Prescription Benefit Coverage Recommended as Preventive Care Benefits

BeneCard PBF monitors the industry, as well as government regulations, for areas that may have an influence on prescription benefits and compliance. Our goal is to help our clients continue to exceed their benefit expectations and provide members with a valuable prescription benefit.

The following information provides an explanation of prescription benefit coverage that is mandated under the Affordable Care Act (ACA) and applicable to non-grandfathered plans.

Preventive Drugs

- The following drugs generally must be covered through the prescription benefit plan with no copayment and no member cost-sharing requirement. If generics are available in the drug category, coverage may be set to generics only, and cost-sharing would apply to brand-name drugs. An exceptions process is available in situations where the generic does not work for the member. Members must obtain a valid prescription.

Drug Category	Preventive Health Services Regulation
Contraceptives	Covered for females 10 years of age or older. Abortifacient drugs are excluded. Certain religious employers, and group health coverage with such plans, may be exempt from the requirement to cover contraceptives.
Aspirin	Covered between ages 50-59 as of the date of service and presenting with risk factors for heart disease (smoking, high blood pressure, high cholesterol, and diabetes) to help prevent cardiovascular disease and colorectal cancer, or asymptomatic pregnant persons after 12 weeks of gestation who are at high risk for preeclampsia and have no prior adverse events with low-dose aspirin.
Bowel Preparation Products	Covered for adults ages 45 years and older as a part of preventive screening colonoscopy procedure.
Statins	Covered for adults between the ages of 40-75 with one or more risks of cardiovascular disease, including dyslipidemia, diabetes, hypertension, or smoking.
Folic Acid Supplement	Covered as a daily supplement containing 0.4mg-0.8mg of folic acid for all women between 10-55 years of age who are planning or capable of pregnancy.
Iron Supplements for Infants	Covered for infants who are between 6-12 months old.
Gonorrhea (Newborn Eye Drops)	Covered for newborns who are between 0-7 days old.
Fluoride Chemoprevention Supplements	Oral fluoride supplementation covered for children who are 6 months to 6 years of age.
Breast Cancer Risk-Reducing Medications Such as Tamoxifen, Raloxifene, and Aromatase Inhibitors	Covered for women who are at increased risk for breast cancer aged 35 years older.
Smoking Cessation	Covered with a valid prescription for FDA-approved pharmacotherapy for cessation in adults who use tobacco.

HIV Prevention Drugs*	Covered for persons who are at risk of acquiring or transmitting HIV.
RSV Treatment / Preventative*	Nirsevimab treatment covered for infants between birth and 8 months.

** These categories are recommended as brand and generic coverage due to limited medication availability.*

Breast Cancer Prevention

- Plans should provide coverage for tamoxifen and raloxifene as well as aromatase inhibitors (arimidex, aromasin, and letazole) under the preventative care category at a $0 copay if a patient meets clinical criteria, including:
    1. Family history of breast cancer.
    2. Results of genetic testing reflect a chance of breast cancer.
- For patients who meet one or more of these criteria, the medication will be provided at a $0 copay, using an available generic as the first step of coverage.

Contraception

- **Certain contraception benefits must be covered at no cost to the member.**
- Coverage should include ***at least one option*** from each of the 18 methods of contraception that are approved by the Food and Drug Administration (FDA), and must be prescribed by a women's health doctor:
    - Sterilization surgery for women
    - Surgical sterilization implant for women
    - Implantable rod
    - IUD copper
    - IUD with progestin
    - Shot/injection
    - Oral contraceptives (combined pill)
    - Oral contraceptives (progestin only)
    - Oral contraceptives for extended/continuous use
    - Patch
    - Vaginal contraceptive ring
    - Diaphragm
    - Sponge
    - Cervical cap
    - Female condom
    - Spermicide
    - Emergency contraception (Plan B/Plan B One Step/Next Choice)
    - Emergency contraception (Ella)
- ***Plans must have an exception process to allow for coverage without cost sharing when another form of FDA-approved contraception is prescribed and considered medically necessary.*** A plan must defer to the provider with respect to a determination of medical necessity.
- Plans are not required to cover drugs to induce abortions and/or services related to male reproductive capacity, such as vasectomies.
- Certain plan sponsors (e.g., religious organizations or those with moral objections) may be exempt under certain circumstances.
- Contraceptive coverage may need to be expanded to meet these guidelines.

