Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for Medicare-primary members of the Missouri Consolidated Health Care Plan.

PURPOSE: This amendment clarifies eligibility for the Pharmacy Employer Group Waiver Plan, the Part B drug benefit, and preventive drugs; updates the Medicare Part D coverage stage and the copayment amounts; and removes language regarding the Medicare Prescription Drug Only Plan.

(1) The pharmacy benefit for Medicare **non-active** primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) *[The following Medicare primary members]* **Non-active subscribers that have Medicare primary coverage** and their dependents that have Medicare primary coverage enrolled in *[the PPO 300, PPO 600, or]* the Medicare *[Prescription Drug Only]* **Advantage** Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan*[:]***.**

[1. Active employee members that have Medicare primary coverage and their dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their dependents that have Medicare primary coverage.]

(B) The non-Medicare *[primary]* dependents of Medicare primary **non-active *[****members]* subscribers** will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(C) Foster parent members that have Medicare primary coverage and their dependents that have Medicare primary coverage will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(D) A retiree Medicare primary member who chooses not to be in the Medicare Prescription Drug Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical or Medicare Prescription Drug Plan at a later date.

(E) MCHCP will pay the Medicare financial penalty incurred by a Medicare primary member who has had a continuous gap in prescription drug coverage of sixty-three (63) days or more after the Medicare Initial Election Period (IEP) and was not covered by any creditable prescription drug coverage and failed to enroll into Part D.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand seven hundred fifty dollars ($3,750)]* **three thousand eight hundred twenty dollars ($3,820)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has *[an eight dollar ($8)]* **a ten dollar ($10)** copayment; sixty- (60-) day supply has a *[sixteen dollar ($16)]* **twenty dollar ($20)** copayment; ninety- (90-) day supply at retail has a *[twenty-four dollar ($24)]* **thirty dollar ($30) copayment**; and a ninety- (90-) day supply through home delivery has a *[twenty dollar ($20)]* **twenty-five dollar ($25)** copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a *[thirty-five dollar ($35)]***forty dollar ($40)** copayment; sixty- (60-) day supply has *[a seventy dollar ($70)]***an eighty ($80) dollar** copayment; ninety- (90-) day supply at retail has *a [one hundred five dollar ($105)]***one hundred twenty ($120) dollar** copayment; and a ninety- (90-) day supply through home delivery has *[an eighty-seven dollar and fifty cent ($87.50)]***one hundred ($100) dollar** copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand seven hundred fifty dollars ($3,750)]* **three thousand eight hundred twenty dollars ($3,820**) and remain below *[five thousand dollars ($5,000)]***five thousand one hundred dollars ($5,100)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars ($5,000)]***five thousand one hundred dollars ($5,100)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars ($5,000)]***five thousand one hundred dollars ($5,100)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and thirty-five cent ($3.35)]***three dollar and forty cent ($3.40)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and thirty-five cent ($8.35)]* **eight dollar and fifty cent ($8.50)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

[6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.]

(G) Medications covered under 22 CSR 10-2.090 will be covered under the Medicare Prescription Drug Plan as non-Part D medications when they are not a Part D covered drug.

(H) Medicare Part B Prescription Drugs **are excluded from the Medicare Presciption Drug Plan**. *[For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:*

1. Diabetes testing and maintenance supplies;

2. Respiratory agents;

3. Immunosuppressants; and

4. Oral anti-cancer medications.]

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

*3.]***2.** *[Influenza vaccine]***Vaccines** and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

*[4.]***3.** Preferred formulary brand contraception and non-preferred contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expired June 29, 2017. Amended: Filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 27, 2017, effective Jan. 1, 2018, expired June 29, 2018. Amended: Filed Oct. 27, 2017, effective May 30, 2018. Emergency amendment filed Oct. 30, 2018, effective Jan. 1, 2019, expires June 29, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

**Original authority: 103.059, RSMo 1992.*