When patients are choosing health insurance, pharmacy or outpatient prescription benefits are usually part of the health insurance package. Medicare Part D is the exception that focuses only on outpatient pharmacy benefits. In this chapter, more detail will be provided on prescription benefits. While prescription benefits are only part of a health insurance package, they may be the most used component of a person’s plan and careful consideration should be given to what they cover.

**PHARMACY BENEFIT MANAGERS**

Functioning as a third-party administrator of prescription drug programs, pharmacy benefit managers (PBMs) are companies (not individuals) often hired to help design, manage, and maintain formularies for insurance companies. However, PBMs may also be utilized to form contracts with pharmacies, negotiate discounts and rebates with medication manufacturers, and process payment for prescription medication claims. PBMs can help maintain or reduce pharmacy costs of insurance plans, while providing value and flexibility to patients. Some PBMs may offer additional resources that provide patients with information, such as lower-cost therapeutic alternatives, medication therapy management, and mail order services.

Pharmacists are often employed by PBMs to provide high quality medication therapy management for members within an insurance plan while considering the pharmacoeconomic implications as well. Managed care pharmacists perform a variety of roles including medication distribution and dispensing, patient safety monitoring, clinical program development, business operations, analysis of therapeutic outcomes, and formulary management.

**FORMULARIES**

Most health insurance plans utilize a formulary, which is a list of particular medications that ensures drug products are used in a rational, safe, and cost-effective manner. Formularies can be either open or closed. Insurance plans with open formularies pay for all medications, even those not on the formulary. Closed formularies only provide coverage for medications that are
listed on the health insurance plan’s formulary. The medication listed on a formulary is often organized into tiers. These tiers will represent different levels of payment by the insurance company and the patient. Generally preferred medications will be cheaper than non-preferred agents as well as generic medications cheaper than brand name. Preferred refers to products that are identified by the insurance company as those that may produce more value or cost savings.

Formularies are typically developed by pharmacy and therapeutics (P&T) committees, which are made up of primary care and specialty physicians, pharmacists, nurses, legal experts, and other health care professionals. As mentioned previously, the goal of this committee is to provide a formulary that represents the optimal therapy for patients based on evidence-based efficacy and safety information. Additionally, elements such as cost and ease of delivery are considered when determining which medications should be on a formulary, which are discussed further in Chapter 6.

PRIOR AUTHORIZATIONS

Health insurance plans have implemented prior authorizations (PAs) to ensure efficacious and safe medications are being covered, optimizing patient outcomes. A PA requires physicians to provide explanations and/or documentations to justify the use of specific medications for a patient. Insurances use this information to determine whether they will approve or deny coverage of the medication. This helps ensure medications are administered according to recommended therapeutic guidelines and provides better control over costs for health insurance plans. PAs may also be used to limit the use of high risk medications or institute other quality measures set by different quality organizations.

For example, a patient presents a prescription for Crestor® to their community pharmacy, which submits a claim to the patient’s health insurance plan. Unfortunately, the brand name medication is not covered by their insurance plan and the claim is rejected or unpaid. Since brand name medications are not on the formulary, the patient may choose to have their prescriber submit a PA to their insurance plan. The prescriber may then do one of two things:

1. Deem the generic medication for Crestor® (rosuvastatin) equally effective for the patient’s condition
2. Deem the generic medication to be non-equivalent and not effective for the patient’s condition

Should the prescriber choose option 2, they must request pre-approval from the insurance plan to cover the brand medication. Thus, the provider submits the appropriate
documentation and/or explanation (to the insurance plan) that Crestor® is medically necessary and more beneficial/effective, than the generic medication, for their patient. The patient’s insurance will then review the prescriber’s request for pre-approval and will determine whether or not the medication will qualify for coverage under the patient’s health insurance plan.

In this example, the brand name medication was deemed medically necessary by the patient’s insurance, and a PA for medication coverage was granted. It is important to note that had the patient’s insurance found no medical need for the brand name medication, the patient would then face several options:

1. Try the generic medication under physician approval
2. Try a different medication under physician approval
3. Pay cash for the full cost of the brand name medication not covered by their insurance plan

Other options may exist based upon the particular situation and patient factors.

