DECEMBER 15, 1999

To: Company Presidents
All Health Maintenance Organizations, Limited Health Service Organizations and Voluntary Health Service Plans

From: Nathaniel S. Shapo, Director

Re: CB #99-7: Section 72 of the Managed Care Reform and Patient Rights Act - Pharmacy Providers - PA 91-617 effective January 1, 2000.

Reply to: David Grant (217) 782-6369

This Company Bulletin has been developed in order to establish more precise industry guidelines for the administration of pharmacy provider contracting and benefit requirements. Section 72 applies to all policies and contracts amended, delivered, issued or renewed on or after January 1, 2000. Terms and conditions of policies and contracts amended, delivered, issued or renewed on or before December 31, 1999 (Effective Contracts) remain in effect until they are amended or expire.

Section 72 has three separate subsections, all of which must be implemented. Subsection (a) deals with pharmacy contracting. Subsection (b) impacts employer or individual contracting and concerns consistency in enrollee cost sharing. Subsection (c) concerns consistency in terms of quantity limits available to enrollees.

Subsection (a)
To satisfy the contracting requirements of subsection (a) on or after January 1, 2000, the health care plan must establish and offer pharmacy benefit terms and conditions (Standard Offer) to all pharmacy providers desiring to do business in its service area. A health care plan must do this even if it has an Effective Contract in place as of midnight on December 31, 1999 (unless the Effective Contract has terms which are exclusive in nature, in which case the health care plan must establish a Standard Offer without exclusive terms when the Effective Contract terminates). In this case, the terms and conditions of the Standard Offer need not conform to the terms and conditions of the Effective Contracts.

A health care plan must have a Standard Offer available to any willing pharmacy provider at all times. A health care plan must make a specific Standard Offer continuously available to any willing pharmacy provider, upon request, until the plan establishes a new Standard Offer.

Standard Offers may, but need not, contain subparts and may, but need not, allow willing providers to accept less than all the subparts. By way of illustration (but not limitation), a Standard Offer may specify in subparts delimiting terms for the:

- duration which a dispense is to cover, e.g. 30 days, 90 days

- list of drugs to be provided by the provider

- total price the provider will be paid (by the plan and by the enrollee through co-pays)

- reasonable geographic area the provider must serve

- records the provider must keep and

- reasonable time frame within which a provider must fill a prescription

- manner of delivery, e.g. at the counter, by personal delivery, by mail, etc.

Pharmacies may accept or refuse the Standard Offer. If sufficient pharmacies accept the Standard offer to form an adequate network the process goes no further. If no pharmacies accept the Standard Offer then a new Standard Offer must be issued.

If the health care plan determines that insufficient pharmacies have accepted the Standard Offer so that there is an inadequate network, then the health care plan may offer other terms and conditions necessary to comply with network adequacy requirements (Supplemental Offer). The terms of the Supplemental Offer contracts would have no impact on the Standard Offer contracts which would remain in effect with no changes. Terms and conditions of a Supplemental Offer may vary from those of the Standard Offer. A health care plan may make a Supplemental Offer to any provider willing to accept it. A health care plan may not enter a contract (either Standard Offer or Supplemental Offer) with any provider that contains a term guaranteeing the pharmacy exclusive rights to any pharmacy business, such as all mail order business.

Subsection (b)
Subsection (b) requires that an enrollee's cost sharing be the same regardless of which participating pharmacy provider fills the drug prescription. Co-insurance, copayments and deductibles cannot vary based on the type of participating pharmacy the enrollee decides to patronize. Health care plans may offer a variety of policies or products to their group or individual purchasers which contain a choice of pharmacy features including tier arrangements and cost sharing arrangements. The group or individual purchasers can select the product with the preferred cost sharing features. Once the selection is made the feature applies to all pharmacies in the network.

Subsection (c)
Subsection (c) provides that an enrollee must be able to obtain a specific quantity of drugs allowed to be prescribed by any pharmacy provider at one time at the same terms from every participating pharmacy provider that offers that quantity of drugs. For example, if a ninety day supply for home delivery is available from one participating provider at a certain copayment, it must be available from all participating providers (whether they are retail operations, mail order operations or Internet operations), offering a ninety day supply for home delivery, at the same copayment. Each pharmacy that participates in the network may contract to dispense any or all of the available quantity limits.

Regardless of the terms health care plans negotiate with pharmacies under subsection (a), subsections (b) and (c) must be applied uniformly to all contracted pharmacy providers.