8 Health Plans for Specialty Services

Objectives

After completing this module, you will be able to:

- explain how a health plan might carve out the delivery of specialty services,
- distinguish between the three main types of dental plans,
- describe the four basic strategies that managed behavioral health organizations (MBHOs) use to manage the delivery of behavioral healthcare services, and
- list some of the services offered by a pharmacy benefit management (PBM) plan.

In the past managed care plans focused on basic medical care—physician and hospital services. But today consumers want other health services, such as dental care, vision care, behavioral (mental) healthcare, and prescription drugs, to be included in their health plans, and employers have responded by offering benefits for these specialty services.

Specialty services are healthcare services that are generally considered outside standard medical-surgical services because of the specialized knowledge required for service delivery and management. Specialty services often involve different types of providers and delivery systems than standard medical services. Specialty services may include:

- dental care
- vision care
- behavioral healthcare
- prescription drugs
- chiropractics
- other forms of complementary and alternative medicine such as acupuncture and naturopathy
- rehabilitation services
- chronic disease care
- home healthcare
- cardiac surgery
- oncology services
- certain diagnostic services, such as radiology and magnetic resonance imaging

Managed care approaches for many specialty services are still in a developmental stage. For others, health plans have found that the application of focused management techniques can yield cost savings and promote quality care. Employers and health plans have two options for arranging and managing the delivery of specialty services:
• They can develop and maintain their own programs.
• They can carve out the delivery and management of these services.

The term **carve-out** carries several different meanings in the healthcare industry. In a general sense, a carve-out refers to the separation of a medical service (or a group of services) from the basic set of benefits in some way. The separation may be either through a different compensation method for providers or through the use of a separate network or delivery system. For example, a health plan might carve out its HIV/AIDS disease management services from its other medical services by contracting with an external company to develop and manage the program. The health plan, however, still retains accountability for the HIV/AIDS services. This type of carve-out is the one that is relevant to our discussion of specialty services.

In this module we will discuss the use of carve-outs as a means of delivering specialty services. We will then provide a more detailed discussion of three specialty services that are frequently carved out of the basic set of benefits: dental care, behavioral healthcare, and prescription drug benefits.

**Carve-Outs**

**Carve-Outs Emerge**

As costs in all areas of healthcare increased in the late 1970s and early 1980s, some health plans began exploring ways of applying managed care techniques to specialty services. These pioneering organizations found that within certain specialties, the application of focused management techniques seemed to yield cost savings.

Independent organizations, whose primary purpose was to deliver a particular specialty service, also began to apply managed care techniques to manage those services. In some instances these independent organizations were able to deliver specialty services more affordably and more effectively than health plans. As a result, many health plans began to contract with these independent organizations to deliver such services.

Health plans often carve out specialty services that have one or more of the following characteristics:

• an easily defined benefit,
• a defined patient population,
• high or rising costs, and/or
• inappropriate utilization.

**Comprehensive Carve-Out Arrangements**

In a **comprehensive carve-out arrangement**, a health plan transfers to the carve-out organization the authority to conduct all the activities necessary to deliver and manage the specialty service. Such activities may include network management, quality management, utilization review, case management, and claims administration. In a
**Partial carve-out arrangement**, the health plan retains the management of selected activities.

Compensation for comprehensive carve-outs in mature health plan markets is typically on a capitation basis. In less mature markets, in partial carve-outs, and for services that do not have well-defined patterns of utilization, compensation is often based on fee-for-service or a fee plus a percentage of savings.

Although many carve-out arrangements have produced favorable outcomes for members, providers, and health plans, there is some concern that healthcare may become too fragmented with numerous carve-out arrangements. Additionally, state legislation may affect the way health plans manage and deliver specialty services. For example, laws in some states mandate that HMOs arrange and manage the delivery of certain specialty services to retain their HMO licenses. Similarly, state consumer protection laws may seek to ensure that health plan members receive integrated, quality care. These concerns have prompted some HMOs and other health plans to roll previously carved-out services back into the basic bundle of services they deliver to their members.

