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

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment corrects the omission of the maximum amount Health Savings Account members will pay for non-preferred formulary drugs and approved excluded drugs.

(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 to non-Medicare primary members.

(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 10-2.053.

1. Network:

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one- (31-) day supply after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance **up to two hundred dollars ($200)** after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Ninety- (90-) day supply of prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program or at select retail pharmacies, as designated by the PBM;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

(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 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;

G. 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;

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy;

I. The following are covered at one hundred percent (100%) when filled at a network pharmacy:

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

(II) One (1) preferred glucometer;

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

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. Emergency rescission filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Rescinded: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Readopted: 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. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Amended: Filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 29, 2021, effective Jan. 1, 2022, expired June 29, 2022. Amended: Filed Oct. 29, 2021, effective May 30, 2022. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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.*