The History, Philosophy, and Principles of Pharmacy Benefits

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OBJECTIVE: To provide an in-depth discussion of the philosophies, design, and structure of the prescription pharmacy benefit.

DATA SOURCES: Benefit consultants, texts

CONCLUSION: Pharmacy benefits are structured using the same principles as other health care benefits. However, the design of benefits as wage alternatives complicates their implementation as employers insist upon performance and employees insist on receiving their ben-

efits as entitlements. The resultant benefit designs are a balance between cost and risk management and provision of the services that beneficiaries expect.

KEYWORDS: Pharmacy benefit, Prescription benefit, Prescription coverage, Beneficiary

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Historically, pharmacy benefits have received only cursory notice in the business literature; they typically are described briefly as one of several options for supplementing medical benefits. However, as the demand for the benefit has increased, so has the complexity of the offerings. Unfortunately, education and training in the basic principles and designs of pharmacy benefits, as well as the availability of information, have not evolved as quickly as the demand. Much of the information is proprietary and considered confidential for competitive marketing purposes. This article is a response to this situation and an attempt to place the benefit on a more rigorous footing.

What is a benefit? How is it structured, and what are the necessary and sufficient components of a benefit? What are the options? Where are they going? These are the basic questions that we will address in this article.

OVERVIEW OF BENEFITS

In its broadest definition, "employee benefits are virtually any form of compensation other than direct wages paid to employees."¹ This definition covers legally mandated benefits, such as Social Security, paid by the government, and private plans that stem from the employee-employer relationship. Another category is the benefit provided by the individual for his or her own welfare. These three categories—legally mandated, employment-related, and individual plans—form a "tripod of economic security" on which literally all individuals and families depend. As a result, benefits are a product of society's wishes and require a balance between the perceived needs of the individual and the cost of meeting these needs.

Health care benefits are a component of each leg of the economic security tripod, and pharmacy benefits are a component of health care. As such, pharmacy benefits are subject to the same philosophies, designs, and drivers that define the health care benefit. Our attention will be focused on the benefits provided under the employee-employer relationship, but it is impossible to ignore the interdependence between employer

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Audience: Health care professionals interested in, or who practice in, managed care; those who want to increase their knowledge of managing and coordinating pharmaceutical care programs; and those responsible for optimizing patient care and satisfaction with managed care.

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benefits and the impact of societal desires and governmental regulations regarding these benefits and their tax status. This interdependence is nowhere more apparent than in the two basic approaches to employer benefits: defined benefits versus defined contributions.

Historically, benefits have been defined according to the employee's service and/or pay (defined benefits), and the employer has been responsible for funding these defined services. As overall benefit costs have risen in both the public and private sectors, a trend has developed to move to a "defined contribution" approach. In defined contributions, the employer provides a fixed contribution and the benefit is the product of what can be purchased based on value of the contribution, age at entry into the program, retirement age, and investment earnings or losses. The relative ascendancy of either approach is heavily based on the state of the economy and the importance that society places on the various elements of its needs versus its wishes.

To understand all benefits, including health benefits, it is crucial to recognize that the premium paid to participate is not necessarily equivalent to the actual cost of all covered services. Benefits are a form of insurance and are governed by insurance principles. Premium payments provide a pool of funds used to pay for services whose price and utilization are predicted using basic actuarial principles. To the extent that an employer's current utilization of services can be budgeted and future utilization can be predicted, then the "risk" of costs and provision for unforeseen (but actuarially predictable) occurrences can be priced.

If the employer is large (has more than 500 employees), then the employer's insurable risk for expenses may approximate that of the general population in its region and premiums will reflect the community rating. Small employers, companies in businesses with high risks for certain diseases, and companies with a high number of older employees or retirees have a greater utilization of services and therefore pay higher costs for benefits (experience rating).

Premiums are also subject to marketing forces and may be discounted to attract a large number of enrollees. In these cases, the insurer hopes that market share will translate into large numbers of covered lives, which will mitigate risk to a degree and provide a fund large enough to cover the risk presented by people with high rates of utilization (adverse selection).

