Pharmacy Benefit Administration Options

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OBJECTIVE:

To discuss and review several approaches to structuring a pharmacy benefit design that will provide appropriate drug benefits to members while meeting the financial and clinical objectives of managed care organizations (MCOs).

DATA SOURCES:

Not applicable.

STUDY SELECTION:

The selection for this review is in an MCO, primarily an HMO. The concepts and principles discussed in the article can be used in any practice setting that provides prescription drug benefits. Certain modifications may need to be made to accommodate specific conditions or requirements that may be unique to the particular setting.

DATA EXTRACTION:

Not applicable.

DATA SYNTHESIS:

The pharmacy benefit offered to employees has grown over the last 30 years from a very limited benefit to comprehensive coverage of most prescription drugs. Pharmacy benefit design allows customization of the pharmacy benefit to meet the goals of the MCO. In this article, these components of benefit design are presented: copayments, deductibles, maximum benefit limits, dispense as written enforcement, prior-approval protocols, generic enforcement, and formulary enforcement. Examples of standard, enhanced, and broad designs are presented.

CONCLUSION:

Pharmacy benefit programs must accommodate many variables to meet the objectives and requirements of MCOs. Administrative procedures that attempt to limit the conditions under which certain medications may be dispensed impose additional burdens on pharmacists, prescribers, members, and the administrator of the prescription claims adjudication system.

KEY WORDS:

Copayments, Dispense as written laws, Prior approval, Generic enforcement, Formulary enforcement.

J Managed Care Pharm 1996; 2: 272-278.

The pharmacy benefit program offered to members of managed care organizations (MCOs) can be designed in many ways. The pharmacy benefit can be fashioned to be very cost effective for the MCO by providing coverage for only those prescription products necessary to treat illness and maintain health, or it can be structured to provide coverage for any drug or device that may be prescribed for the member. The design of the pharmacy benefit offered will depend on the prerequisites of the MCO for whose members the pharmacy benefit is being administered. The pharmacy benefit can be modified through the use of the following utilization tools:

- ▲ Copayments
- ▲ Deductibles
- ▲ Maximum benefit limits
- ▲ Dispense as written (DAW) enforcement
- ▲ Prior approval protocols
- ▲ Generic enforcement
- ▲ Formulary enforcement
- ▲ Benefit design modifications

Some or all of these components can be varied to achieve the pharmacy benefit design that will satisfy all of the needs and objectives of any MCO. This article will dis-

cuss each of these components in detail and will provide some insight into their impact on the member and the MCO.

HISTORY

The pharmacy benefit offered to employees has grown over the last 30 years from a very limited benefit (often part of a "major medical" benefit) to comprehensive coverage of most prescription drugs, requiring members to pay only a portion of the prescription cost (copayment) at the time the prescription is received. Most pharmacy benefit programs before the early 1960s required covered individuals to pay the usual and customary charge (U&C) to pharmacies for their prescriptions out-of-pocket and then submit the appropriate receipts and documents to the designated prescription claims processor for reimbursement. The entity responsible for processing prescription claims was generally a health insurance company. These "pharmacy benefits" often required that a substantial deductible and/or co-insurance be satisfied before any reimbursement to the member. Plans with deductibles and co-insurance requirements still exist today but many have been replaced by "first-dollar" coverage plans, which require members to make only a copayment to the

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pharmacy at the time the prescription is dispensed.

In the 1960s, the United Auto Worker's Union (UAW) was able to negotiate an innovative pharmacy benefit as part of the collective bargaining agreement with the "Big Three" automotive manufacturers (Chrysler, Ford, General Motors). The negotiated benefit allowed covered UAW members to obtain prescriptions from pharmacies by paying only the negotiated copayment (\$2.00) to the pharmacy at the time the prescription was dispensed; the balance of the prescription's cost was paid to the pharmacy by the pharmacy benefit administrator (initially, the local Blue Cross/Blue Shield organization). The original benefit included coverage of most prescription drugs and insulin.