**Specialty HMOs**

Some states provide for the formation of specialty health maintenance organizations for specialty services. A *specialty health maintenance organization (specialty HMO)* is an organization that uses an HMO model to provide healthcare services to a subset or single specialty of medical care. Typical specialty HMOs include dental HMOs, vision HMOs, and behavioral health HMOs. Although they are based on an HMO model, specialty HMOs may differ greatly in structure and operations from basic medical HMOs. In states which specify a broad range of services that must be provided by a licensed HMO, specialty HMOs are not an option. In those states, managed specialty service organizations do exist, but not in the legal form of a specialty HMO.

**Dental Care**

The term *managed dental care* was once synonymous with dental HMOs, and later it was used to refer to other network-based plans as well. Today virtually any plan that includes some level of oversight of provider fees, utilization, quality of care, and other such matters could be considered managed dental care.¹

Managed dental care has grown, as more employers have sponsored dental benefits and as those benefits have been increasingly provided by health plans. A large majority (93 percent in 2008) of very large employers (500 or more employees) offer dental coverage,² and a majority (56.6 percent in 2007) of Americans have dental coverage.³ And a large and growing majority of this coverage is managed care (see table).

**Dental Plan Enrollees by Plan Type**⁴

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<th>Plan Type</th>
<th>2001</th>
<th>2008</th>
<th>Percentage Change 2008 vs. 2001*</th>
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<tr>
<td>Indemnity</td>
<td>38%</td>
<td>14%</td>
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One reason for the growth in managed dental care is an increased willingness of dentists to affiliate with health plans. The costs of maintaining a dental practice have risen steadily, and an oversupply of dentists in some areas has made it difficult for dentists to acquire or retain market share, making participation in health plans attractive. Another cause of this growth is that managed plans are generally less costly to purchasers than traditional indemnity plans.

The three main types of managed dental plans are dental health maintenance organizations (DHMOs), dental preferred provider organizations (dental PPOs), and dental point-of-service (dental POS) options.

**Dental Health Maintenance Organizations**

A dental health maintenance organization (DHMO) (also known as a capitated plan) has the following characteristics:

- Members must see a network dentist, except for emergencies and in some cases specialty services when network specialists are unavailable.

- Dentists are usually paid on a capitation basis, meaning that they assume the majority of financial risk for providing all necessary services in exchange for a guaranteed cash flow.

- Members pay a small portion of costs by making copayments based on a schedule. There are usually no annual deductibles, coinsurance, or yearly maximums. Copayments are not charged for diagnostic and preventive services, which are fully covered by the dentist’s capitation payment.

DHMOs almost always have the smallest network, lowest cost, least amount of choice, and greatest restrictions when compared to the other types of dental plans.

Many dentists are reluctant to join DHMOs because of the low reimbursement and financial risk. Plan administrators have taken measures to enlarge DHMO networks by providing supplemental payments to dentists for certain procedures, guaranteeing them a minimum income per member, or reducing their financial risk or increasing their compensation in other ways.

As the table above shows, DHMOs make up a small portion of the market, and this share has been declining. In fact, for many years industry experts have been predicting their demise. But this has not happened, because DHMOs serve a need. They have a small but loyal following among individuals who are dentally needy and/or very price-sensitive and willing to trade freedom of choice and a large network for low cost.

### Health Plans for Specialty Services

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<th>PPO</th>
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<td>39%</td>
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<td>66%</td>
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**Dental Preferred Provider Organizations**
A dental preferred provider organization (dental PPO) has the following attributes:

- Members can see the dentist of their choice—they do have to use a network dentist. However, they generally pay less if they stay in network. It is common for a PPO to have a lower deductible, lower coinsurance, and a higher annual maximum for in-network care. Or a plan may require a member who visits an out-of-network dentist to pay the difference between that dentist’s fees and an in-network dentist’s discounted fees.