Individuals have a high perceived need for medical benefits. One option available to fulfill this need is the basic medical benefit, which is hospital-oriented and geared to acute care services. A second option is the major medical benefit plan, which is broader in coverage and directed to catastrophic or large, unpredictable, and therefore unbudgetable medical care expenses. Comprehensive medical policies blend the basic medical and the catastrophic. There are wide variations in the designs and services included, but certain principles are standard in all designs and apply equally as well to supplemental benefits such as the pharmacy benefit. The key principles are:

- ▲ Define the range of services to be provided by analyzing the population (age, sex, demographics, and historical usage patterns).
- ▲ Balance payor and marketplace considerations with cost projections for provision of defined services.
- ▲ Define maximum limits on services and payments.
- ▲ Ensure participation of the insured in the cost of care through deductibles and coinsurance.

The marketplace has moved toward comprehensive plans in an effort to simplify the reimbursement and the description of covered services to the member. (For the purposes of this discussion, insured beneficiaries—also known in various circumstances as insureds, enrollees, enrolled members, and employees—will be referred to as members). Due to the increasing complexity of benefit designs, medium to large payors use benefit consultants or benefit managers as advocates to assist with all elements of the process. Small employers/payors use brokers who sell one or more insurance plans, or they purchase a predefined benefit from an insurer or health plan. Of relatively recent vintage is the use of product-specific benefit managers, such as pharmacy benefit managers (PBMs). These managers combine the traditional fiscal intermediary role for bill paying with the additional roles of provider network contracting and benefit design.

BENEFITS AS A WAGE ALTERNATIVE

Why are benefits, including pharmacy benefits, part of employment agreements? Other countries have federally funded benefits, yet 160 million Americans receive their health care benefits from employers. To understand this situation, it is necessary to review the history of benefits since World War II (see Table 1).

During World War II and the Korean conflict, wages were frozen but benefits were not. As a result, the benefit moved from being a "fringe" to an active component of an employee's compensation. Offering benefits as part of compensation became a method for competitively recruiting and retaining capable employees.¹ In addition, employers hoped that employee efficiency, productivity, and morale would be fostered by good benefits. As a balance to the employer incentives, the Labor Management Relations Act (LMRA), or the Taft-Hartley Act, placed benefits under good-faith collective bargaining with unions. Subsequent rulings by the National Labor Relations Board (NLRB), which administers LMRA, made it clear that wages include pension plans (*Inland Steel v. NLRB*) and that good faith bargaining includes group health and accident plans (*W.W. Cross & Co. v. NLRB*). As a result of these rulings, LMRA expanded to apply to retirement and welfare benefits, which led to an entitlement for employees.

The imposition of government restrictions on wages and the expansion of entitlements increased the continuing fear of further government intervention (or "moral suasion") into private business. As a result, multiple tax laws have been passed to favor employee benefit plans (Federal Tax Regulations

1.162-7; IRC Sections 2039, 2056, 2001, 2010, 101[b], 691[c], 402[b], and 83). In general, employer contributions are deductible as business expenses; employer contributions in many circumstances are not considered income to employees; and in certain plans the assets to fund retirement or capital accumulation are tax-free until the employee withdraws these funds. Further, multiple opportunities exist for integrating government benefits with employee benefits that tend to enrich the benefit package.

However, entitlements do have a negative aspect. The cost of the average employee benefit package has risen to approximately 30%–50% of payroll. The nature of the entitlement is such that employees cannot place a market value on the compensation package, whereas the employer wants pay-for-performance. The benefit has increasingly become a source of dissatisfaction and distrust, and rarely a source of motivation and productivity. Goodwill evaporates when employers increase premiums, switch networks, or deny claims. The result for employers is a conflict between paternalistic relationships with employees and the economic decisions of running a business.

PHARMACY BENEFITS

The benefit issues discussed apply to pharmacy benefits as well. Outpatient medications are included in the major medical benefit, which is the core benefit and covers predominantly physician and hospital services. Inpatient medications are covered under the basic hospital, major medical, or comprehensive medical plan benefits. This discussion focuses on prescription medications used in an outpatient environment. Non-prescription medications, devices, herbals, nutraceuticals, and other over-the-counter (OTC) items traditionally have not been included in pharmacy benefits because they are considered to be discretionary and not medically necessary. However, because these items are often less expensive than prescription medications, they are now being considered for inclusion in some benefits.