The pharmacy benefit negotiated by the UAW in the 1960s became a model for many such benefits that spread to other industries. As this type of pharmacy benefit became more prevalent, pharmacy benefit managers (PBMs) began to evolve. These organizations specialize in administering the many variations of pharmacy benefits offered by employers and MCOs. PBMs offer a menu of services including claims processing, reporting, pharmacy network contracting, and formulary development and administration. PBMs can aid in the design of an appropriate pharmacy benefit to meet a variety of requirements. They also can offer recommendations and provide data about the impact of contemplated design changes or modifications.

MCOs using the services of a PBM must carefully evaluate which services offered by the PBM will best serve the needs of the MCO. The pharmacy benefit administration capabilities the MCO is able to provide through its own internal capabilities will determine which services will need to be delegated to the PBM. The PBM must provide those services required by the MCO and administer the pharmacy benefit in a manner that satisfies the needs and goals of the MCO. To assure this alignment of services, the MCO must perform a careful evaluation of the capabilities and services that can and will be provided by the PBM.

PHARMACY BENEFIT DESIGN STRUCTURE

The structure of the pharmacy benefit design allows customizing of the pharmacy benefit to meet the goals of the MCO and to define clearly specific benefits and/or limitations that will be in effect. It is the benefit design that specifies the drugs or drug categories that will not be covered (such as oral contraceptives), the number of units or days' supply of drug that a member may receive at one time, the conditions under which certain drugs may not be covered, the length of time that certain drugs or drug categories can be received, the inclusion of certain drug categories that would normally not be a covered benefit, and any other specific detail not addressed by the other components of the pharmacy benefit administration options.

COPAYMENTS

Copayments are the predefined portion of the prescription's cost that members are required to pay before receiving the prescription from the pharmacy. They are used to help offset some of the costs paid by the MCO and to minimize unnecessary use of the prescription benefit. Copayments, when appropriately designed, help control use of unnecessary prescriptions and encourage generic use and formulary compliance. Copayments must be designed that they are not so burdensome that they prevent members from obtaining needed prescriptions; this could eventually lead to increased health care costs for the MCO and negatively affect the members' health and quality of life.

Copayments can be imposed in various fashions. They can be a fixed dollar amount for all prescriptions received by members, or they can be varied based on the member receiving a generic, brand name, formulary, or nonformulary drug. Additional options include percentage copayments based on the ingredient cost of the prescription obtained. Varying percentages can be imposed for generic drugs, brand name drugs, and formulary drugs. A percentage copayment may be used for brand name drugs, with a fixed dollar amount for generic drugs. Almost any combination is possible. It is important to not impose unrealistic burdens on members requiring very expensive drug therapy. This can be accomplished by placing an upper copayment limit when percentage copayments are used. A 20% copayment with a \$25.00 maximum limit per prescription is reasonable.

The selected copayment structure should encourage members (and prescribing physicians) to use generic and formulary drugs preferentially. This will help control drug costs for the MCO while providing a quality pharmacy benefit to its members. The appropriate structuring of the copayment as well as other pharmacy benefit options may allow the MCO to offer certain enhancements to the pharmacy benefit that might otherwise have to be excluded to satisfy budgetary considerations. An example of a copayment structure designed to encourage generic and formulary compliance is the following:

- ▲ 20% copayment for formulary brand name drugs with a \$25 limit per prescription.
- ▲ 35% copayment for nonformulary brand name drugs.
- ▲ \$5 copayment for generic formulary drugs.
- ▲ 35% copayment for generic nonformulary drugs with a \$10 limit per prescription.

Higher copayments should always be charged when a member receives a brand name drug regardless of whether the drug is only available as a brand (single source) or if the prescriber has indicated dispense as written (DAW) or similar notation as required by applicable state law. When the higher copayment requirement is not imposed, members are not encouraged to ask their physicians to prescribe drug therapies for which a generic drug is available. The use of generic drugs, whenever possible and appropriate, is the single most effective

way to control pharmacy benefit costs. Imposing higher copayments on expensive brand name drugs is the most effective way to encourage members to communicate actively with their physicians about generic alternatives. Pharmacists have repeatedly stated that, when patients' money can be saved, physicians will prescribe lower cost drugs.