HIV Preventative Drugs

- There are now two preventative care recommended oral medications approved for daily use as PrEP (pre-exposure prophylaxis):
    - Truvada® (emtricitabine/ tenofovir disoproxil fumarate) is for all people at risk for HIV through sex or injection drug use. Generic products are also available.

  - Descovy® (emtricitabine and tenofovir alafenamide) is for sexually active men and transgender women at risk of getting HIV. Descovy® has not yet been studied for HIV prevention for receptive vaginal sex.
- The recent recommendation included the long-acting injectable form of PrEP, Apretude®, that has also been approved by the FDA. It is administered by a health care provider every two months instead of daily oral pills.
- Plans should provide coverage for Truvada (Emtricitabine / Tenofovir Disoproxil Fumarate) as well as the recent addition of Descovy**.**

Vaccines

- Vaccines can be covered through either the prescription or the medical benefit.
- **Children 0 through 18 years** are eligible to receive vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) without any cost-sharing requirements when administered by an in-network provider:
  - Diphtheria, Tetanus, Pertussis
  - Hib (Haemophilus Influenzae Type B)
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (HPV)
  - Inactivated Polio Virus
  - Influenza (flu shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Rotavirus
  - Pneumococcal
  - Varicella (Chickenpox)
  - COVID-19
  - RSV – (Respiratory Syncytial Virus) *infants 0-8 months
  - Dengue (Age 9–16 years living in dengue endemic areas AND have laboratory confirmation of previous dengue infection)
    - 3-dose series administered at 0, 6, and 12 months
    - Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing please visit https://www.cdc.gov/dengue/index.html.

- **Adults 19 years and older** are eligible to receive vaccines recommended by the ACIP without any cost-sharing requirements when administered by an in-network provider:
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (for females)
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal

- Tetanus, Diphtheria, Pertussis
- Varicella
- Zoster
- COVID-19
- RSV – (Respiratory Syncytial Virus) **people ages 60 years and older*

Out-of-Pocket Maximum

- **For the 2024 plan year, out-of-pocket (OOP) amounts for non-grandfathered plans cannot exceed the established annual federal limit.**
  - $9,450 for single coverage and $18,900 for family coverage.
  - These amounts are adjusted annually.

- **For a health savings account (HSA)-qualified high deductible health plan (HDHP), the out-of-pocket Internal Revenue Service (IRS) limits differ for 2024.** The IRS defines an HDHP as a health plan that meets certain requirements. A principal requirement is that the annual deductible and annual out-of-pocket expenses (deductibles, copayments, coinsurance, and other amounts, but not premiums) must meet these standards.
  - The annual deductible must be at least $1,600 for self-only coverage or $3,200 for family coverage.
  - The maximum out-of-pocket limit is $8,050 for single coverage and $16,100 for family coverage.
  - These amounts are adjusted annually.

- **Clients may structure a benefit design to separate OOPs among service providers.**
  - Separate limits can be applied, but the total amount cannot exceed the federal limit. For example, for single coverage, a prescription benefit can have an OOP of $3,600 and the medical plan can have an OOP of $5,850 bringing the total amount to $9,450.
  - If the OOP is separated, a member may hit the limit on either benefit early. In this instance, the plan will pay the full cost of covered medications or covered medical services for the rest of the year, losing out on some cost-share dollars.

- **Clients may offer an integrated OOP with a total accumulation calculation.**
  - This is achieved through weekly or daily data sharing between vendors.

- **The following costs are not applied toward the OOP calculation:**
  - Member cost-share applied as a penalty for selecting a brand name medication over an available generic, or member expenses that are incurred for using an out-of-network provider.
  - Non-covered prescription medications or medical services.

Next Steps

Please notify your BeneCard PBF Account Executive by December 1, 2023, to initiate these adjustments to your plan. If you have any questions that will assist in your decision-making process, please contact your BeneCard PBF Account Executive, or call our Client Service Center at 1-877-587-2239.

We look forward to continuing to serve your prescription benefit program and supporting your members.