Guidelines and administrative policies for PA’s may vary between insurance plans and companies. Although prior authorizations may be time consuming and frustrating for consumers and health providers, they can help minimize overall health care costs by helping avoid inappropriate medication use and promote utilization of evidence-based medication therapy when used appropriately.⁴

Prior authorizations can be implemented in a variety of ways. Some prior authorizations require additional clinical patient information, such as diagnosis and laboratory results, before a provider is allowed to prescribe that medication.⁴ Figure 5-1, identifies common types of prior authorizations that may be utilized.⁴,⁵
Types of Prior Authorization

| Indication                                                                 | • Off-label
| • One indication vs. another
| Prescriber Coverage for Particular Medication | • Specialist vs. Primary Care Physician
| Quantities outside FDA-Approval | • Duration of therapy
| • Days supply
| • Maximum daily dose limits
| Non-step Therapy | • Utilizing second-line, more complex, and/or more expensive options/alternatives before first line options
| Medications outside of patient’s health insurance plan’s formulary | High misuse or abuse potential medications

**Figure 5-1.** Types of prior authorizations

In another example, a patient presents a prescription to their community pharmacist for a migraine medication, which they have been prescribed to take four times daily. However, their insurance company rejects the submitted claim. According to their formulary, the insurance plan will only cover (or pay) for the migraine medication to be taken three times daily. The patient may then choose to have their prescriber submit a PA to their insurance plan. Should the prescriber provide appropriate documentation and/or explanation that proves taking the migraine medication four times daily is medically necessary, the insurance plan may issue a PA for coverage of medication costs.

**EXCEPTION AND APPEALS PROCESS**

Prior authorizations may also be referred to as exceptions. Insurance plans can evaluate coverage based on individual patient cases to determine whether or not coverage exceptions will be made. Patients may also request an exception when an insurance plan executes a change to their formulary and their medication is no longer covered.

Insurance plans differ on the amount of time it takes them to review an exception. Some plans, such as Medicare Part D, offer expedited requests based on prescriber recommendations for the patient’s overall health. In the event that coverage exceptions or PAs are denied, patients may complete an appeal to request further evaluation or reevaluation of their original exception. Because certain exceptions must be initiated by the
payer, completed by the prescriber, and reviewed by the payer, the response time can vary. If possible, pharmacists can assist patients by suggesting an alternative medication to avoid this lengthy process.

**HOW TO READ AN INSURANCE CARD**

Although insurance cards may look different, they often contain similar information needed to complete claim submissions for payment. In order to submit a claim to an insurance plan, a patient’s member identification, BIN, Group, and PCN number are necessary. Should a member’s coverage be expired or not active until a later date, submitted claims will not be reviewed for coverage. Help phone numbers are typically found on the back of an insurance card and may be utilized for various issues, such as when insurance card components are missing or claims are rejected. Figure 5-2 defines common components of an insurance card, whereas Figures 5-3 and 5-4 are examples of what an insurance card may look like.6,7

<table>
<thead>
<tr>
<th>Components of an Insurance Card</th>
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<tbody>
<tr>
<td>Member Identification Number</td>
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<td></td>
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<tr>
<td>Group Number</td>
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<td>BIN Number</td>
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<td></td>
</tr>
<tr>
<td>PCN Number</td>
</tr>
<tr>
<td>Plan Type</td>
</tr>
<tr>
<td>Phone Numbers</td>
</tr>
<tr>
<td>Effective Date</td>
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</tbody>
</table>

Figure 5-2. Components of an insurance card
SUBMITTING CLAIMS

Pharmacy claims are most often transmitted at the point of sale. Usually, when a patient brings a prescription to the pharmacy, a pharmacist, technician, or intern will either access their insurance information stored within their pharmacy computer (entered from prior...
transactions) or enter/update their insurance card information. The pharmacy’s computer system will transmit the patient’s claim electronically to the insurance company or pharmacy benefit manager. This digital information will be processed electronically and information will be sent back to the pharmacy to determine whether or not the patient is currently enrolled under the entered insurance plan, if the prescription is covered under the plan, what amount the patient owes for the prescription, and what amount of reimbursement the pharmacy can expect to receive for the prescription. Although the information can be viewed within the pharmacy’s computer system, the amount owed by the patient and saved by the insurance is typically printed along with the patient prescription label, which are packaged with the medication and distributed to the patient.

If a prescription is not covered, the pharmacy staff can communicate with the patient and prescriber to help determine what steps should be taken. Patients may decide to pay cash or a discount price (using eligible discount cards or coupons), but most often patients will choose to work with the physician and/or pharmacist to determine alternative therapies which may be covered through the insurance or available at cheaper costs for the patient. If a prior authorization process is required, the pharmacy staff will communicate that to the prescriber’s office and/or staff electronically. At this point, the prescriber will need to complete the prior authorization process with the patient’s insurance company before the pharmacy can re-submit a claim. Most prior authorizations are completed within 72 hours.