- Dentist reimbursement is commonly based on a fee schedule (discounted fee-for-service). Affiliated dentists also agree to other requirements and administrative oversight provisions, such as maintaining an active license to practice, having a minimum level of liability insurance, and cooperating with audits, quality assessment, utilization management, dispute resolution, and others.

- Members pay an annual deductible and coinsurance. The deductible is generally $25 to $75 for an individual and $75 to $150 for a family. The coinsurance percentage members pay is typically 20 percent for basic services such as fillings and 50 percent for major services such as crowns. There is no deductible or coinsurance for diagnostic and preventive services. There is usually also an annual maximum benefit, generally $1,000 to $2,500.

**Point-of-Service (POS) Option**

Definitions of a point-of-service (POS) option vary. For our purposes, we define a POS program as any that involves a combination of networks, where members can choose any dentist (including out-of-network) and the benefit level and provider reimbursement vary accordingly. The most distinguishing feature of POS plans is that members do not have to choose any particular dentist or network during annual open enrollment—they are free to switch at will, depending on their needs and preferences, with the benefit available being determined at the point of service. Usually a member who goes out of network incurs higher out-of-pocket costs. The most common POS program in dental benefits involves combinations of PPOs and DHMOs.

**Behavioral Healthcare**

The treatment of mental disorders and substance abuse is known as behavioral healthcare. Such problems are widespread in the U.S. population—in a given year about one quarter of adults are diagnosable for one or more disorder, and about 6 percent suffer from a seriously debilitating mental illness. And the incidence among young people is even higher—nearly half of teenagers have had some sort of mental disorder or substance abuse problem during their lives, and about one in five have had a serious mental illness. Because of the high frequency of these conditions, their treatment is a major component of the healthcare system. In 2008 13.4 percent of adults in the United States received some form of behavioral healthcare.5

**Controlling Behavioral Healthcare Costs—Initial Strategies**
Decades ago behavioral healthcare represented a very small percentage of healthcare spending. But beginning in the early 1980s, the demand for services rose. This was caused by increases in people’s awareness of mental health and substance abuse problems, in the social acceptability of treatment, in the availability of behavioral health services, and perhaps also in the stress on individuals and families.

As a result of this rising demand, behavioral healthcare costs to health plans and sponsoring employers soared. To control costs and limit their financial liability, plans sought to reduce the utilization of inappropriate or unnecessary services. But existing utilization management strategies were not designed for the complexities of behavioral healthcare and were not effective.

So plans turned to special cost-sharing, benefit limits, and exclusions for behavioral healthcare. Some plans charged higher deductibles or coinsurance for behavioral care than for medical care. Some limited the number of outpatient visits and inpatient care days covered each year and placed annual and lifetime dollar caps on behavioral care benefits. Some excluded or limited coverage of certain illnesses (such as chronic illnesses, organic psychoses, and personality disorders); services (inpatient psychiatric services, long-term outpatient treatment, and marital counseling); and populations (geriatric patients, patients with developmental disabilities, substance abusers). Ultimately, these strategies did little to reduce costs, and in some cases they limited access to necessary and appropriate care. They also led to mental health parity legislation, which restricts a plan’s ability to impose special cost-sharing and limitations on behavioral healthcare, as discussed below.

Second Generation Strategies

A managed behavioral health organization (MBHO) provides behavioral healthcare services and implements health plan techniques. MBHOs emerged in the 1980s, and health plans and employers turned to them for access to care and cost management. MBHOs’ specialized knowledge and experience in behavioral healthcare enable them to determine which services were necessary and appropriate for particular patients and to deliver the types of services that led to better outcomes. MBHOs use four basic strategies to manage the delivery of services: alternative treatment levels, alternative treatment settings, alternative treatment methods, and crisis intervention. MBHOs have also developed mechanisms to help match these services with patients’ needs.