DEDUCTIBLES

Deductibles provide a mechanism for MCOs to avoid "first dollar" coverage of their members' pharmacy costs. Deductibles require members to pay the full retail (or negotiated) price for their prescriptions until a predetermined dollar amount (deductible) has been exceeded. After this deductible has been exceeded, members are able to purchase their prescriptions by paying only the applicable copayment specified by their pharmacy benefit. The deductibles are usually per member and per family. Typically this would be \$50 per member and/or \$100 per family. The deductible amount can be varied as required by the MCO. Pharmacy deductibles should be free standing and not part of the member's or family's overall medical deductible. Combined deductibles are very difficult to administer and require considerable administrative support. Deductibles should be by calendar year and may be prorated based on when the member becomes eligible for benefits during the calendar year.

The method used to value the cost of prescriptions that the member has paid "out-of-pocket" needs to be defined to calculate accurately and consistently the status of the member's deductible. Credit should be given only for prescriptions filled at affiliated pharmacies or "emergency prescriptions" filled at nonaffiliated pharmacies. This adds more value to the deductible, since the prices charged for prescription drugs at affiliated pharmacies will generally be lower than the "usual and customary" prices charged at nonaffiliated pharmacies. Allowing only prescriptions filled at affiliated pharmacies (or emergency prescriptions) to be counted toward satisfying the member's deductible results in the member receiving more prescriptions for the required deductible contribution, and therefore, increases the number of prescriptions the member will pay for "out of pocket" before the MCO becomes financially responsible for the members' prescription costs. Giving credit only for prescriptions filled at affiliated pharmacies also benefits those members who never exceed the predetermined deductible since they have paid less for the prescriptions for which they were financially responsible.

The manner in which the deductible is calculated and accumulated determines the administrative effort required to administer this type of program. Any deductible program is more labor intensive in terms of software requirements and "help desk" effort than a nondeductible program. Additional charges are imposed by most claims-processing companies to administer this type of program.

Deductible programs do not promote the cost-effective use of drugs; they only increase the member's contribution to the cost of prescription drugs. They eliminate the "first dollar" coverage of concern to some MCOs when switching from a major medical program to a pharmacy benefit program in which members are only required to pay a copayment for each prescription received. Deductibles can save MCOs drug costs but may shift some costs to other medical areas even though the appropriate use of pharmaceuticals could have saved money. This is especially true if the deductibles are set so high that they prevent members from filling prescriptions that they need to treat their medical conditions appropriately.

MAXIMUM BENEFIT LIMITS

To an MCO's exposure for drug costs, a maximum benefit limit can be imposed on each member eligible for pharmacy benefits. Monthly or annual limits can be established. Simultaneous monthly and annual limits should not be imposed. Further, I recommend that the maximum benefit limit be administered only for the annual amount.

The administration of this option is labor intensive because of the number of member inquiries about the current status of their benefit level. The number of inquiries is greater if monthly limits are imposed and greater still if monthly and annual limits are imposed concurrently.

The annual limit would most likely have an impact only on the elderly, very sick, or members who overuse prescription drugs for nonmedical reasons. Imposing maximum benefit limits on individuals who cannot afford to purchase prescription drugs if their limits are exceeded can have a negative effect on MCOs when the limit forces members to use more expensive medical services such as emergency rooms or increased office visits. The advantage to annual limits is that the MCO's maximum exposure for drug costs can be calculated.

I do not recommend pharmacy benefit limits. If used, limits should analyze for impact on the members who reach the cap frequently.

DAW ENFORCEMENT

Physicians are given the option, by state law, of preventing prescriptions that they have prescribed from being filled with generic drugs. The mechanisms by which they prevent the pharmacist from dispensing a generic drug is by indicating "dispense as written," "DAW," or similar notations (per state law) on the prescription. Generic drugs are generally 50% less expensive than their brand name counterparts. The generic drugs mandated by most pharmacy programs must be "A" rated by the FDA (*Orange Book—Therapeutic Equivalent Ratings*) and are identical to brand-name drugs in chemical content, strength, dosage form, and therapeutic effects. However, for several reasons, some physicians and many plan

members believe brand-name drugs are better than generic ones. To encourage members to request generic drugs, a mechanism must be put in place that will provide financial incentives so that members request that their physicians not indicate "DAW" on their prescriptions.

Members may request that a brand-name drug be dispensed even if their physician has written for a generic drug or has not indicated "DAW" on the prescription. Under such circumstances, the member should be required to pay the difference between the cost of the generic drug and the brand-name drug (calculated per the pharmacy's reimbursement terms), including any applicable copayment. This process is incorporated in the vast majority of pharmacy benefit designs offered today.

