Section-by-Section of the Pharmacy Access Improvement (PhAIm) Act of 2006

Section 1- Short Title

- This is the Pharmacy Access Improvement (PhAIm) Act of 2006.

Section 2 - Strengthening Standards for Access to Pharmacies

- This subsection would require that plans count only "open" pharmacies – those that are accessible to the general public – in meeting the TRICARE standard as applied by the MMA, except for pharmacies operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization. This subsection would further require that plans count only their preferred in-network pharmacies.
- This subsection would allow pharmacies to initiate negotiations with plans under the "any willing pharmacy" provision regardless of any previous offers, or the expiration thereof, from the plan. This subsection also would prevent plans from specifically excluding 340B entities in the terms of their contracts. It also would require plans to apply the Model Safety Net Pharmacy Addendum to their contracts if a 340B entity so requests. It also would require plans to include a provision to allow 340B entities to waive cost-sharing if a 340B entity so requests.
- This subsection would require plans to ensure that long-term care residents have access to long-term care network pharmacies
- This section would take effect on January 1, 2007.

Section 3 - Prompt Payment by Prescription Drug Plans and MA-PD Plans under Part D

- This section would require plans to remit payment to pharmacies (other than mail order only or long-term care pharmacies) within 14 days for clean claims submitted electronically and within 30 days for claims submitted otherwise. Plans also would be required to pay interest on amounts that they do not pay pharmacies timely, which plans would not be able to count against their administrative costs. This section also would require plans to pay pharmacies by electronic funds transfer for claims they submit electronically if the pharmacy so requests.
- This section would take effect on January 1, 2007.

Section 4 - Medicare Part D Informational Resources and Customer Service

- This subsection would require the Secretary of HHS to establish a pharmacists' toll-free hotline.
- This subsection would require plans to establish separate pharmacists' and physicians' toll-free hotlines and to ensure that customer service complies with standards established by the Secretary.
- This section would take effect on January 1, 2007.

Section 5 - Transaction Standards

- This section would require plans to use standardized technology in their communications and transactions with pharmacists and for the cards plans issue their members. The most recent standards adopted by the Secretary are the applicable standards. This section would take effect 60 days after enactment.

Section 6 - Restrictions on Pharmacy Co-Branding by Prescription Drug Plans and MA-PD Plans

- This section would prohibit cards issued by plans from bearing the name, brand, logo or trademark of any pharmacy. It would also require any other co-branded marketing materials to carry the disclaimer "Other pharmacies are available in our network." This section would take effect 60 days after enactment.

Section 7 - Submission of Claims by Pharmacies Located in or Contracting with Long-Term Care Facilities

- This section would allow pharmacies in or that contract with long-term care facilities no less than 30 days and no more than 90 days to submit their claims for reimbursement to the plans. This section would take effect on January 1, 2007.

Section 8 - Assuring Pharmacy Access by Requiring Reasonable Payment of Pharmacies

- This subsection would require plans to pay reasonable dispensing fees to pharmacies (other than mail order only or long-term care pharmacies). For plan years beginning with the 2009 plan year, dispensing fees would be established by an expedited negotiated rulemaking. This rulemaking would involve all stakeholders and require the Secretary to publish a rule by March 1, 2008 including the fees that would then be reviewed annually. This subsection also contains a special rule on dispensing fees for plan year 2008, which specifies that plans shall set dispensing fees based on a list of criteria relevant to costs of dispensing.
- This subsection would require the HHS Inspector General to conduct a study of dispensing fees and issue a report on its findings by March 1, 2007. The report would be considered by the group responsible for negotiating the rule.
- This subsection would require plans to encourage generic utilization by paying an increased dispensing fee for generic drugs. This subsection would take effect on January 1, 2008.
- This subsection would require plans to update their prescription drug pricing standard no less frequently than every 7 days, beginning with an initial update on January 1 of each year.
- This subsection would take effect on January 1, 2007.