Alternative Treatment Levels

People with behavioral disorders have a wide range of care needs. There are a large number of disorders, and the severity of a particular disorder can vary dramatically among different patients and in the same patient over time. Many patients suffer multiple disorders. To meet these varied needs, MBHOs cover the following levels of care:

- **Acute care** is for those who need continuous, intensive, individualized care, often in conjunction with medical care. This is the most secure and restrictive level of care.

- **Post-acute care** is for those who need continuous monitoring in a safe, structured environment but not acute care.
• **Partial hospitalization** is for those who need substantial care and supervision but not 24-hour monitoring. Patients in partial hospitalization programs typically spend part of the day or week in a facility and part outside working or attending school. Many programs are designed to treat substance abuse.

• **Intensive outpatient care** is for those who need extensive individual or group therapy but not continuous care and supervision in a confined setting. Such patients may attend therapy sessions for several hours per day, several days per week.

• **Outpatient care** is for those who need less frequent therapy (once or twice a week or once a month) and shorter sessions (typically one hour or less) compared to intensive outpatient care. Outpatient care is the least intensive and restrictive level of care.

The level of care a patient receives typically depends on the risk to himself, others, and property; his ability to function effectively at home or in the community; and his medical needs.

*Alternative Treatment Settings*

Behavioral healthcare can be delivered effectively in a variety of settings. Acute care is typically provided in psychiatric hospitals, psychiatric units of general hospitals, or hospital observation units. These facilities are equipped to address the needs of patients who pose a significant risk to themselves or others, are unable to function without assistance or supervision, or have suffered acute episodes such as drug overdoses. Post-acute care is most often provided in subacute care facilities. Partial hospitalization programs are typically in psychiatric hospitals, rehabilitation hospitals, or halfway houses. Outpatient care takes place in the offices of therapists and mental health clinics.

*Alternative Treatment Methods*

Behavioral healthcare involves a variety of approaches. These include drug therapy, psychotherapy, and counseling, sometimes in combination. Psychotherapy may be brief and goal-oriented or last a long time, and it may be administered individually or to groups. Methods used with children and adolescents often differ from those for adults.

There is also a variety of care providers. In some cases services are provided by psychologists, psychiatric nurses, licensed clinical social workers (LCSWs), or marriage, family, and child counselors (MFCCs). In other cases care is provided by psychiatrists, who can prescribe medications as well as conduct psychotherapy and counseling.

*Crisis Intervention*

One of the key elements of behavioral healthcare is **crisis intervention**—the intensive treatment of acute episodes of a mental disorder. The purpose is to keep the patient safe and to stabilize his condition so that he can begin psychotherapy or other treatment. Appropriate treatment in the acute phase of a behavioral health disorder helps reduce the likelihood of recurrent acute episodes.

**Directing Patients to Appropriate Care**
Assessing members’ behavioral healthcare needs and providing quality services to meet those needs are important aspects of managed behavioral care. Directing members to the most appropriate services in order to manage costs and utilization is also important. In many health plans and MBHOs members can access behavioral healthcare services directly, but in others they must go through a gatekeeper or referral process. Three common approaches are primary care providers (PCPs), centralized referral systems, and employee assistance programs.

PCPs as Gatekeepers

In the past some plans required members to access behavioral healthcare services through a primary care provider. The PCP assessed a member’s needs, gave her a referral to a behavioral healthcare specialist, and sometimes authorized payment for services. But this has become much less common. Although incorporating behavioral healthcare into primary care promotes coordination and continuity of care and supports utilization management, PCPs often lack the knowledge and experience needed to diagnose behavioral problems and determine whether services are needed and if so what kind.

