Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. 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 Pharmacy Benefit Summary for the [PPO 600 Plan, PPO 1000 Plan] **PPO 750, PPO 1250,** *Health Savings Account (HSA) Plan of the Missouri Consolidated Health Care Plan.*

PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO *[600]* **750 Plan** and PPO *[1000]***1250** Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: *[Eight dollars ($8)]***Ten Dollars ($10** for up to a thirty-one- (31-) day supply; *[sixteen dollars ($16)]* **twenty dollars ($20**for up to a sixty- (60-) day supply; and *[twenty-four dollars ($24)]***thirty dollars ($30)** for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: *[Thirty-five dollars ($35)]***Forty dollars ($40)** for up to a thirty-one- (31-) day supply; *[seventy dollars ($70)]* **eighty dollars ($80)** for up to a sixty- (60-) day supply; and *[one hundred and five dollars ($105)]***one hundred twenty dollars ($120)** for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

*[D.]***E.** Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

[E.] **F.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars ($8)]***Ten dollars ($10)** for up to a thirty-one- (31-) day supply; *[sixteen dollars ($16)]***twenty dollars ($20)** for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars ($35)]* **Forty dollars ($40)** for up to a thirty-one- (31-) day supply; *[seventy dollars ($70)]***eighty dollars ($80)** for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents ($87.50)]***one hundred dollars ($100)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

*[F.]***G.** Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

*[G.]***H.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[H.]***I.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

*[I.]***J.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

*[J.]***K.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply;

*[K.]***M.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration 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:

[(I) 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;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

*[(III)]***(I)** *[Influenza]* vaccine *[and administration as]* recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

*[(IV)]***(II)** Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

*[(V)]***(III)** Prescribed preferred diabetic test strips and lancets; and

*[(VI)]***(IV)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

[C. PPO 600 Individual—five thousand one hundred dollars ($5,100).

D. PPO 600 Family—ten thousand two hundred dollars ($10,200).

E. PPO 1000 Individual—two thousand one hundred dollars ($2,100).

F. PPO 1000 Family—four thousand two hundred dollars ($4,200).]

A. Network individual—four thousand one hundred fifty dollars ($4,150).

B. Network family—eight thousand three hundred dollars ($8,300).

C. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met.

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration 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:

[(I) Prescribed Vitamin D for all ages.

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

*(III)]***(I)** *[Influenza vaccine]* **Vaccines** and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

*[(IV)]***(II)** Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. The member is responsible for paying the full price for the prescription drug unless the member's provider prescribes a first-step drug. If the member's provider decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the provider may request a preauthorization from the PBM. If the preauthorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested preauthorization is not approved, then the member is responsible for the full price of the drug.

(3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form and follow its instructions;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions except diabetic supplies; and

(C) A member must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the PBM, less any applicable copayment, deductible, or coinsurance. A member is responsible for any charge over the network discounted price and the applicable copayment.

(4) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug;

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit unless otherwise specified; or

(C) A drug is determined to have a safety issue by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer covered under the pharmacy benefit.

(5) Medicare Part B Prescription Drugs—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 an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.

(6) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: 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.*