annual Deductible:\*

Insured is responsible for satisfaction of an annual deductible ranging from \$ 415 to \$ 638 depending upon income level. (Note this is an option in lieu of premium under the catastrophic coverage plan.)

IV. Annual Coverage Limitation:

IV. Annual Coverage Limitation:\*

There is no annual limitation on the amount of coverage provided to an insured.

Name of Company Contact Person:

Address:

Telephone No.:

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