Typically, pharmacy benefits were lumped with vision and dental plans as complementary to medical benefits and treated as “riders” that could be added to the major medical package for relatively small additional premiums. Yet prescription drugs differ from vision and dental care in that vision and dental are frequently elective and predictable. Prescription drugs may be predictable for many chronic conditions, but they are infrequently elective.

Additionally, with continued prescription drug price inflation, the introduction of new medications, and increased outpatient drug therapy, the pharmacy benefit (or prescription drug benefit) has received a focus uniquely its own. Before the 1970s, drug prices lagged behind the consumer price index (CPI). In the 1980s, drug expenditures soared, outpacing the general CPI as well as the CPI of the medical component.² As a result, prescription drug benefit programs have focused on decreasing overall drug costs relative to the medical CPI.

Table 1. History: Benefits as a Wage Alternative

Year	Historical Situation
1940	10% of work force (i.e., 12 million people) covered by health insurance—primarily Blue Cross/Blue Shield and Kaiser
1942	Stabilization Act—employer paid insurance plans in lieu of wage
1945	War Labor Board ruling—illegal to modify/terminate group insurance during the life of the contract; NLRB ruling—insurance and pension benefits are “wages”
1949	Liberty Mutual introduced major medical coverage
1951	100,000 lives covered
1960	32 million lives covered
1979	97% of full time equivalents (FTEs) in medium to large companies had employee-sponsored health insurance
1986	156 million lives covered
1991	87% of FTEs covered by employee-sponsored health insurance—the contingent work force increased
1971-1991	Cost of medical care rose 70% faster than inflation Cost of all fringe benefits is 40% of compensation (vs. 17% in 1995) 12% of total revenues spent on employee benefits vs. 4.4% in 1950s

Pharmacy Benefit Design Options

Pharmacy benefit design is based on the same principles as other benefits offered for medically necessary services, which are generally predicated by age, sex, and the experience of the insured population. For the purposes of this discussion, we will define the major types of benefit design:

- ▲ Utilization designs—address adversely selected populations who utilize more than the general population;
- ▲ Cost-management designs—address expenses to manage insurable risk; and
- ▲ Integrated drug/medical designs—address the mitigation of risk by improving collateral medical outcomes.

Utilization designs usually provide a fixed number of prescriptions per member per month. These designs assume that medical providers will manage risk that is insurable—such as expected chronic care and predictable short-term acute care—in a manner that maximizes outcomes and minimizes the medical risk of complications, and at a budgetable cost. The difficulty with these designs occurs when the benefit limits are set at levels below the experience of the population, or the population has a higher utilization rate than expected. Then the pharmacy fund is insufficient to carry the burden and the reserves have not made enough return to cover the actual

expenses. The result is that either premiums are raised or benefit levels are reduced.

Integrated drug/medical benefit designs are based on substituting drug therapy for medical provider care (surgery or acute hospital care) and require that drug cost inflation be applied to medical cost, with a commensurate decrease in medical premium inflation. Alternatively, designing the pharmacy benefit to integrate with the major medical benefit presumes that the entire medical delivery system is modified to achieve economies of scope (i.e., appropriate allocation of care sites including health care maintenance) and scale (i.e., efficiency and productivity increases across the entire health care continuum). These benefit designs are rarely used and are dependent on a second stage of maturation of managed care that targets scope and scale. Until then, pharmacy benefit design will continue to focus on cost management.

Pharmacy Benefit Design—Cost Management

Pharmacy benefit designs based on cost management emphasize generic substitution, patient incentives, and a benefit definition of covered and excluded costs. Generic substitution is a method to counteract the increasing expense of current medications and is a longer-term approach to limiting the impact of new medications. This strategy required the growth of generic market share, which did occur during the 1980s and 1990s due to the repeal of ant substitution laws in all states and in the District of Columbia and the passage of the Drug Price and Competition and Patent Restoration Act (Hatch/Waxman) in 1984. As a result, generic market share increased to 20% in 1990 and an estimated 40% today.³ The impact of generics was further driven by the mandate of many states to pass substitution savings on to the consumer and the wide price variation between brand and generics. The matter of generic drug quality is a recurring theme that is addressed regularly by the Food and Drug Administration, which is charged with monitoring the quality and safety of all prescription drugs.