Typically, when a prescribing physician has indicated "DAW" on a prescription per applicable state laws, most pharmacy benefits allow members to receive the brand-name drug without paying the difference in cost between the brand-name drug and the available generic alternative. This pharmacy benefit design encourages members to ask their physicians to write "DAW" on any prescription for which the member does not wish to receive a generic equivalent. I recommend that the plan not allow this to occur by always requiring the member to pay the difference in cost between the brand-name drug and the generic equivalent, including the applicable copayment—even when the physician has indicated "DAW."

MCOs should establish and follow a process that prevents (or does not mandate) generic drugs not approved by the MCO from being dispensed to its members. This may be accomplished by setting strict guidelines about which generic drugs members must accept without having to pay for the cost difference between the available generic and the brand name drug. The on-line prescription claims adjudication system can be programmed to reject payment to pharmacies for generic drugs that are not "A" rated by the FDA. Drugs with narrow therapeutic dosage ranges or known therapeutic equivalence problems should not be subject to mandatory generic enforcement.

PRIOR-APPROVAL PROTOCOLS

The prior-approval process is a mechanism that allows prescriptions to be dispensed to members only when specific predefined conditions have been satisfied. This allows for enhanced control of high-priced or overused medications. The prior-approval process can be used, for example, to control the inappropriate dispensing of growth hormone by limiting its use to pediatric endocrinologists. Similarly, the process can limit the approval of medications having multiple uses to only those situations considered to be medically appropriate.

The prior-approval process must be used only in limited situations and where the additional administrative burden required is not greater than the benefit received from placing a drug on prior-approval status. Prior approvals require extra work by the

pharmacist and the prescriber; they may cause delays to members attempting to have their prescriptions filled. Prior approval for appropriate drugs and situations is recommended.

GENERIC ENFORCEMENT

Generic drugs are substantially less costly (by as much as 90%) than their brand-name counterparts. Encouraging and/or mandating the use of generic drugs is the single most effective cost-control mechanism available to reduce pharmacy benefit costs. The drugs that require generic substitution are typically listed on a maximum allowable cost (MAC) list. The MAC is the maximum dollar amount that the prescription claims adjudication system will reimburse the pharmacy provider for the particular drug being dispensed. When a MAC price is established for a drug, it is normally lower than the cost of the brand-name drug, thereby requiring the pharmacist to dispense a generic drug to be adequately reimbursed; it is important to note that the list does not necessarily require the pharmacist to dispense a generic drug, it only defines the maximum amount that will be reimbursed for the drug. The MAC list maintained by most pharmacy benefit managers includes only those drugs that have been shown to be clinically equivalent to their brand name counterparts. Most MAC lists contain only drugs that have received an "A" rating from the Food and Drug Administration (FDA) or have been used extensively for many years without any documented therapeutic problems.

Two effective methods are available to maximize the use of generic drugs. They have been discussed in detail in the sections titled "DAW Enforcement" and "Copayments." Through appropriate copayment designs and restrictive "DAW" enforcement strategies, the use of generic drugs can be maximized. This is in the best interest of the MCO and does not negatively affect the member.

FORMULARY ENFORCEMENT

The incorporation of a formulary requirement into the pharmacy benefit structure of any plan can result in substantial savings to the MCO and help in the provision of the most efficacious pharmaceutical care to the member. Formularies are developed through the careful and thorough review of the most current medical and scientific literature to include only the most efficacious and cost-effective drugs in each therapeutic class. Members benefit from formularies by having the most efficacious agents prescribed for their medical condition, and MCOs gain by paying only for the most cost-effective agents.

