



2017

The Impact of Accountable Care: Interactions between patients and payers – Where do pharmacists lie?

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Thesis title The Impact of Accountable Care: Interactions between
patients and payers – Where do pharmacists lie?

Intended date of commencement May 6, 2017

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Certified by _____
Director, Honors Program Date

For Honors Program use:

Level of Honors conferred: University _____
Departmental _____

Danielle Stone

A Thesis

Presented to the College of Pharmacy and Health Sciences

and

The Honors Program

of

Butler University

In Partial Fulfillment

of the Requirements for Graduation Honors

Danielle Sara Stone

March 1, 2017

The Impact of Accountable Care:

Interactions between patients and payers – Where do pharmacists lie?

BACKGROUND:

Since the passing of the Patient Protection and Affordable Care Act (PPACA), providers have become more focused on the outcomes of their *patients*, rather than just therapeutic interventions. Patient centered medical homes and neighborhoods provide care coordination and focus on the needs of patients through team based care, email communication, and greater flexibility through seven-day week appointment options. Accountable Care Organizations (ACOs) are groups of health care providers focused primarily upon providing coordinated, high quality care driven by financial incentives. Thus, ACOs promote provider responsibility for, not only therapeutic treatment of their patients, but overall care and outcomes of their patients. In response, health care providers are stepping into new roles as part of the health care team. Pharmacists are no exception.

As health care professions continue incorporating patient centered care, educational facilities must also respond to the new wave spreading over the health care system. The Accreditation Council for Pharmacy Education (ACPE) has new standards, which emphasize curricula that prepare students to provide patient-centered collaborative care to better ensure adaptation within accountable care models. Additionally, ACPE standards indicate that students should be practice ready for several topics including: 1. Examination of the U.S health systems; 2. Contemporary reimbursement models in which patient-centered and/or population-based care is provided and paid for; 3. How social, political, economical, organizational, and cultural factors influence providers' ability to ensure patient safety and deliver coordinated interprofessional care services. Through these additions, pharmacy graduates can combine clinical knowledge with real life challenges of cost, coverage, and access, thereby meeting accreditation standards. Pharmacists can then be positioned to meet these demands and ultimately support the growing need for cost, access, and quality minded health care providers.

In response to changes within the health care system and pharmacy accreditation standards, Butler University College of Pharmacy and Health Sciences faculty are responding to these changes, in hopes of producing pharmacists known not only for their strong clinical skills, but also for the unique support they can provide to their patients and other health care providers as accountability begins driving practices toward overall patient outcomes and care. Recently, faculty, who teach pharmacy practice, health care delivery, biostatistics, drug information, evidence based medicine, research design, and public health, have joined together to create a required, four semester course series titled Pharmacy Practice and Healthcare Administration. As outlined in new pharmacy accreditation standards, all students would benefit by understanding the mechanisms that these entities use to balance access, cost, and quality of care.

Currently used in the new course series mentioned above, The Health Care Handbook (Elisabeth Askin and Nathan Moore) represents a text that was written by and for medical students and residents to provide a basic review of health care delivery, reform, and system structure. Although the text is suggested to be useful for any health professionals, the handbook remains physician centric with little content on pharmacy practice. Ultimately, it is our goal to utilize the textbook in the new course series and locate a publisher to make the text available to other schools as they begin to integrate their teaching in response to accreditation standards.

THESIS DESCRIPTION:

For my project, I researched details regarding patient interactions with private health insurers and government payers. Additionally, I investigated the role health care providers play, if any, in these interactions. My ultimate intent revolves around improving patient centered care through educating future pharmacists on the interactions their patients may or may not know they face. In other words, many patients may not realize the overall process required upon entering a pharmacy and if pharmacists will become ultimately responsible for helping explain the process

to their patients. Although my research primarily consisted of a literature review, I also drew upon personal experiences within various community pharmacies to better help identify and address challenges faced by patients, technicians, interns, and pharmacists, in hopes of focusing my chapter more appropriately for future pharmacy graduates to use as a resource for assisting their patients. Thus, although the overall purpose of authoring a chapter relates to the publication of a pharmacy handbook, I hope that my chapter can also be utilized as a standalone resource in community pharmacies for providing answers to everyday and unique questions/situations, in addition to serving as a resource for finding additional information on these topics. Ultimately, I hope that my chapter can help current and future technicians, interns, and pharmacists to better assist and serve their patients in an ever changing health care system.

