House
Legislative
Analysis
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UNIFORM PRESCRIPTION DRUG INFORMATION CARD OR TECHNOLOGY

House Bill 4607 as enrolled
Public Act 708 of 2002
Sponsor: Rep. Andrew Raczkowski

House Committee: Insurance and Financial Services
Senate Committee: Financial Services

Second Analysis (1-3-03)

THE APPARENT PROBLEM:

Health benefit plans currently issue to their members or enrollees prescription cards or membership cards that contain information on medical coverage as well as prescription coverage. The cards differ in the type and amount of information supplied, but generally contain the member or enrollee's name, and plan or member identification number. Some list the names of all individuals covered under the plan along with any other information the health plan deems necessary.

According to pharmacists, because the prescription cards differ in the types of information provided, the time to process some prescriptions can be quite lengthy. Almost all prescription claims are submitted electronically by the pharmacists. In fact, pharmacists submit the claims at the time the prescription is turned in to be filled. This enables the pharmacist to know if the drug prescribed is on a plan's formulary (meaning that the drug will be covered by the plan), if the plan requires the prescription to be filled with a generic drug if available, and the amount of the copay.

Reportedly, about 20 percent of the electronic transmissions (or one in five prescriptions) cannot be processed because of incorrect or missing information on the benefit card, or because the pharmacist cannot tell from the card what information needs to be transmitted. Pharmacists maintain that a significant amount of work is created in order to track down the missing information and complete the transaction. This results in delays and often long lines at the pharmacy window. Though such cases seem to represent a fraction of the number of prescriptions filled by pharmacists on a daily basis, pharmacists claim that these cases take up about 68 percent of their time. This is time, they emphasize, that could be spent with clients explaining drug interactions and answering questions regarding medications. Many in the industry assert that requiring health plans to issue uniform pharmacy benefit cards, with information necessary for efficient claims processing on each card, would resolve many of the current problems and delays.

THE CONTENT OF THE BILL:

The bill would amend the Insurance Code to require the commissioner of the Office of Financial and Insurance Services (OFIS), by July 1, 2003, to develop a uniform prescription drug information card and uniform prescription drug information technology. The card and technology would have to be based on the standards and format approved by the National Council for Prescription Drug Programs pharmacy ID card implementation guide. A health benefit plan that provided coverage for prescription drugs or devices and that issued, used, or required a card or other technology for prescription claims submission and adjudication would have to issue for the plan's insureds, enrollees, members, or participants a uniform prescription drug information card or other technology as provided under the bill.

The card or other technology would have to include all of the National Council for Prescription Drug Programs standard information required by the health plan for submission and adjudication of claims for prescription drug or service benefits, or at a minimum contain all of the following labeled information:

• The card issuer name or logo and the cardholder's name and identification number on the front of the card.

• Complete information for electronic transaction claims routing. This would include the international ID number labeled as RXBIN and, if needed for proper routing of electronic claims submissions, the processor control number labeled as RXPCN and the group number labeled as RXGRP.

• The name and address of the benefits administrator or entity responsible for prescription claims submission, adjudication, or pharmacy provider correspondence for prescription benefits claims.

• A help desk telephone number that pharmacy providers could call for assistance.

The information would have to be included in a clear, readable, and understandable manner. Content and formatting of all information would have to be in the current content and format required by the health plan for electronic claims routing, submission, and adjudication.

The card or technology would be issued by a health plan upon enrollment and reissued upon any change in coverage that affected data on the card or technology. However, a card or other technology would not have to be issued more than once each calendar year. If stickers or other similar mechanisms were used to update the information and sent to the plan's enrollees, etc., a health plan would not have to reissue a card or technology more often than once in three years from the time the first stickers were issued. However, this would not preclude a health plan from issuing new cards or technology more often.

In addition, the card or technology could be used for any and all health insurance coverage. A separate card just for the prescription coverage would not have to be used as long as the card could accommodate the required information.