Additional cost savings are available for many drugs included in the formulary through rebates available from pharmaceutical manufacturers. The decision to include a particular pharmaceutical agent in the formulary should never be made based solely on the rebate available. Formulary decisions

Table 1. Pharmacy Benefit Designs

Plan	Covered Benefits	Limitations	Exclusions
Standard	<p>All prescription legend drugs, except as noted in the Exclusions Section.</p> <p>All compounded prescriptions containing at least one federal legend drug.</p> <p>Insulin.</p> <p>Disposable insulin needles and syringes when used for the injection of insulin.</p>	<p>Prescriptions may only be dispensed in quantities up to a 30-day supply.</p> <p>Prescription quantities may never exceed the quantity authorized by the prescriber.</p> <p>Benefits will only be provided for generic drugs appearing on the MAC list. Members receiving prescriptions for drugs appearing on the MAC list on which the prescriber has indicated "DAW" or for which the member has chosen to receive a brand name version will need to pay the difference between the MAC price of the generic drug and the discounted price of the brand-name drug received plus any applicable copayment.</p> <p>Prescriptions filled at nonaffiliated pharmacies will document a medical emergency that required the prescription to be filled at a nonaffiliated pharmacy.</p> <p>Nicotine patches or gum will only be a benefit for one continuous 90-day period and only after the member has enrolled in a smoking cessation program.</p> <p>Retinoic acid for patients over 25 years of age.</p>	<p>Growth hormone.</p> <p>Injectable and oral fertility agents.</p> <p>Nonprescription drugs.</p> <p>Prescription legend drugs for which a generically equivalent product of identical strength is available without a prescription.</p> <p>Injectable drugs except for insulin, cyanocobalamin, epinephrine (any form).</p> <p>Oral contraceptives.</p> <p>Devices.</p> <p>Contraceptive implants.</p> <p>Any brand-name drug used to treat obesity.</p> <p>Topical minoxidil.</p>
Enhanced	<p>All prescription legend drugs except as noted in the Exclusions Section.</p> <p>All compounded prescriptions containing at least one federal legend drug.</p> <p>Insulin.</p> <p>Disposable insulin needles and syringes when used for the injection of insulin.</p> <p>Oral contraceptives.</p>	<p>Prescriptions for drugs not listed on the maintenance drug list may only be dispensed in quantities up to a 30-day supply.</p> <p>Prescriptions for drugs on the maintenance drug list may be dispensed in quantities of 100 units or a 30-day supply—whichever is greater.</p> <p>Prescription quantities may never exceed the quantity authorized by the prescriber.</p> <p>Benefits will only be provided for generic drugs for those drugs appearing on the MAC list unless the prescriber has indicated "DAW" on the prescription in accordance with State laws. Members choosing to obtain brand name versions of drugs appearing on the MAC list on which the prescriber has not indicated "DAW" must pay the difference between the MAC price of the generic drug and the discounted price of the brand name drug received plus any applicable copayment.</p> <p>Prescriptions filled at nonaffiliated pharmacies will only be reimbursed if the member can satisfactorily document a medical emergency that required the prescription to be filled at a nonaffiliated pharmacy.</p> <p>Nicotine patches or gum will only be a benefit for one continuous 90-day period and only after the member has enrolled in a smoking-cessation program.</p> <p>Oral fertility therapy will be limited to 10 cycles total.</p> <p>Retinoic acid for patients over 25 years of age will require prior approval to determine that the drug is not prescribed for cosmetic purposes.</p>	<p>Growth hormone (regardless of intended use).</p> <p>Injectable fertility agents.</p> <p>Nonprescription drugs.</p> <p>Prescription legend drugs for which a generically equivalent product of identical strength is available without a prescription.</p> <p>Injectable drugs except for insulin, cyanocobalamin, epinephrine (any form).</p> <p>Devices.</p> <p>Contraceptive implants.</p> <p>Topical minoxidil.</p> <p>Branded drugs used to treat obesity.</p>
Broad	<p>All prescription legend drugs except as noted in the Exclusions Section.</p> <p>All compounded prescriptions containing at least one federal legend drug.</p> <p>Insulin.</p> <p>Disposable insulin needles and syringes when used for the injection of insulin.</p> <p>Oral contraceptives.</p> <p>Contraceptive devices, implants, and "depot" injections requiring a prescription.</p> <p>Fertility agents (limitations apply as defined in the Limitations Section).</p>	<p>Prescriptions for drugs not listed on the maintenance drug list may only be dispensed in quantities up to a 30-day supply.</p> <p>Prescriptions for drugs on the maintenance drug list may be dispensed in quantities of 100 units or a 30-day supply—whichever is greater.</p> <p>Prescription quantities may never exceed the quantity authorized by the prescriber.</p> <p>Benefits will only be provided for generic drugs for those drugs appearing on the MAC list unless the prescriber has indicated "DAW" on the prescription in accordance with State laws. Members choosing to obtain brand-name versions of drugs appearing on the MAC list on which the prescriber has not indicated "DAW" must pay the difference between the MAC price of the generic drug and the discounted price of the brand-name drug received plus any applicable copayment.</p> <p>Prescriptions filled at nonaffiliated pharmacies will only be reimbursed if the member can satisfactorily document a medical emergency that required the prescription to be filled at a nonaffiliated pharmacy.</p> <p>Oral fertility therapy will be limited to 10 cycles total.</p> <p>Injectable fertility therapy will be limited to six cycles total.</p> <p>Growth hormone must be prescribed by a pediatric endocrinologist and must meet established protocol.</p>	<p>Nonprescription drugs.</p> <p>Prescription legend drugs for which an equivalent product of identical strength is available without a prescription.</p> <p>Devices (other than contraceptive).</p>