Patient incentives are used in benefit design to encourage generic substitution and to introduce price considerations into provider/patient drug selection. The simplest incentive for the patient is to offer a lower copayment (two-tier) when a generic product is dispensed. The provider incentive is usually based on payment of an additional surcharge for dispensing a generic, which in fact may also be a patient incentive. To understand these incentives, it is necessary to introduce the methods of reimbursement for outpatient prescriptions.

Prescription Drug Reimbursement—Traditional Indemnity Approach

In the traditional indemnity environment, drugs are covered under major medical or comprehensive medical policies. To receive the prescription drug benefit, a member must first fulfill an annual deductible and thereafter pay a coinsurance, usually set at 20% of the cost of the medication. The prescription may be filled at any licensed retail pharmacy, which will

charge its "usual and customary" fee for the prescription so that the patient participates in drug-cost inflation through the copay. The patient pays the entire cost of the prescription and, if the cost is low, may not submit a claim to the employer. This "shoebox" effect was estimated within the industry to occur approximately 15%–17% of the time. (An unscientific study estimated it to be 15%–20% while an empirical investigation found the shoebox effect to be 9.8% of claims and 8.9% of expenditures.^{4,5}) However, as medications became more expensive and claims were filed electronically, the shoebox effect and other hidden costs were reintroduced into the system, adding cost to the benefit. The potential for other costs to be introduced exists—for example, noncovered drugs are frequently claimed, because there is less oversight of the prescription filling process.

Prescription Drug Reimbursement—Card Plans

Prior to 1960, very few health plans or medical benefits had separate prescription drug benefits. In the late 1960s, collective bargaining between the "Big Three" automakers and the United Auto Workers led to card plans. In card plans, the insurance company, Blue Cross/Blue Shield affiliate, or PBM contracts with pharmacies. Under a master contract, pharmacies may choose to accept or reject their involvement and, depending on the size and breadth of the employer, the contracts may be regional or nationwide. The emphasis is on volume purchasing of pharmacy services and wide access to pharmacies. Chain, discount, and mail-order pharmacies that can offer volume price discounts and access within five miles of physician groups or hospitals have competitive advantage over independent pharmacies. Regional contracts level access in remote areas, and, in these cases, providers are judged on access first and discounts second.

This approach is complicated in those states that require any willing provider to be included in the contract; however, this issue is usually addressed when insurers offer different networks of pharmacies, each offering different pricing options. A further consideration is the cost of paying claims, which is estimated to be about \$5 to \$7 per claim, although actual costs vary. Writing fewer checks and paying fewer pharmacies minimizes administrative expenses. Because the contracts are nationwide and information is free-flowing as benefits managers consult employers in the purchasing decision, the competitive marketplace is expanded to include nationwide pricing information. With nationwide competitive price pressures, market forces control the cost of medications and contracts shift their emphasis from cost management to service considerations. Primary among service considerations for employers are disruptions in employee access to pharmacies, complaints about pharmacy service, and disruptions in current therapies.

From the members' perspective, their benefit card allows them to patronize participating pharmacies to fill their prescriptions. Members pay a per-prescription copayment that is identified on their card or computed at the time the claim is

Table 2. Usual Benefit Coverage

- ▲ Federal legend drugs (listed in the formulary)
- ▲ State-restricted drugs (i.e., in some states certain nonlegend drugs require a physician's prescription to be dispensed)
- ▲ Compound medications containing a federal legend drug or state restricted drug
- ▲ Injectable insulin and in some cases needles and syringes when purchased with insulin
- ▲ Medications or devices required by the purchaser or that have become common components in similar benefit plan offerings
- ▲ Quantity limits (number of prescription units, i.e., tablets, capsules, ml) allowable per-prescription.

adjudicated. If the employee patronizes a nonnetwork pharmacy, the employee must pay the entire cost of the medication and submit a paper claim, also known as a "direct" or "non-participating" reimbursement, for the cost of the medication minus the applicable copay. A "reasonableness" test may be applied to the prescription if the employee used a nonnetwork pharmacy in an area containing network providers. In this case, the employee may be penalized and required to pay the entire cost of the prescription or an additional surcharge.