The term "health plan" would not include a Department of Community Health pharmacy program but would include the following:

• an insurer providing benefits under an expense-incurred hospital, medical, or surgical policy or certificate (but not to any policy or certificate that provided coverage only for vision, dental, specific diseases, accidents, or credit; a hospital indemnity policy or certificate; a disability income policy or certificate; coverage issued as a supplement to liability insurance; or medical payments under automobile, homeowners, or worker's compensation insurance);

• a multiple employer welfare arrangement (MEWA) providing hospital, medical, or surgical benefits;

• a health maintenance organization (HMO); or

• a third party administrator (TPA).

The bill would take effect January 1, 2003 and apply to all health plan coverages issued or renewed on or after July 1, 2005. The bill would specify that it was the intent of the legislature that pharmacists, by July 1, 2008, be able to obtain information on and submit claims for prescription drug or device benefits by electronic means, including, but not limited to, the Internet.

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FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill would impose new duties on the Office of Financial and Insurance Services (OFIS) and would increase state costs incurred by the OFIS by an indeterminate amount. An analysis of Substitute H-2 by the OFIS indicated that these duties could "take away staff from other necessary functions unless OFIS is able to add staff to perform these new duties." (9-18-02)

ARGUMENTS:

For:

The bill would solve a problem faced by every pharmacist in the state – that of trying to fill a prescription for a person whose benefit card lacks the information necessary to process the transaction in a timely manner. Processing prescriptions with insurance cards that lack all the necessary information can be very time consuming, meaning that the pharmacist has less time to answer clients' questions regarding health issues or drug interactions and precautions.

Consider the situation reported by a pharmacist from an independent pharmacy: almost 91 percent of the prescriptions he fills are covered by a pharmacy benefit manager (PBM). He reported that he deals with almost 116 PBMs. Within those PBMs are thousands of group numbers. Even groups covered by the same insurer can have different pharmacy benefits. To fill a prescription, he must file

electronically, but some of the cards do not have the proper PBM identified, or he cannot tell from the card what information needs to be transmitted in order to complete the transaction. Sometimes he must transmit the transaction five or six times before it can go though, at a cost of 6 cents per transmission. That seems like a small amount, but pharmacists typically make only $2 to $3 per prescription filled.

Moreover, if the card contains outdated information as to the persons covered under the prescription benefit, a pharmacist may dispense medicine to a person no longer covered. If a person is not properly included in the information, the pharmacist may have to require the person to pay the amount in full. In such cases, it would be the person's responsibility to seek reimbursement from the health plan. However, considering the cost of some prescription drugs, this scenario often presents a hardship to low income or elderly persons living on a fixed income.

The uniform prescription benefit card created by the bill would remedy these problems. Under the bill, information that is necessary for proper routing of claims would be available on every benefit or prescription card, along with a phone number for a help desk should questions or problems occur when submitting a claim.

Against:

A national standard and format already exists for pharmacy ID cards for prescription drug programs. Why can't health plans voluntarily adopt these standards? Why should the legislature have to mandate a uniform system in statute? Such a mandate could prove costly to insurers, which means that eventually, the cost would be passed along to consumers in the form of higher premiums.

Response:

Yes, there would be an initial expense for plans to issue the first standardized card. However, the bill would create a low-cost mechanism by which the cards could be updated when pertinent information changed, such as when a person's dependents changed or when employers made changes to benefit plans. Instead of issuing a new card every time there was a change in coverage, a health plan could issue a sticker that a person could place on his or her prescription benefit card. The sticker would contain the new, updated information. If a sticker were used, a new card would not have to be issued until three years after the date the first sticker was issued. By using stickers to update the cards, health plans should be able to mitigate the costs involved in switching over to the new system. Besides, by some reports, the cards cost only pennies to issue (plus mailing costs), and some of the expense can be recouped because not as many staff people are needed to deal with claims problems.

Regarding the decision to seek a statutory solution, reportedly there has been an effort for several years to get insurers to put all the necessary information for billing purposes on the pharmacy cards, but only a few have responded. However, at least 19 states have some form of a standardized pharmacy benefit card. Reportedly, the PBMs and others love the uniform cards because they decrease calls to help desks and reduce claims problems. In short, uniform systems for pharmacy benefit cards streamline the claims process for all involved.

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.