MY CHAPTER: PATIENT TO PAYER INTERACTIONS

INTRODUCTION:

Due to recent healthcare reform, healthcare providers are becoming financially tied to the successful *outcomes* of their patients, rather than initiation of care. Patient centered medical homes and neighborhoods focus on the needs of patients as a central component to delivery of care. This may include multidisciplinary team based care, email communication directly with providers, and greater flexibility through extended hours or seven-day week appointment options. Patient centered medical homes provide key components for coordination of patient care and are usually a component of Accountable Care Organizations (ACOs) discussed in chapter 1.

Providers must be prepared for patient-centered collaborative care. Successful patient outcomes must be achieved regardless of the patient's health literacy, health status, and socioeconomic considerations. Studies have shown that a positive relationship exists between health literacy levels and an individual's knowledge of health services, such as available healthcare providers, and results in improved overall health outcomes.¹ Individuals who

understand their payer coverage are more likely to successfully navigate their financial benefits. Providers, including pharmacists, can help bridge the literacy gaps that may exist between patients and payers.

Pharmacists can assist patients with low health literacy, both clinically and financially. Community pharmacists are an easily accessible source of clinical knowledge. Community pharmacists may assist patients' transition home after an inpatient stay, which includes navigating new providers and care necessary for a new diagnosis. Additionally, community pharmacists are directly involved with the patient to payer interactions for medications and are typically very familiar with medication costs. They may use this knowledge to help their patients traverse the medical and prescription insurance lingo such as copays, coinsurance, types of cards, prior authorization requirements, and appeals.

Pharmacists who consider the economic, social and cultural issues of the patient population they serve are most likely to be successful. Pharmacists have the clinical knowledge to meet heightened demands for patient centered care and support the growing need for cost, access, and quality minded health care providers.

PATIENT TO PAYER CONNECTIONS: FROM INSURANCE BASICS TO PLAN SELECTION

Health Insurance Basics

Fundamental knowledge of insurance terminology is necessary for navigating patient to payer interactions. The primary purpose of health insurance is to help protect an individual from financial risks of medical expenses, which can often be very high, and to help avoid significant financial loss.² Health insurance in the United States usually includes both medical insurance (doctor and hospital coverage) as well as prescription coverage. A common misconception is the