REIMBURSEMENT LEVELS

The purchaser and/or the insurer, when contracting with PBMs, decides the fee reimbursed to the pharmacy under the card plan. The elements of the reimbursement formula usually include:

Ingredient cost (or raw drug cost) + professional (dispensing) fee + state sales tax (when applicable, may be passed to the employee) - share of cost (coinsurance or copayment).

The ingredient cost is based on a standard reference, such as the average wholesale price (AWP). Discounts off the AWP define specific network options and are subject to competitive price pressures. Purchasers tend to drive the AWP discount until they arrive at what is believed to be the actual cost of medications. The discounted AWP is then determined to be the actual cost and the negotiation between purchaser and provider turns to "cost plus" considerations for administrative costs, professional fees, and estimates of fair or competitive provider profits.

Covered Costs and Exclusions

The Summary Plan Description (SPD) is a legal document that defines the benefit in language the member can understand. The cost management benefit design includes several components, those covered and those excluded (see Tables 2 and 3). Benefits are also designed to ensure that the right payor bears responsibility for the claim if several benefits apply (subrogation of claims) and that duplicate claims are prevented when the member is eligible for benefits under

several plans (coordination of benefits or COB), such as workers' compensation.

Claims Processing

Fiscal intermediaries, such as third-party administrators and PBMs, process (adjudicate) and pay pharmacy claims. The pharmacy claim is either a paper universal claim form (UCF) or an electronic version adjudicated when the prescription is processed. In both cases, the member signs the UCF or a log acknowledging receipt of the prescription, assigning benefits beyond the copayment to the pharmacy, and authorizing the release of information upon payor request. Payors have to put aside funds in escrow accounts or maintain expense accounts to pay claims. Under this system, it is necessary to predict the expenses to be incurred each month and to provide adequate cash flow for payment in a timely manner—typically every two weeks to network pharmacies.

Payors favor electronic claims because they lead to defined cash flow and minimize the risk of lagged claims for which funds must be allocated but held until the claim is processed. Also, adjudicating high volumes of claims leads to lower processing costs of usually less than \$1 per claim. Alternatively, the cost of processing paper claims is high and introduces additional administrative expense. Payors get into trouble when they have not expensed enough funds for the incurred claims (also known as "incurred but not received") or have used funds for other expenses.

Advantages and Disadvantages of Card Plans

Card plans exploit the economies of scale in high-volume claims processing, volume discount contracting, and data to audit the financial performance of the benefit. On the positive side, card plans offer financial predictability and data to monitor benefit performance. Both indemnity and card plans include exclusions and copayments, which place the member at increased risk for drug inflation, so that the net payout is manageable and budgeted in line with the CPI for medical costs. Also, the fees negotiated with the pharmacy provide a ceiling on provider reimbursement and a predictable cost for the benefit for a guaranteed period, usually two to three years. Electronic claim adjudication provides data for statistical evaluation of benefit performance and profiles of employee and provider utilization.

Table 3. Common Benefit Exclusions

- ▲ Drugs for investigational use (outcome of therapy is uncertain so not an insurable risk)
- ▲ Contraceptives (a discretionary item in some plans)
- ▲ Cosmetic agents (usually considered to be not medically necessary)
- ▲ Immunizing agents/cost to administer a drug (both are usually covered under the medical portion of the benefit)

On the negative side, the cost for card plans is frequently higher than for the traditional indemnity plan. All prescriptions are covered and the use of electronic claim adjudication removes most of the shoebox effect, so that even minor drug costs are included in the benefit. In addition, there is significant concern that a card plan removes the disincentive to the member involved in having to pay the full price, at least initially, out-of-pocket—the hesitation factor—and, therefore, prescription utilization rises.

Mail-Order Prescription Benefits

The card plan has led to the rise of mail-order pharmacies to capitalize on automation techniques for high-volume and high-productivity dispensing. The Department of Veterans Affairs first developed mail-order dispensing programs after World War II, and the American Association of Retired Persons Pharmacy Service programs followed; but the private sector did not embrace this concept until the 1980s. In the private sector, the mail-order benefit was designed to focus on prescriptions for chronic medications, which are estimated to account for 70% of all prescriptions. Because senior citizens are the highest utilizers of chronic medications, mail order offered convenience when home delivery was not available.

