



Continuing Education



Managing the pharmacy benefit

Learning Objectives

Describe strategies used to manage the pharmacy benefit.

Describe the role of drug utilization evaluation in managing the pharmacy benefit.

Describe the roles of physicians and pharmacists in managing the pharmacy benefit.

Describe how pharmacy benefit management companies operate.

List the types of services offered by pharmacy benefit management companies.

This second article in a three-part series discusses different aspects of managing the pharmacy benefit. Topics include cost-control strategies, drug utilization evaluation, the roles of physicians and pharmacists, and pharmacy benefit management companies.

Norman V. Carroll, Ph.D., professor of pharmacy administration, department of pharmacy, Medical College of Virginia, Virginia Commonwealth University, Richmond; and David A. Sclar, B.Pharm., Ph.D., professor of health policy and administration, director, pharmacoconomics and pharmacoepidemiology research unit, College of Pharmacy, Washington State University, Pullman, served as consultants for this article for the Certified Medical Representatives Institute Inc.

Managed care organizations and hospitals must balance cost control with providing high-quality care. Managed care plans, in particular, use aggressive methods to control the cost, utilization and quality of pharmaceutical products. These strategies include restrictive formularies, prior authorization, generic substitution, therapeutic interchange and drug utilization evaluations.

Restrictive formularies. These formularies restrict their member physicians and pharmacists to prescribing and dispensing only those drugs that are included on the formulary. There are varying degrees of formulary restriction, and managed care administrators use several means to encourage compliance.

Prior authorization. When prior authorization is required, pharmacies must obtain explicit and individual approval before dispensing drugs that are not on the formulary. Prior authorization is usually used to control the use of very expensive products or products that are associated with high risk to patients.

Generic substitution. Generic substitution occurs when the pharmacist dispenses a product that is chemically the same as the one prescribed but is

manufactured or distributed by another company. A generic formulation typically has a lower acquisition cost than either the brand-name formulation or a brand-name medication that has no generic; this enables MCOs to reduce their expenditures for pharmaceuticals. However, one study linked the use of generic drugs to higher utilization of other healthcare resources and higher overall patient costs. Even so, less than half of all prescriptions today are filled with brand-name products.

Therapeutic interchange. Within the context of the formulary, therapeutic interchange (also referred to as therapeutic substitution) allows the pharmacist to substitute drug products that are deemed therapeutically equivalent, although not chemically equivalent. This usually requires the physician's explicit approval. The most popular classes of drug therapy for therapeutic interchange are analgesics, antibiotics, antihistamines, anti-inflammatory agents, antiulceratives and oral contraceptives. The decision to allow therapeutic interchange is usually made by the pharmacy and therapeutics (P&T) committee.

The use of therapeutic interchange in managed care settings has been criticized. Patients in the

RECEIVE CREDIT AND RECOGNITION

Continuing Education in Pharmaceutical Representative aims to provide reps with information to help them meet the needs of the people they serve and to contribute to reps' personal and professional development. Every third issue includes a self-assessment quiz covering the previous three Continuing Education articles. The quiz for this article appears in the March issue. Reps who correctly complete the quiz and return it to the CMR Institute with a nominal handling fee will receive a completion recognition form showing that they have successfully completed the three-part educational series and earned .25 CEU (2.5 contact hours). The CMR Institute also will send a letter of recognition to reps' managers upon completion of a quarterly series. A Certificate of Achievement will be awarded to any representative who successfully completes four quizzes or has obtained 1.0 CEU.

Note: The Continuing Education quizzes are not part of CMR Institute's certification program and do not count as credits toward the CMR® designation.

About the CMR Institute:

The Certified Medical Representatives Institute is an independent non-profit educational organization established in 1966 to provide a source of professional development and certification for pharmaceutical representatives. The Institute provides an up-to-date, approved continuing education curriculum designed to expand and enhance internal company training and development in a cost-effective manner. The curriculum concentrates on providing a general knowledge base and avoids such areas as selling skills and specific product education.

© 2006 The Certified Medical Representatives Institute Inc., Roanoke, VA 24014. All rights reserved. No part of this article may be reproduced by any method or in any form without written permission from the CMR Institute. Reprints of this article are available from the CMR Institute. Request Continuing Education article FP-2.