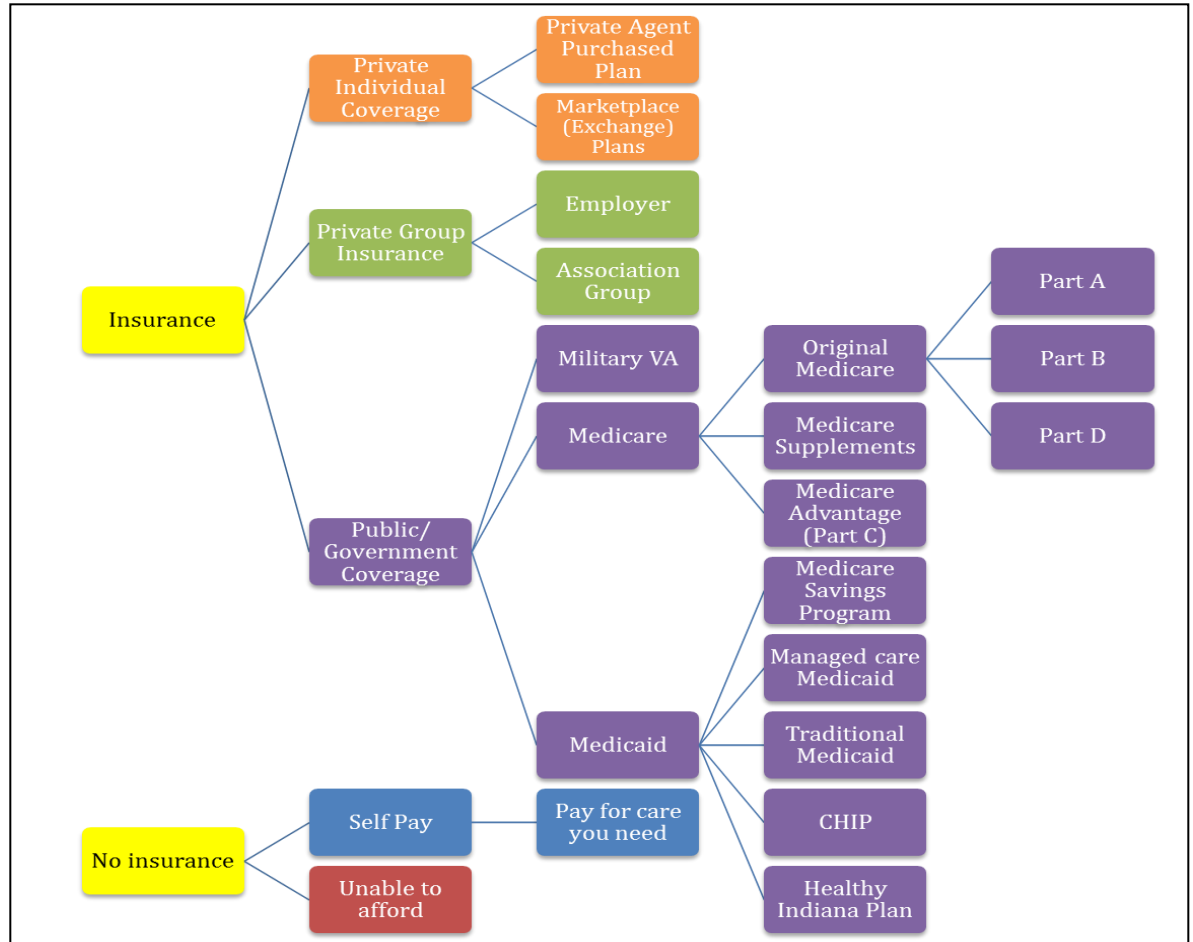
belief that insurance will pay for all health care expenses that occur. Chapter 1 discusses the concept of insulation versus insurance in more detail.²

Health insurance plans may have set services or expenses that are covered or eligible for insurance payment.³ It may also list items that are excluded, where an individual will pay any expenses incurred without insurance help. When a health care provider or patient submit these expenses to the insurance company for processing (send in the bill), the expenses are referred to as claims. Additional terminology such as deductible, coinsurance, etc. is defined in the glossary and explained more in chapter 1. Figure 1 below provides an overview of the primary types of health insurance coverage available in the US.³

Types of Insurance Coverage

Figure 1: An overview of the types of insurance coverage available to Americans.

Created by Carriann Smith, PharmD



There are several ways to obtain health insurance (see figure 1). Health insurance may be purchased privately, either individually or as part of a group, or publically, through state or federal government. Employer coverage is the most common type of private insurance.³

Employers who offer health insurance plans to their employees generally offer better coverage at a cheaper rate than if the employee were to purchase it on their own. This may make comparing individual and group insurance coverage difficult. Employers may also choose to cover a portion of the premium for each employee. The employees then pay their portion of the premium through paycheck deductions.³

Others are not able to obtain employer health insurance. These individuals may not work enough hours to qualify for employer coverage, are unemployed or work for a small employer

who does not offer regular group coverage. These individuals can purchase private coverage through the health insurance marketplace (online) or from private agents.

IN-DEPTH LOOK AT THE MARKETPLACE

Marketplace

The Patient Protection and Affordable Care Act, PPACA, created a new, private insurance marketplace in all 50 states and the District of Columbia.⁴ Some states created their own marketplace and others utilize the federal health insurance marketplace. These marketplaces include a central online location, called the Small Business Health Options (SHOP) Exchange, that enable individuals and small groups to shop for private health insurance plans.^{4,5} Here, small businesses, currently defined by the federal government as 100 or fewer employees, can set up accounts to allow individuals to compare available plans specifically selected by the small employer.⁵ In the SHOP, individuals have less options but the employer pays a portion of the premium.⁵ States may choose to restrict their SHOP Exchange to businesses of 50 or fewer employees or, in 2017, states may elect to open SHOP Exchanges to larger businesses.⁵