The mail-order benefit is usually designed as an add-on to the major medical or comprehensive medical plan, or it is integrated with the card plan. In the add-on design, the annual deductible is waived and a reduced copayment is charged to provide the member with an incentive to use the benefit. The quantity allowance is raised to typically a 90-day supply with a copayment, which is less than the comparable copayment for three 30-day supplies. In the integrated design, mail order is used as an option to the retail network and a lower copayment is sometimes used as an incentive for members to use the mail-order system after one or two refills.

The mail-order benefit is intended to reduce cost by increasing the use of generic medications, by lowering the costs of branded medications through volume purchasing discounts, and by reducing administrative costs and dispensing fees by favoring automation over labor-intensive dispensing. Yet debates continue about whether benefit costs have actually risen under mail-order options. The unit cost of medications is cheaper with volume purchasing, but other factors, such as waste (not using a 90-day supply when the prescription is changed within a month) and stocking up to receive an extended benefit at the end of the year or when terminating employment, often lead to increased costs.

Techniques for Cost Management

With the advent of the prescription card and PBMs, several tools for proactively managing the cost of the benefit have been developed. Among these tools are:

- ▲ Point-of-sale/service (POS) for electronic claim adjudication;
- ▲ Maximum allowable costs (MAC) for generic reimbursement;
- ▲ Formularies for introducing competitive pressures in therapeutic categories with similar offerings;

▲ Drug utilization review (DUR) for evaluating drug utilization for medical conditions; and

▲ In-house pharmacies to provide oversight on drug use in defined populations.

POS tools have allowed for the introduction of eligibility verification and more complex deductibles, copayments, and benefit exclusions at the point of processing the prescription. POS also can allocate the cost of the prescription to the applicable primary payor when more than one payor exists (e.g., Medicaid or third party), and to check for duplicate therapies, drug interactions, and potential dosing problems (prospective DUR). Because one PBM is adjudicating claims regardless of the site of care, the opportunity for one medication profile allows for further retrospective DUR with which to evaluate the performance of the benefit and to segment the population of users to determine the need for further refinements in the benefit and the impact of trends in drug use.

MAC programs provide a ceiling to the reimbursement of often-used generics. The MAC programs were originally based on the Health Care Financing Administration MAC (HCFA MAC) concept, which placed a threshold on the cost of generics. However, the lack of breadth in the federal program led PBMs to define an estimated actual acquisition cost MAC for the bulk of generic medications. This cost is based on an estimate chosen from the lowest, average, or discounted AWP among a portfolio of identical generic products. As a cost-management tool for the generic portion of the benefit, the MAC is a proprietary number used for competitive bidding between PBMs but is usually in the range of AWP minus 30%–60%. One negative aspect of the implementation of MAC pricing has been a mismatch between payor and pharmacy incentives. With MAC pricing, the profit margin of the pharmacy is frequently lower than the generic incentive surcharge, leading to a lack of incentive for the pharmacy to encourage generic substitution when the patient prefers a brand.

The formulary provides a list of medications that define benefit inclusions or exclusions. The goals are to limit inappropriate utilization and to aggressively introduce competitive price pressures on frequently prescribed and therapeutically equivalent medications. Under this concept, the formulary is of particular use for ailments commonly seen in primary care practice. Multiple variations in formulary design exist, such as preferred medications for common problems; step-care protocols for medical management of specific conditions; and therapeutic algorithms to provide oversight to the drug-use process.

To achieve further cost reduction, formulary designers frequently tie drug choices to manufacturers' rebates, which are a result of the volume purchasing arrangement for increasing market share of specific medications or bundles of medications. These rebates also provide a further cost-reduction tool for the payor by providing additional revenues to fund the pharmacy benefit or to provide a "negative cost" to expenses booked for funding of the benefit. The actual impact of the rebate tool is measured by the offset of the cost impact of rebated drugs versus the cost of therapeutic options. Rebate

Figure 1. Managed Care Pyramid⁶

levels of less than 5%–10% are common, although accurate levels are held in the strictest confidence by PBMs and must be evaluated in light of the financial impact versus disruptions in member therapies that can lead to increased complaints and disenrollment.