should be based on the medical efficacy of the product and its total cost. The total cost is a combination of the price paid for the drug to the dispensing pharmacy, the rebate available, and most importantly, the total cost of the drug therapy including monitoring costs (blood tests and office visits) and concomitant drug therapy required.

The inclusion of a formulary option in a pharmacy benefit can be accomplished through a "closed" or "open" approach. These terms are often defined, respectively, as "mandatory" and "advisory." The two approaches, regardless of the terms used to define them, differ in the consequences to the member if a nonformulary drug is dispensed. In an open formulary, the physicians and/or members are provided with copies of the MCO's formulary and asked to restrict their prescriptions to those drugs included in the formulary. When a drug is prescribed that is not on the formulary, there is no penalty to the member; the formulary is advisory in nature. Closed formularies require that only drugs included in the formulary be prescribed and dispensed. Members receiving nonformulary drugs must either pay for the entire cost of the prescription or pay a substantially higher copayment; these formularies are mandatory.

Mandatory or closed formularies are the most cost effective for MCOs. They can be cost neutral to members if they are educated about the formulary process and learn to work with their physicians to encourage them to only prescribe formulary drugs. A procedure can be incorporated into a closed formulary structure whereby members who cannot be adequately treated with formulary drugs may receive nonformulary drugs without penalty. This process must be carefully structured and rigorously followed to prevent abuse by members and physicians; if exceptions are readily granted without a sound medical basis, the benefits of the closed formulary approach are lost, yet all the administrative burden and related costs must be endured. Exceptions without penalty should not be applicable to drugs not defined as part of the MCO's pharmacy benefit. MCOs may make exceptions to this rule if they choose to pay for the particular pharmaceutical agent for which the member has requested an exception. This can be handled through the prior-approval process, which will specify the length of time during which the member may receive the particular drug for which the exception was granted.

I recommend a closed formulary plan that incorporates a substantially higher copayment on prescriptions for nonformulary drugs (refer to recommendations under "Copayments"). An exception process should be developed that clearly defines the circumstances under which members may receive nonformulary drugs without penalty.

BENEFIT DESIGN EXAMPLES

Three pharmacy benefit design examples are provided in Table 1. The designs are termed for ease of reference, "Standard," "Enhanced," and "Broad."

Table 2. Enhancements to Benefit Designs

- ▲ Coverage of all nonprescription drugs^a
- ▲ Coverage of certain nonprescription drugs that may be prescribed in place of more expensive "prescription only" alternatives. The selection of "covered" OTCs must be carefully reviewed. Coverage should be limited to generics (when available) only.
- ▲ Coverage of all injectable drugs
- ▲ Coverage of member-requested DAWs (member may choose to receive a brand name drug at no additional cost even when an "A" rated generic is available)^b
- ▲ Coverage of oral contraceptives
- ▲ Coverage of "prescription only" contraceptive devices.
- ▲ Coverage of growth hormones subject to established prior-approval protocols
- ▲ Coverage of diabetic accessories (does not include glucose meters)

^a Not recommended.

^b Never recommended.