Pharmacy benefit design

MCOs have considerable flexibility in determining the specific features of their pharmacy benefit programs. The pharmacy benefit design of an intensively managed health plan usually includes:

- A drug formulary.
- A preferred pharmacy network (or in-house pharmacies).
- Provider financial risk-sharing.
- Member cost-sharing.
- Coverage for Food and Drug Administration or compendium-approved indications only.
- Prescription volume limitations.

ambulatory setting are not as closely monitored, which may increase the risk of interchange-related problems resulting in patient harm. There have been successful lawsuits that have allowed patients to receive the medication they were taking before therapeutic substitution. Formularies operated by MCOs may raise ethical conflicts when they provide physicians and pharmacists with financial incentives to make therapeutic interchanges.

Drug utilization evaluation

One of the most important mechanisms healthcare organizations use to monitor compliance with the formulary is drug utilization evaluation (DUE), also known as drug utilization review. DUE is an authorized, criteria-based, formal program for improving the quality of drug use within a healthcare organization. The DUE process balances the influence of cost-containment measures against decisions involving appropriate drug therapy for patients (quality of care). DUEs are usually conducted in-house by a special committee (often the P&T committee).

DUE is most often applied for:

- High-cost drugs.
- Drugs with a high potential for abuse.
- High-risk drugs.
- Highly prescribed drugs (such as antibiotics).

DUEs can form the basis for adding, deleting or restricting the use of drugs on formulary. For example, DUEs can help compare the therapeutic advantages of one product with those of another. Those drugs offering few or no therapeutic advantages may then be removed from the formulary. DUEs can also be used to assess the adverse effect profiles of different products on the formulary for comparison with drugs being considered for formulary inclusion.

The DUE process can have a significant impact on a healthcare representative's relationships with physicians and pharmacists. Healthcare representa-

tives should be sensitive to the fact that most physicians they call on – particularly those who work in health maintenance organizations – will have their drug utilization monitored to some extent. It is important for healthcare representatives to realize that appropriate drug use within formulary guidelines or clinical practice guidelines is becoming more important to their success. Pharmacists also play a key role in DUEs, particularly in maintaining computerized pharmacy databases on drug use patterns.

Trends in the use of DUE suggest that MCOs may attempt to manage drug prescribing prior to treatment through methods such as:

- Drug-prescribing protocols (starter or trial-dose protocols for certain high-cost drugs that control the use of these agents by mandating that physicians try less expensive alternatives first).
- Prescribing restrictions (limiting the use of a drug to a particular medical or surgical specialty or requiring prior authorization before it can be ordered by other physicians).

Role of physicians and pharmacists

Without the participation of physicians and pharmacists in prescribing only formulary-approved drugs, the work of the P&T committee may be undone.

Managed care plans commonly use clinical practice guidelines – often developed by the P&T committee – to improve the quality of drug therapy while minimizing unnecessary expenditures. Clinical practice guidelines are road maps for physicians that include all aspects of care (such as drug therapy, surgery and follow-up treatments) based on disease severity, stage of disease and various patient characteristics. Thus, when selecting drugs for inclusion on the formulary, P&T committees may consider whether or not these drugs are included in practice guidelines, what outcomes are associated with their use and how their use may reduce the overall costs of patient management.

Physicians interact with the pharmacy benefit in several other ways:

Electronic prescribing. Computers and personal digital assistants are being used by many physicians and MCOs, giving them direct access to drug formularies, patient drug histories, drug interaction screens and allergy screens. Physicians can also use this technology to enter prescriptions, order lab tests, monitor test results and write specialist referrals.

Input to the P&T committee. In hospitals and other institutional settings, physician and pharmacist members of the P&T committee are selected from the organization's medical and pharmacy staffs. However, in many MCOs, formularies are developed with little input from the healthcare professionals who will be subject to them. Physicians and pharmacists will therefore be much less likely to comply with such formularies.

Advocacy. If physicians are convinced that a nonformulary product has substantial clinical or economic benefits over other alternatives, they may become key advocates for that product, often forwarding written requests to P&T committee members regarding the addition of the product to the organization's formulary.

The pharmacy department has a great deal of influence on the drugs included on a formulary and prescribed by physicians. It provides critical support for the P&T committee by maintaining the formulary, educating physicians on the benefits of using particular therapies, and preparing monographs on drugs and educational newsletters for the medical staff. It also provides drug information services that can have a positive impact on physician prescribing and medical outcomes.

Pharmacy benefit management companies

Although prescription drugs represent only about 11% of the national healthcare dollar, methods for reducing pharmacy costs have received much attention, particularly in MCOs. Many MCOs have "carved out" the pharmacy benefit and contracted with pharmacy benefit management companies

(PBMs) to administer some or all aspects of the pharmacy benefit. Many MCOs turn over these administrative tasks to PBMs because it frees their personnel to concentrate on other areas and because PBMs have stated that they can reduce pharmacy expenditures.