**LOWER COST SUPPORT/ASSISTANCE**

Inability to afford medications is a major cause of non-adherence. Uninsured patients lacking prescription and/or health insurance entirely and in need of assistance paying for their medications have several options. Many pharmacies offer free or discounted prescriptions for products such as vitamins, antidiabetic agents, antihypertensive medications, and antibiotics. Underserved medical clinics may also provide limited medications at no cost.

Patient assistance programs are available for certain medications. Individuals who qualify can receive free or discounted medications for a particular period of time. Websites such as NeedyMeds.org, RxAssist.org, and PPARX.org can be used to determine if an assistance program is available for a given medication and what that programs’ eligibility criteria might be. Patients who qualify may even apply for a program using these websites.

Patients can also lower costs with discount cards. Although most discount cards have similar formatting and claims information, discount cards are not insurance cards. Offered by a
number of companies, discount cards offer savings on a variety of medications. Unfortunately, most discount cards cannot be combined with insurance coverage. Discount cards may hold the most utility for consumers when a particular medication is not covered by their insurance. In this situation, a discount card may be used in place of the insurance card. Most online medication coupons work the same way as a discount card and hold the same limitations, but resemble a regular merchandise coupon. Medication coupons are often specific to one medication, whereas discount cards can be applied to a variety of medications. Advertising claims for discount cards and medication coupons can be misleading, as most consumers do not understand the implications regarding their use.

Manufacturer assistance cards, also known as co-pay assistance cards, can be found on manufacturer websites. Unlike discount cards or coupons, most manufacturer assistance cards can be used with an individual’s health insurance coverage. Although benefits vary between medication manufacturers, most manufacturer assistance cards offer a one time or twelve-month savings program. However, manufacturers will often set a maximum annual savings limit and most manufacturer assistance cards must be pre-ordered or downloaded, printed, and brought into community pharmacies by the patient. This may create some barriers for individuals lacking access to online resources. Unfortunately, most pharmacies do not have access to manufacturer assistance cards, but some physicians’ offices may provide them or are willing to help patients locate them.

Uninsured patients are not the only patients who may need assistance. Underinsured patients, who have minimal health and/or prescription insurance coverage, also may have just as much difficulty affording medications. There are various resources available for such patients. Families with children can go to InsureKidsNow.org to check if their child is eligible for Children’s Health Insurance Program (CHIP). CHIP is jointly funded by the state and federal government and provides health and prescription coverage to low-income children and, in some states, pregnant women who do not qualify for Medicaid.

Patients with Medicare Part D may qualify for low-income subsidy or “Extra Help” and can apply online at Socialsecurity.gov/extrahelp. Both full and partial help is available through the federal government, but states often offer additional programs as well. State based programs are usually referred to as State Pharmaceutical Assistance Programs (SPAPs). Finally, patients can also be referred to a local State Health Insurance Assistance Program (SHIP) office when they are in need of advice about prescription and/or health insurance or extra assistance.
CONCLUSION

In order to compare medical and prescription insurance coverage it is helpful to first consider the type of coverage that are available options and then the payer-provider relationship. Ultimately, understanding the details of the coverage can allow beneficiaries to select the best coverage for them. Pharmacists can help patients and caregivers compare prescription drug coverage and educate them about the different insurance terms.
**Benefits**
Items, services, or payments covered in full or part by the insurance company for the beneficiary

**Co-insurance**
A percentage fee paid by an individual for health care services

**Co-payment/Co-pay**
Flat fees that must be paid by an individual for particular services, like a visit to a primary care physician

**Deductibles**
A set amount that one must pay each year before the insurance company will begin to pay on healthcare costs for an individual

**Formulary**
List of particular medications available for coverage by insurance companies that have been demonstrated as safe, effective, and providing the highest cost-benefits for patients

**Health Literacy**
The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

**Member**
Individual enrolled under a particular health insurance plan

**Network**
Group of healthcare providers who provide services that are eligible for coverage under an insurance plan

**Out-of-Pocket Limits/Maximum**
Maximum amounts a patient, also known as a beneficiary, has to pay out of their own pocket for covered health care expenses
**Pharmacoeconomic**
A branch of economics that compares pharmaceutical products and treatment strategies through analysis of cost-benefit, cost-effectiveness, cost-of-illness, cost-minimization, and cost-utility

**Premium**
What one must pay in order to have insurance coverage

**Prior Authorization**
Insurance requirement that physicians provide explanation and/or documentations to support the use of a specific medication therapy in order to determine medical necessity and appropriate therapy

**Step Therapy**
A treatment approach that utilizes the most cost-effective medication therapy and then progresses to alternative therapies, which may be more expensive or lack comprehensive research evaluating efficacy, to better control costs for insurance providers
REFERENCES