In-house pharmacies are a product of the staff model HMO concept but have been expanded to include employers who deploy pharmacies in the workplace and health plans or physician groups who sign exclusive agreements with individual or chain pharmacies for the provision of prescription services. For the pharmacy provider, these agreements lead to more traffic, higher volumes of business, and the ability to offer collateral merchandise in addition to the prescription. The purchaser is looking for lower drug costs and the ability to ensure formulary compliance and generic substitution.

Oversight of the Pharmacy Benefit

Intuitively, all benefits are expected to deliver value to the beneficiary. However, benefits consultants and managers, purchasers, and benefits designers do not deliver care. As a result, they are dependent on the quality programs of providers to provide a return, which is an acceptable medical outcome as well as a service component that meets the desires of the member. These issues are also heavily linked to the need to maintain the financial viability of the benefit and to ensure that long-term risk is managed. Correspondingly, to mitigate risk, appropriate therapy must be instituted at the appropriate time and in the appropriate setting. This implementation requires the use of DUR and the assurance that therapy process follows total quality management principles. Pharmacy and therapeutics committees are expected to provide oversight by scrutinizing formulary decisions to ensure the measurement of predictable outcomes, which allows a realistic assessment of whether therapeutic goals are achieved within the context of what can be expected at the current state of medicine.

The insurance approach for integrating financial and quality goals is designed to ensure that the benefit is built on a

sound foundation of insurable risk (see Figure 1). The foundation of the insurable risk is the cost-management program. The next step is the design of a benefit that obeys the basic principles discussed in this article, and then the choice of a delivery system (plan) that is based on quality-management principles. Finally, the delivery of care must meet the oversight obligations discussed.

If the benefit can achieve this model, then unforeseen expenses can be mitigated through reinsurance. Reinsurance is a method for sharing some of the financial risk with other parties. The original insurer assumes a certain level of financial exposure (risk) and maintains an additional "corridor of risk," typically 10%. The rest of the premium and the concomitant financial risk of losses are passed to the reinsurer. Because reinsurance is expensive, it is crucial for the insurer to provide a benefit that contains the discipline described in this article and configured in the managed care pyramid (see Figure 1).

TRENDS IN BENEFIT DESIGN

The move to employer-based benefits has led to tensions over the employers' goals for benefits and the entitlement that employees expect. Automation has led to more complex benefit structures and a body of data with which to evaluate the performance of benefit designs and the preferences and value that employees desire. National health plans bolster the entitlement attitude but not the competitive pressures for marketplace controls on quality and cost. Increasing benefit costs motivate the purchaser to pass additional costs to the member or to pay only for catastrophic care and let the member pay for ordinary medical expenses. Yet society has not begun discussing the really difficult questions of benefit limits and the types of services that need to be financed by the member. This concern is the next major revolution and the still-unrealized prospect for managed care approaches to benefit design and management.

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C E E X A M

The History, Philosophy, and Principles of Pharmacy Benefits

Upon completion of this article, the successful participant should be able to:

1. Discuss the elements of benefit design and identify the drivers of different design options.
2. Describe the cost management approach to pharmacy benefit design.
3. Detail the elements of the prescription card plan.
4. Discuss managed care techniques and approaches to oversight of the pharmacy prescription benefit.