Centralized Referral Systems

Some health plans and MBHOs have a centralized behavioral healthcare referral system. Members call and talk to a mental health/substance abuse case manager, who conducts an initial assessment and refers the member to the appropriate provider for treatment or a more detailed evaluation. Today such systems are much more common than PCP gatekeepers, as they offer quicker access to care and often a more accurate diagnosis, more effective treatment, and more efficient use of resources (although they may decrease coordination and continuity of care).

Employee Assistance Programs

Another way people can be directed to appropriate behavioral healthcare services is through employee assistance programs (EAPs) established by employers or MBHOs. EAPs are frequently the first point of contact for employees and family members in need of information or assistance regarding behavioral problems. EAP professionals generally encounter behavioral problems early and can direct plan members to providers and services before a problem turns into a crisis. But unlike PCPs or case managers, EAP professionals may not have the background necessary to diagnose behavioral disorders and may lack experience with managed behavioral health programs.

Other Strategies

MBHOs and health plans manage quality and cost in other ways as well. They develop clinical practice guidelines—recommendations for providers on the best treatment approaches (discussed in detail in a later module)—which improve patient outcomes and reduce the use of inappropriate services. In many cases they direct members to effective outpatient services instead of unnecessary and more costly inpatient care. They negotiate with providers for reduced fees and greater acceptance of practice guidelines in exchange for increased patient volume. More recently, they have focused on the development of alternative treatment options, the incorporation of community-based
resources into the healthcare system, case management, and the better integration of behavioral care and primary care.

In recent years there has been an increased focus on long-term outcomes. For instance, it has been found that in some cases higher-cost drugs result in lower overall costs because of fewer office visits and hospitalizations and greater patient acceptance and compliance. Another example: In some cases (especially in substance abuse) increasing coverage for follow-up treatment can reduce relapses, resulting in lower long-term costs.

**Mental Health Parity**

An important issue in behavioral healthcare is mental health parity—equivalent coverage of behavioral healthcare and medical care. As we have seen, to limit their liability in the face of rapidly rising costs, some health plans provided more limited benefits for behavioral care than for medical care, and many mental health advocates contended that this was unfair. In response, Congress enacted the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Neither MHPA nor MHPAEA requires health plans to cover behavioral healthcare, but if a group plan with more than 50 members does cover it, the plan must comply with certain parity rules. MHPA requires that lifetime and annual dollar caps on benefits for behavioral care not be lower than for medical care. MHPAEA continues this requirement and adds the following:

- Cost-sharing and out-of-pocket limits for behavioral care cannot be greater than for medical care.
- Limitations on behavioral coverage (such as on the number of visits or the frequency or duration of treatment) can be no more restrictive than for medical care. Nonquantitative limitations, such as medical management and preauthorization, also cannot be more restrictive.
- If a health plan pays benefits for out-of-network medical care it must do so for behavioral care as well.
- MHPAEA extends these rules (including those of MHPA on lifetime and annual caps) to substance abuse treatment (which was not covered by MHPA).

It should be emphasized that MHPA and MHPAEA do not require a health plan to provide behavioral healthcare benefits, but if a plan does so it must comply with the above rules. Both laws do not apply to individual policies or group plans with 50 or fewer members. They do apply both to insurers and to employers with self-insured (self-funded) plans (with some exemptions). Finally, it should be noted that some states have mental health parity laws that go beyond this federal legislation.

**Pharmacy Benefit Plans**

Prescription drugs account for a substantial portion of all U.S. healthcare spending—in 2009 more than 3.6 billion prescriptions were filled, at a cost of over $200 billion, more
than 10 percent of all healthcare expenditures.\textsuperscript{7} And drug costs have generally risen at an even faster rate than overall medical costs. This has prompted employers and health plans to focus on managing the cost and utilization of pharmaceuticals.\textsuperscript{8}

But drugs also play a role in the quality of healthcare. For example, a significant portion of hospital admissions of people 65 and older result from the inappropriate use of prescription drugs, and this often occurs because several healthcare providers are treating the same patient and prescribing drugs for her without knowledge of her other prescriptions, leading to harmful drug interactions. This problem can be addressed by tracking and coordinating members’ drug use.

