NASTAD

FEDERAL PRESCRIPTION DRUG ACCESS PROTECTIONS:

Third-Party Payment Regulation and Mail Order Opt Out

The following fact sheet details the federal protections for prescription drug access related to private insurance acceptance of third-party payments and the ability to opt out of mail-order pharmacy requirements. For questions, please contact Amy Killelea.

Third-Party Payment Regulation

Federal regulation 45 CFR §156.1250 requires issuers offering individual market Qualified Health Plans (QHPs) to accept third-party payments from certain entities, including payments made by ADAP, other Ryan White HIV/AIDS Program grantees and sub-grantees, and state and local health departments providing insurance assistance for pre-exposure prophylaxis (PrEP).

The rule applies to premium payments made directly to the issuer as well as cost-sharing payments to "downstream entities" contracted by the issuer, including providers and pharmacies that regularly collect co-payments/co-insurance. This means that pharmacies contracted with issuers covered by the rule – including specialty, mail-order, and brick-and-mortar pharmacies – must accept co-payment/co-insurance payments from the entities described above. Administrative difficulty with invoicing third-party payers at the point-of-sale is not an acceptable reason for non-compliance with this federal regulation. If you think that a plan is violating this rule, you should contact your state department of insurance.

The Regulation: 45 CFR §156.1250

Requires QHPs (and their contracted providers and pharmacies) to accept premium and cost-sharing payments made on behalf of beneficiaries from:

- Ryan White HIV/AIDS Program grantees
- An Indian tribe, tribal organization, or urban Indian organization; and
- Federal, state and local government programs and their grantees (would include PrEP programs being run out of state or local health departments)

Mail Order Opt Out

For plans offered on or after January 1, 2017, federal regulation 45 CFR § 156.122(e) requires any health plan subject to Affordable Care Act (ACA) Essential Health Benefits (EHB) requirements – including individual and small group plans – to allow enrollees to access prescription drug benefits at in-network, brick-and-mortar, retail pharmacies.

The only exceptions to this opt-out requirement are: 1) if the drug is subject to restricted distribution by the U.S. Food and Drug Administration or 2) if there are specific safety or special handling requirements that would preclude use of a retail pharmacy. While a plan may charge different cost sharing for mail order and retail pharmacies, if a consumer opts out of a mandatory mail-order requirement, any cost sharing associated with prescription drugs received at the brick-and-mortar retail pharmacy must count toward the plan's annual out-of-pocket maximum.

The Regulation: 45 CFR § 156.122(e)

Requires any plan subject to the ACA's EHB requirements to:

- Allow enrollees to pick up prescription drugs at in-network brick-and-mortar retail pharmacies, except in limited circumstances

To request the opt out, consumers should call the pharmacy benefits number on the back of their insurance card and request the option to pick up medications at an in-network, retail pharmacy instead of through mail order. If you think that a plan is violating this rule, you should contact your state department of insurance.