People who select insurance plans through the individual health insurance marketplace may be eligible for tax credits to help cover their premium based on the person's income and help balance differences between costs faced under these plans compared to employer plans, where the employer pays a portion of the patient's (employee) premium costs.⁶ Some individuals may also choose to self-pay for medical bills, rather than pay for insurance coverage. However, this choice will result in penalty taxes that the individual will be required to pay, unless they qualify for a tax exemption.⁶

Marketplace exchanges have enabled more individuals to access and compare health insurance coverage. Resources are available to help individuals navigate the exchanges. HealthCare.gov offers a wide variety of information regarding navigation and utility of the

federal health insurance marketplace. Individuals can apply online, by phone, via a paper application, or with in-person help using a tool on HealthCare.gov, which enables individuals to enter their location information, and select the type of coverage they are searching. Then results are populated for assisters, agents, and brokers located near or in their surrounding area.^{6,7}

CASE 1 – EVALUATING INSURANCE OPTIONS

This case will allow the reader to better understand the differences between private individual insurance options.

Following completion of this case the learner will be able to:

1. Apply the terms premium, deductible and out-of-pocket maximum to comparing insurance options.
2. Identify common differences between PPO and HMO plans.

Your friend has an older sister, LL who is 27. She graduated from the university a few years ago. She has been working as a nanny near campus making \$15/hr, approximately \$30,000 a year. She has not been offered health insurance through her job so she is looking at plans on the market place. She uses the health care.gov website and pulls up several plans. She asks you to help her compare a few of them. Use the screen shots from HealthCare.gov to answer the questions below.

Plan A

CareSource · CareSource Just4Me Healthcare with Heart

Compare

Silver | HMO

Plan ID: 54192IN0010003

ESTIMATED MONTHLY PREMIUM

\$209

Number of people covered: 1
Premium before tax credit: \$260

ESTIMATED DEDUCTIBLE

\$3,500

Estimated individual total





ESTIMATED OUT-OF-POCKET MAXIMUM

\$6,500

Estimated individual total

COPAYMENTS / COINSURANCE

Primary doctor: **\$20**
Specialist doctor: **\$50**
Emergency room care: **\$500 Copay after deductible**
Generic drugs: **No charge**

-  [Summary of Benefits](#)
-  [Plan brochure](#)
-  [Provider directory](#)
-  [List of covered drugs](#)

Plan B

Assurant Health · Assurant Health Silver Plan 001

Compare

Silver | PPO

National Provider Network

Plan ID: 91842IN0190014

ESTIMATED MONTHLY PREMIUM

\$379

Number of people covered: 1
Premium before tax credit: \$430

ESTIMATED DEDUCTIBLE

\$3,500

Estimated individual total





ESTIMATED OUT-OF-POCKET MAXIMUM

\$3,500

Estimated individual total

COPAYMENTS / COINSURANCE

Primary doctor: **No charge after deductible**
Specialist doctor: **No charge after deductible**
Emergency room care: **\$100 Copay before deductible**
Generic drugs: **No charge after deductible**

-  [Summary of Benefits](#)
-  [Plan brochure](#)
-  [Provider directory](#)
-  [List of covered drugs](#)

1. How much more premium would LL pay for Plan B? Give two reasons why she may pay more.

Answer: Plan B premium is \$170 a month higher. This may be because it is a PPO and she has more choice in providers. Moreover, because her out of pocket limit is lower than for Plan A.

2. Which plan encourages healthy behavior by charging a low copay to see your primary care physician? Why?

Answer: Plan A encourages healthy behavior by allowing LL to pay a copay without first having to meet her deductible. Plan A is an HMO, Health Maintenance Organization, plan and they typically encourage primary care through low copays.

3. Which plan will provide some coverage if you see a health care provider outside of the network?

Answer: Plan B will allow for out of network coverage since it is a PPO, Preferred Provider Organization.

4. Which plan has an out of pocket limit the same as the deductible? What does this mean?

Answer: Plan B has the same deductible and out of pocket maximum. This means that when the patient meets their deductible they will not have to pay anything else for coverage. This is also shown below the chart in the copayment/coinsurance section.