**The Pharmacy Benefit Management (PBM) Plan**

In response to rising costs and quality of care issues, pharmacy benefit management plans emerged. A pharmacy benefit management (PBM) plan (also know as a prescription benefit management plan) is a specialty health plan designed to contain the costs of prescription drugs while promoting more efficient and safer use of them. The great majority of health plans contract with PBMs. PBMs use various managed care cost-control techniques, and they promote quality in a number of ways. For instance, a PBM may screen for drug interactions, using integrated data systems that provide a link among the provider, the health plan, and the pharmacy network. A PBM may promote quality in prescribing among providers through feedback and reporting.

**Clinical Services Offered by PBMs**

Pharmacy benefit management plans typically interact with physicians and pharmacists in performing four types of clinical services: physician profiling, drug utilization review, formulary management, and prior authorization. These services are not unique to PBMs; they may also be performed by health plans, hospitals, retail pharmacies, or other specialty organizations.

*Physician Profiling*

**Physician profiling** consists of compiling data on physicians’ prescribing patterns and comparing the actual prescribing patterns of individual doctors for select drug categories to those of most doctors. Peer comparison is typically based on medical specialty and region. The PBM then seeks to educate doctors whose patterns differ from the norm, reviewing with them the appropriateness and cost of their prescribing patterns through mailings, telephone calls, and face-to-face visits.

*Drug Utilization Review*

**Drug utilization review (DUR)** is a program that evaluates whether drugs are being used safely, effectively, and appropriately. DUR is an important component of quality management programs because it promotes patient safety by identifying potential and actual problems related to the ordering, dispensing, administration, and use of drugs. Drug utilization review programs identify problems with:

- inappropriate dosage,
- overuse identified from early refills,
- underuse identified through late refills,
• the length of time a medication is taken,
• duplication,
• side effects, and
• drug interactions.

PBMs monitor an individual patient’s drug problems through prospective (before drug therapy), concurrent (during drug therapy), or retrospective (after dispensing or post-drug therapy) review. Patient-specific DUR is typically used to identify the following potential problems:

• drug-disease conflicts,
• drug-drug interactions,
• chronic overutilization,
• underutilization (noncompliance),
• drug-sex and drug-age conflicts, and
• drug-pregnancy contraindications.

Computerized systems at the point of dispensing play an important role in reducing the incidence of these problems. Following up with physician and patient education programs is an integral component of DUR.

Formulary Management

A formulary is a listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by a health plan’s providers in prescribing medications. The formulary is usually developed by an independent panel comprised of physicians, pharmacists, and other clinical experts.

Formularies can be either closed or open. In a closed formulary only those drugs on the preferred list are covered by the health plan. In an open formulary drugs not on the preferred list are covered, but the plan member usually pays more in cost-sharing for them (as discussed below). Open formularies are more common today.

Copayment amounts are often based in part on formularies. Two common approaches are two-tier and three-tier copayment structures. A two-tier structure requires that a member pay one copayment amount for a generic drug and a higher copayment amount for a brand-name drug. A three-tier structure requires a member to pay one copayment amount for a generic drug, a higher amount for a brand-name drug included on the health plan’s formulary, and an even higher amount for a nonformulary drug.

Formularies are often a key program that a PBM or health plan uses to negotiate for rebates from drug manufacturers. A rebate is a reduction in the price of a particular pharmaceutical obtained from the manufacturer. Most PBMs enter into discount rebate agreements with pharmaceutical manufacturers, under which the PBM receives a rebate on the price of a drug and in exchange the manufacturer has fewer restrictions on getting its drug into the PBM’s formulary than companies without such an agreement.
However, the PBM’s formulary panel must be careful to ensure the quality of the pharmaceuticals that it endorses by including in the formulary the safest, most medically effective, and cost-effective drugs.