SELF-ASSESSMENT QUESTIONS

1. In a defined contribution approach to designing a benefit, the following elements are used to define the value of the benefit:
 - a. Employee age when hired
 - b. Employee's personal investment earnings
 - c. Employer contribution
 - d. Employee's expected retirement age
 - e. All of the above
2. The key principles for designing a benefit are:
 - a. Defining maximum limits on benefits and services
 - b. Defining the range of benefits to provide
 - c. Ensuring that members provide a share of cost
 - d. Making cost projections for services to be provided
 - e. All of the above
3. Which of the following circumstances do not favor employer benefits?
 - a. Employer contributions are tax deductible as business expenses
 - b. The benefit represents 30% of payroll
 - c. Employer contributions are not considered income to employees until withdrawn
4. The following statements are false except:
 - a. Utilization benefit designs are directed to adversely selected populations
 - b. Drug price inflation is not a cause for cost-management designs
 - c. OTC medications are included in benefit designs because they are discretionary
 - d. Historically, vision was a rider, but dental and pharmacy were not
5. Traditional indemnity plans differ from card plans in the following ways:
 - a. Both card and indemnity plans require a share of cost contribution
 - b. Card plans reimburse based on negotiated discounts with pharmacies, and indemnity plans reimburse on usual and customary fees
 - c. The shoebox effect is more prominent in indemnity plan designs than in card plans
 - d. All of the above
6. The Summary Plan Description defines:
 - a. The subrogation of benefits requirement
7. The MAC pricing schedule
 - c. The requirements for COB
 - d. None of the above
7. Card plans obey the basic rules of benefit design by:
 - a. Defining benefit limits
 - b. Providing formularies and SPDs to define benefit inclusions, and negotiating discounts with which to predict costs
 - c. Using POS technology
 - d. None of the above
8. Which of the following is not a technique used in cost-management benefit designs?
 - a. Wastage and stocking up
 - b. Drug utilization review
 - c. POS
 - d. Formularies
9. Reinsurance is an available option when:
 - a. Cost management is not a consideration
 - b. Stop loss has already been factored into the risk arrangement
 - c. The primary insurer has assumed risk for the corridor
 - d. B and C
 - e. None of the above
10. Tools used by benefit designers to manage insurable risk are:
 - a. DUR
 - b. P & T Committees
 - c. TQM
 - d. All of the above

The Academy of Managed Care Pharmacy is approved by the American Council on Pharmaceutical Education (ACPE) as a provider of continuing pharmaceutical education. Individuals may obtain up to 1.5 contact hour of credit or .15 Continuing Education Unit (CEU). The Universal Program Number is 233-000-99-006-H04. Certificates will be mailed between four and eight weeks to participants who successfully complete the CE exam and achieve a score of 70% and submit the exam to AMCP prior to December 31, 2000. See text of article beginning on page 525.

CE EXAM

DEMOGRAPHIC INFORMATION *(Not for scoring.)*

11. In what type of setting do you work?
(Leave blank if none of the responses below applies.)
 - a. HMO
 - b. PPO
 - c. Indemnity insurance
 - d. Pharmacy benefits management
 - e. Other
12. Did this program achieve its educational objectives?
 - a. Yes
 - b. No
13. How many minutes did it take you to complete this program, including the quiz? *(Fill in on answer sheet.)*
14. Did this program provide insights relevant or practical for you or your work?
 - a. Yes
 - b. No
15. Please rate the quality of this CE article.
 - a. Excellent
 - b. Good
 - c. Fair
 - d. Poor

INSTRUCTIONS

This test affords 1.5 hours (.15 CEUs) of continuing pharmaceutical education in all states that recognize the American Council on Pharmaceutical Education. To receive credit, you must score at least 70% of your test answers correctly. To record an answer, darken the appropriate block below. Mail your completed answer sheet to: Academy of Managed Care Pharmacy, 100 N. Pitt Street, Suite 400, Alexandria, VA 22314. Assuming a score of 70% or more, a certificate of achievement will be mailed to you within six to eight weeks. If you fail to achieve 70% on your first try, you will be allowed only one retake. The ACPE Provider Number for this lesson is 233-000-99-006-H04. This offer of continuing education credits expires December 31, 2000.

	A	B	C	D	E
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐		
4.	☐	☐	☐	☐	
5.	☐	☐	☐	☐	

	A	B	C	D	E
6.	☐	☐	☐	☐	
7.	☐	☐	☐	☐	
8.	☐	☐	☐	☐	
9.	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	

11. ☐A ☐B ☐C ☐D ☐E
12. ☐Yes ☐No
13. Minutes _____
14. ☐Yes ☐No
15. ☐A ☐B ☐C ☐D

Participant Identification: Please type or print

Date: _____

Social Security #: _____

For Identification Purposes Only

Work Phone #: _____

Name: _____
LAST FIRST MIDDLE

Company: _____

Address: _____
STREET (with Apt. No.) or P.O. Box CITY STATE ZIP

State & Lic. No.: _____
STATE LICENSE NO.

Member Type: ☐ Active ☐ Supporting Associate ☐ Student ☐ Nonmember

Signature: _____

I verify by my signature above that I have completed this examination independently.