PBMs contract with customers (payers) – including employers, MCOs, government programs and insurance companies – to provide cost-effective, accessible and high-quality drug benefits to the members of the payers. Membership is usually referred to in terms of the number of covered lives. PBMs use this measure for promotional purposes as they compete with each other for payer contracts.

PBM contracts can be based on capitation. The payer limits its financial risk by paying the PBM a specified amount per member per unit of time. The PBM must provide all contracted services for that fixed amount or lose money. However, most PBMs are still paid on a fee-for-service basis. PBMs can be direct providers of these services; they may also subcontract with other businesses.

Physicians who contract with MCOs may also be asked to share in the financial risk by receiving capitated payments (a set amount per plan member per month) from the MCO for their professional services, regardless of the actual number or types of services required by plan members.

The main issues that concern health plans with regard to pharmacy capitation are formulary management and the question of who should receive rebates. Whoever controls product selection and drug utilization can demand and receive rebates and discounts from pharmaceutical manufacturers. Rebates used to be an unexpected additional source of revenue for both health plans and PBMs. Today, rebates are an integral part of the revenue anticipated by these healthcare organizations. Without rebates, many health plans would shift greater financial risk to providers of care.

PBM services

The following types of services are offered by PBMs. They may vary from organization to organization depending on the contract negotiated.

Establishing pharmacy networks. PBMs establish agreements with pharmacies so they can offer payers a network of pharmacies geographically accessible to the payers' members. In exchange, the pharmacies agree to the PBMs' reimbursement formula.

Claims processing. PBMs can link networks of pharmacies to a processor for point-of-service evaluation of prescription drug claims. Information about member eligibility, benefit coverage and drug pricing is transmitted electronically or on paper from the PBM to the pharmacy.

Report generation. PBMs use compiled claims data to prepare a variety of routine and customized reports that enable their customers to evaluate many aspects of drug utilization and cost.

Generic substitution. PBMs can offer options

Article Summary

- **Hospitals and managed care organizations use various strategies to control the cost, utilization and quality of pharmaceutical products.**
 - These strategies include restrictive formularies, prior authorization, generic substitution, therapeutic interchange and drug utilization evaluations.
- **One of the most important mechanisms healthcare organizations use to monitor compliance with the formulary is drug utilization evaluation.**
 - DUEs can form the basis for adding, deleting or restricting the use of drugs on formulary.
 - The DUE process can have a significant impact on a healthcare representative's relationships with physicians and pharmacists.
- **Without the participation of physicians and pharmacists in prescribing only formulary-approved drugs, the work of the P&T committee may be undone.**
 - Managed care plans commonly use clinical practice guidelines.
 - Physicians interact with the pharmacy benefit in several ways, including electronic prescribing, input to the P&T committee and advocacy.
 - The pharmacy department has a great deal of influence on the drugs included on a formulary and prescribed by physicians.
- **Many MCOs contract with pharmacy benefit management companies to administer some or all aspects of the pharmacy benefit.**
 - PBMs contract with customers (payers) to provide cost-effective, accessible and high-quality drug benefits to the members of the payers.
- **PBMs offer payers numerous services, which can vary among organizations.**

that encourage the use of generic products (for example, by offering higher reimbursement rates for high generic-to-brand-name ratios).

Formulary development and management. PBMs may incorporate a plan's existing formulary into the pharmacy benefit program, assist health plans in customizing their own individualized formulary or provide a pre-established national formulary.

Academic detailing. Also known as counterdetailing, this refers to the use of educational interventions – such as one-on-one sessions, telephone calls or newsletters – to promote formulary guidelines to specific prescribers.

Maintenance drug programs and mail-order businesses. PBMs have developed programs for providing maintenance medications to patients more efficiently. In addition, PBMs channel prescriptions to mail-order pharmacies because their costs are lower than community pharmacies'.

Pharmaceutical manufacturer rebates. PBMs often try to negotiate rebates from pharmaceutical manufacturers in return for delivering a certain volume of product or achieving a targeted market share of a product within its therapeutic category.

Drug utilization evaluation. Clinically trained pharmacists employed by PBMs establish DUE criteria and standards, analyze the data obtained, transform the data into useful information, and communicate the results to providers, health plans and others.

Disease management programs and outcomes assessments. Disease management programs range from newsletters on optimal management of a specific disease to comprehensive, complex programs. Many PBMs are forming alliances with MCOs, pharmaceutical manufacturers, computer analysis experts and other players to develop integrated databases for disease management and outcomes assessment.

The next article will focus on the role of the healthcare representative in managing the pharmacy benefit.