Most PBMs use their formulary to perform generic and therapeutic substitution. **Generic substitution** is the dispensing of a generic equivalent; **therapeutic substitution** is the dispensing of a different chemical entity within the same drug class. Generic substitution can be performed without physician approval in most cases, but therapeutic substitution always requires physician approval. Many PBMs use benefit design (such as copayment differentials) to encourage both therapeutic and generic substitution.

*Prior Authorization*

**Prior authorization**, sometimes known as a medical necessity review, is a program that requires physicians to obtain certification of medical necessity before prescribing a drug. Many PBMs have established protocols for physicians to receive prior authorization over the telephone, using a semi-automated system. In some of these programs, the physician is prompted through a series of interactive menus requesting clinical and patient information. At the end of the telephone menus, the physician is either given a prior authorization number or connected to a pharmacist, who asks further questions.

*Other Services Offered by PBMs*

PBMs also offer a number of services to members, providers, and health plans that can control costs and improve convenience.

*Mail-Order Pharmacies*

In a **mail-order pharmacy program** drugs are ordered and delivered through the mail to members at a reduced cost. Some PBMs operate their own mail-order pharmacy services, while others contract with outside vendors. PBMs that operate their own program generally negotiate a high-volume purchase contract with each drug manufacturer and pass the cost savings on to their clients. PBMs that contract this operation out usually negotiate a discounted rate with the vendor based on the size of the pharmacy network. This discounted rate is applied to all drugs that are covered under the PBM’s mail-order contract with the vendor.

*Card Services*

PBMs may also use **pharmaceutical card services** to facilitate the processing and tracking of pharmaceutical claims. Pharmaceutical cards, also known as drug cards or prescription cards, are identification cards issued by the PBM to plan members. A member must present her card to a participating pharmacist to receive PBM benefits. The card identifies the plan a person belongs to and other information the pharmacist needs, such as the copayment amount. Some PBMs do not issue separate pharmaceutical cards but use the health plan member identification card as a pharmaceutical card.

A pharmaceutical card program allows a PBM to process a claim electronically when a prescription is filled by a pharmacist. It also enables the PBM to transmit information to
the pharmacist about ingredient duplicates, therapeutic duplicates, severe drug interactions, early refills, age precautions, benefit restrictions, etc.

**PBM Contractual Arrangements**

PBMs typically operate under one of three contractual arrangements: fee-for-service, risk sharing, and capitation.

**Fee-for-Service**

Under fee-for-service arrangements, the PBM creates a retail pharmacy network that offers discounts on prescription drugs and can perform online claims processing. For each prescription filled for members of a health plan, the plan pays the PBM a claims administration fee. However, the health plan generally saves money compared to unmanaged drug benefits.

**Risk Sharing**

A risk-sharing contract may be used when an employer contracts with a PBM to manage pharmacy benefits. The PBM and the employer agree on a target cost per employee per month. If the actual cost per employee per month is greater than the target, the PBM pays part of the cost overrun, and if the actual cost is less than the target, the PBM shares in the savings.

The PBM bases the target cost per employee per month on a combination of factors: price discounts (a percent reduction in the average wholesale price), rebates for formulary products, and savings from clinical services. The target cost per employee per month may be disease-specific or related to therapeutic drug class.

**Capitation**

Under a capitation contract, a PBM agrees to provide all pharmaceutical services in exchange for a fixed dollar amount per employee per month. Capitation contracts are increasing in popularity, but not quickly. One reason for this slow growth may be that PBMs have not yet determined how to accurately project or account for future pharmaceutical expenditures. Also, many employers are hesitant to put in place strong utilization control measures (such as prior authorization and closed formularies), particularly when they may affect a negotiated benefit of a trade union.

**Notes**

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1. Some content in this section is adapted from the dental module of AHIP’s FHIAS course, written by Cathye Lynne Smithwick RDH MA, Consultant to the Health Care Industry.
