FEHB Program Carrier Letter

All Experience-Rated Carriers

U.S. Office of Personnel Management
Insurance Services Programs

Letter No. 2004-09C **Date:** 9/8/04

Fee-for-service [ ] Experience-rated HMO [8] Community-rated HMO [ ]

SUBJECT: Changes to the Standard Contract

2005 Contract Year. Please review the enclosed Standard Contract changes for Federal Employees Health Benefits Program experience-rated carriers for Contract Year 2005. If you have comments, please provide them by August 27, 2004.

Send any comments to Tanya Woodyard at OPM, with a copy to your OPM contract representative. You may email comments to Tanya.woodyard@opm.gov or send them by fax to (202) 606-0633.

We look forward to working with you on your contract.

Sincerely,

Frank D. Titus
Assistant Director
For Insurance Services Programs

Attachment

Changes to Standard 2005 Experience-Rated Health Benefits Contract

New Section 1.25 -STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM) ARRANGEMENTS (JAN 2005)

(a) Transparency Standards - The Carrier will ensure that it includes standards in its new or renewing contracts or contract amendments for PBM services consistent with the following requirements:

(1) The PBM is not majority owned or majority controlled by a pharmaceutical manufacturing company.

(2) The PBM agrees to pass along any negotiated net cost savings including payments received from pharmaceutical manufacturers to the group health plan or the insurance issuer. Payments will mean compensation or remuneration including but not limited to, discounts; credits; rebates, regardless of how categorized; market share incentives, commissions, mail service purchase discounts, and administrative or management fees. It also includes any fees received for sales of utilization data to a pharmaceutical manufacturer, and fees received from a pharmaceutical manufacturer for formulary placement and/or access.

(3) The PBM agrees to provide, at least annually, the group health plan or the health insurance issuer with all financial and utilization information requested by the plan or issuer relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to the plan or issuer. A PBM providing information under this paragraph may designate that information as confidential and/or proprietary. The PBM, by contracting with the group health plan or the health insurance issuer offering benefits under the FEHB Program, consents to the disclosure of this information to OPM. Otherwise, information designated as confidential and/or proprietary by a PBM and provided to a plan or issuer under this paragraph may not be disclosed to any person without the consent of the PBM.

(4) The PBM agrees to provide, at least annually, the group health plan or the health insurance issuer with all sources and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including formulary management and drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees.

(5) The PBM agrees to provide, at least annually, the group health plan or the health insurance issuer with the percent of manufacturer's payments received by the PBM that are passed back to the group health plan or the health insurance issuer on a drug-by-drug basis.

(6) The group health plan or the health insurance issuer agrees to provide any information it receives from the PBM, including a copy of its contract with the PBM, to OPM upon OPM's request, and will provide the information obtained from the PBM under standards (3) through (5) above at least annually.

(b) Integrity Standard. The Carrier will ensure that its PBM contractors agree to adopt and adhere to the Code of Ethics of the American Pharmacists Association.

(c) Performance Standards. The Carrier will ensure that its PBM contractors develop and apply a quality assurance program specifying procedures for assuring contract

quality. At a minimum, the PBM will meet the following standards and submit reports to the carrier on their performance.

(1) Retail Pharmacy

(i) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to network pharmacies.

REQUIRED STANDARD: less than two seconds

(ii) POS system availability – The PBM's network electronic transaction system is available and accessible.

REQUIRED STANDARD: 99 percent availability 24 hours a day, 7 days a week

(iii) Prescription accuracy – The percentage of total prescriptions that are accurately dispensed for the correct patient, correct drug, drug strength and dosage.

REQUIRED STANDARD: 99.9 percent accuracy rate or better

(iv) Paper claims processing timeliness

REQUIRED STANDARD: 90 percent processed within 6 working days.

(v) Paper claims processing accuracy – The percentage of paper claims processed accurately.

REQUIRED STANDARD: 98 percent accuracy rate or better

(2) Mail Service Pharmacy

(i) Dispensing accuracy – The percentage of total prescriptions that are accurately dispensed for the correct patient, correct drug, drug strength and dosage.

REQUIRED STANDARD: 99.9 percent or better

(ii) Turnaround time – The timeframe within which the PBM dispenses and ships all prescriptions.

REQUIRED STANDARD: 98 percent within 3 working days

(3) Customer Service

(i) Written member inquiries – The number of working days taken to respond to an FEHB Program member's written inquiry.

REQUIRED STANDARD: 90 percent within 3 working days, 100 percent within 7 working days

(ii) First call resolution rate – The percentage of calls resolved during the initial contact.

REQUIRED STANDARD: 90 percent

(iii) Average answer speed – The average number of seconds elapsing before the PBM connects a member's telephone call to its service representative.

REQUIRED STANDARD: 30 seconds or less

(iv) Telephone abandonment rate – The percentage of calls attempted but not completed (presumably because callers tired of waiting to be connected to a PBM representative).

REQUIRED STANDARD: less than 5 percent

(v) Telephone blockage rate – The percentage of time that callers receive a busy signal when calling the PBM.

REQUIRED STANDARD: less than 2 percent

(4) Prior Approval – if applicable

(i) Average approval time – The timeframe within which the PBM will review and respond to requests for prior approval for specific drugs.

REQUIRED STANDARD: 90 percent within 3 working days, 100 percent within 7 working days

(d) Alternative Drug Options. The Carrier will ensure that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug switches other than generic substitutions.

(1) The patient has the final say whether or not his or her drug is switched.

(2) The PBM will memorialize in full detail, including contact person's first and last name at physician's office, all conversations with patients and physicians in connection with drug-switching.

(3) The PBM may only obtain authorizations for a drug switch from the patient's physician, physician assistant, or RN.

(4) The PBM will not switch a patient's drug from a lower priced drug to a higher priced drug to patient or plan.

(5) The PBM will not switch a patient's drug from a multi-source drug to a single source drug.

(6) The PBM will not switch a patient's drug once a patient requests that his or her drugs not be switched.

(7) The PBM will give patients price information on brand to generic switches, when requested.

(8) The PBM will provide physicians, patients, and plans with the cost difference between switch-to drugs and switch-from drugs.

(9) The PBM will permit pharmacists to express their professional judgment: on impact of switches; and to physicians asking about dosing. Pharmacists do not have to initiate calls to physicians for interventions that in their professional judgment should not be done.

(10) The PBM will not limit the Carrier's ability to select intervention pairs.

(11) The PBM will provide full disclosure to physicians, plans, and patients why it is suggesting a drug switch, and disclose how much the PBM, the plan, and the patients each will financially benefit from it.

Section 2.13 – BENEFIT PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 1998). **This section was incorporated back into the contract. It was inadvertently taken out of the 2003 contract.**

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers. This provision does not apply to debarred providers (see Section 2.7).

<u>Section 3.2(b)(2)(v)</u> – Amended section (FAR 52.202-1) (July 2004)

<u>FAR Definitions.</u>

a) When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as he definition in FAR 2.101 in effect at the time the solicitation was issued, unless—
   (1) The solicitation, or amended solicitation, provides a different definition;
   (2) The contracting parties agree to a different definition;
   (3) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning; or
   (4) The word or term is defined in FAR Part 31, for use in the cost principles and procedures.

b) The FAR Index is a guide to words and terms the FAR defines and shows where each definition is located. The FAR Index is available via the Internet at http://www.acqnet.gov at the end of the FAR, after the FAR Appendix.