Standard Designs

The Standard plan is designed for those MCOs choosing to offer a basic pharmacy benefit to members that will provide them with high quality pharmaceutical care while requiring members to absorb the cost of certain medical therapies that do not directly affect their health. This design requires members to take an active role in advising their physicians to prescribe the most cost-effective drug therapies available to treat their medical conditions. This benefit design is recommended for most MCOs.

Enhanced Designs

The Enhanced plan is recommended for those MCOs offering prescription coverage for pharmaceutical agents beyond those required to maintain the members' health and prevent illness. This design provides the same high level of pharmaceutical benefits as the Standard plan but adds coverage of oral contraceptives, oral fertility agents (limited to 10 cycles), retinoic acid therapy for members over age 25 (with prior approval granted only if for noncosmetic usage), up to 100 dosage units of drugs included on the "maintenance drug list." It does not require members to absorb the difference in cost between brand name and generic drugs when the prescriber has designated that the brand name drug be dispensed.

Broad Designs

Those MCOs providing very comprehensive drug coverage to members have a Broad pharmacy benefit design. If necessary, the design can be customized further by using the benefit design modifications outlined in the next section. The Broad design includes all the benefits included in the Enhanced plan along with coverage of injectable fertility agents (limited to six months' therapy); all contraceptive devices requiring a prescription; contraceptive injections; growth hor-

Table 3. Limitations to Benefit Designs

- ▲ No coverage of any fertility agents
- ▲ No coverage of injectable fertility agents
- ▲ No coverage of anti-acne therapy
- ▲ No coverage of "brand name" analgesics for which an "A" rated generic equivalent drug is available^a
- ▲ No coverage of medications used to treat attention deficit disorder (these products are often abused)
- ▲ No coverage of drugs used to treat obesity regardless of intended use
- ▲ No coverage of DESI drugs (pre-1962 drugs never determined by FDA to be efficacious)
- ▲ No coverage of cough and cold medications (regardless of intended use)
- ▲ No coverage of vitamins ("prescription only" prenatal vitamins, fluoride—not in combination, injectable cyanocobalamin and "prescription strength" folic acid—not in combination are *always* covered)
- ▲ No coverage of amphetamines regardless of intended use
- ▲ No coverage of retinoic acid regardless of intended use^b
- ▲ No coverage of benzoyl peroxide-containing products (used to treat type I acne; these products are generally available without a prescription)^a

^a Highly recommended.^b Recommended.

money; the removal of the number of months for which nicotine therapy may be received along with the requirement that the member provide proof of enrollment in a smoking-cessation program. The Broad benefit design is not recommended, and should only be used when necessary to attract members who, through negotiated pharmacy benefit designs, are entitled to this very costly drug-benefit level.

BENEFIT DESIGN MODIFICATIONS

Certain features can be incorporated into any pharmacy benefit design that allow further customizing of the pharmacy benefit structure to meet the needs and objectives of the MCO offering the pharmacy benefit to its members. Modifications

may be enhancements (Table 2) or limitations (Table 3) to any basic pharmacy benefit design.

CONCLUSION

The development of a pharmacy benefit must be able to accommodate a large number of variables to meet the objectives and requirements of the MCO whose members will be covered by the pharmacy benefit. The variety of options presented above will accommodate numerous pharmacy benefit requirements. Additional options may be requested or suggested. Typical prescription claims-adjudication systems are capable of administering a large number of benefit design options. However, all options must be carefully evaluated to determine their impact on the members' well-being and administrative costs relative to the benefit received from their implementation.

Administrative procedures that attempt to limit the conditions under which certain medications may be dispensed impose additional burdens on pharmacists, prescribers, members, and the administrator of the prescription-claims adjudication system. These additional administrative processes may require additional compensation to those entities affected by the processes. Before such requirements are implemented, the cost (in terms of increased compensation and inconvenience) of these requirements must be compared with the benefit derived. Any limitations to the members' pharmacy benefit may result in increased medical costs secondary to increased physician visits, emergency room use, or increased hospitalizations. This is not only costly to the MCO responsible for the members' medical care, but also, and most importantly, it may have a negative impact on the members' well-being and quality of life. The pharmacy benefit should be structured to be cost effective, but it must first meet the needs of the members who will be covered by it. ■

A is for Apple,
B is for Ball,
C is for Cancer.
Cancer?

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