Summary of the Pharmacy Access Improvement Act of 2006

The Pharmacy Access Improvement (PhAIm) Act seeks to address immediate and ongoing problems facing pharmacies and pharmacists providing prescription drugs under the new Medicare drug benefit.

Strengthening Access Standards:

The PhAIm Act will strengthen standards for access to pharmacies, requiring plans to use only pharmacies that are true points of access for the general public in order to meet their coverage requirements. It will also help safety net pharmacies, those covered by section 340B of the Public Health Service Act, to negotiate participation contracts with plans by improving the "any willing pharmacy" provision of the MMA.

Making Reimbursement Faster:

The PhAIm Act will require drug plans to pay pharmacies more quickly – in as little as 14 days, in some instances – and will require plans to pay interest to pharmacies if they do not reimburse for drugs in a timely fashion. It also will require plans to pay pharmacies by electronic funds transfer, upon request, for electronically submitted claims.

Creating Help Hotlines:

The Secretary of HHS will establish a pharmacists' toll-free hotline. Drug plans will be required to establish separate pharmacists' and physicians' toll-free hotlines as well.

Ensuring Clarity for Cards and Marketing:

The Act will require plans to follow HHS standards in their communications and transactions with pharmacists, and for the cards issued to plan members. It also will restrict pharmacy co-branding by prohibiting cards issued by plans from bearing the name, brand, logo or trademark of any pharmacy. It will require any other co-branded marketing materials to carry a disclaimer that other pharmacies are available.

Helping Long-Term Care Pharmacies:

Pharmacies contracting with long-term care facilities will be allowed no less than 30 days and no more than 90 days to submit claims for reimbursement.

Requiring Reasonable Dispensing Fees:

The PhAIm Act will require plans to pay reasonable dispensing fees to pharmacies. A special rule on dispensing fees for plan year 2008 specifies that plans shall set their own dispensing fees based on a list of relevant criteria. Beginning in 2008, plans will be required to pay an increased dispensing fee for generic drugs to encourage use of generics. For the 2009 plan year and later, dispensing fees will be established by an expedited negotiated rulemaking. This rulemaking will involve all stakeholders and require the Secretary to publish a rule by March 1, 2008, including minimum fees (to be reviewed annually). The HHS Inspector General will 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.

Making Pricing Standard Updates More Frequent:

Plans will be required to update their prescription drug pricing standards at least every seven days, beginning with an initial update on January 1 of each year.