Function and Navigation

Individuals, such as the one in the previous case, can enroll in plans during yearly open enrollment periods (OEP) that is set by the federal government.⁶ During this timeframe, individuals may browse and enroll in a health insurance plan for the following year. Enrollment outside of the OEP cannot

Tip

- Pharmacists can easily help patients find health insurance plans by showing them how to navigate through the websites. Go to [Healthcare.gov](https://www.healthcare.gov) to purchase plans from the marketplace or [Medicare.gov](https://www.medicare.gov) to purchase Medicare plans.

occur unless the patient, also known as a beneficiary, qualifies for a special enrollment period.⁶ Special enrollment periods occur over a 60 day period following particular life events that result in a change of family status, such as marriage, child birth, or after the loss of prior health coverage.⁶

HealthCare.gov offers screening tools to help individuals determine if they are eligible for either Medicaid, Children’s Health Insurance Program (CHIP), or a special enrollment period. Both Medicaid and CHIP are discussed later within this chapter.

Marketplace Plans

The federal health insurance marketplace categorizes insurance plans into four ‘metals:’ Bronze, Silver, Gold, and Platinum. Although a common misconception, the ‘metals’ do not reflect or categorize plans according to quality or amount of care provided by each plan.⁸ Each ‘metal’ category reflects the cost of monthly plan premiums and the portion of costs for care or services, such as hospital visits or prescriptions, that the patient will be expected to pay.⁸ ‘Metal’ categories are defined in Figure 2 below.⁸

Figure 2:

| ‘Metal’ Federal Health Insurance Marketplace Categorizes: | |
|--|--|
| Bronze: | <ul style="list-style-type: none"> - Health plan covers approximately 60% of total average costs - Beneficiary covers approximately 40% of total average costs |
| Silver: | <ul style="list-style-type: none"> - Health plan covers approximately 70% of total average costs - Beneficiary covers approximately 30% of total average costs |
| Gold: | <ul style="list-style-type: none"> - Health plan covers approximately 80% of total average costs - Beneficiary covers approximately 20% of total average costs |
| Platinum: | <ul style="list-style-type: none"> - Health plan covers approximately 90% of total average costs - Beneficiary covers approximately 10% of total average costs |

Catastrophic health plans, often referred to as a ‘fifth category’ within the marketplace, exist for individuals under 30 years of age or those who have a hardship exemption.⁸ Hardship exemptions are a set of specific criteria, such as being homeless, experiencing domestic violence, or facing substantial medical debt, that enable an individual from having to obtain health insurance coverage for a particular period of time.^{8,9} Catastrophic plans focus their benefits on high medical costs such as serious injury or hospitalization rather than outpatient, chronic care.⁸ Under these Catastrophic plans, health insurance companies pay less than 60% of the total average costs of care, placing more payment responsibilities upon patient.⁸ These plans are an option for younger individuals who are healthier and do not utilize their insurance coverage on a regular basis.⁹ Individuals under hardship exemptions are eligible, regardless of age or income, to purchase a Catastrophic health plan, but are not required.⁹

CASE 1B –EVALUATING INSURANCE OPTIONS PART 2

Review the information in case 2 and answer the questions below.

1. Describe the levels of coverage for marketplace plans
2. Identify tax credits available to some individuals purchasing coverage on the marketplace
3. Which metal plan are these plans? What coinsurance percent would patient pay for claims under this plan?

Answer: Silver, 30%

4. How much will this person save on the cost of their coverage with tax credits from the Affordable Care Act with Plan A and Plan B?

Answer: Plan A = \$51, Plan B = \$51.

Public/Government Insurance Coverage Options

People who have little to no income, and a medical need may obtain health insurance through the state government, Medicaid program. Medicaid is a collection of multiple programs available for different levels of need. Medicaid provides multiple health insurance options for low-income families and children, pregnant women, the elderly, and people with disabilities. Low income in most states is defined as at or below 133 percent of the federal poverty level.¹⁰ Some states have expanded their Medicaid programs to cover all adults below 138% (133% +/- 5%) levels.¹⁰ Medicaid recipients typically don't pay a premium since the coverage is funded by the state and federal government and require little to no copays.

Although each state administers the program, the federal government provides some financial support to the state to assist with Medicaid funding. The federal government also sets minimum guidance standards, such as criteria for enrollment and evaluation of claims, Medicaid programs must follow to ensure some consistency of coverage between state programs.¹⁰ Therefore, even though all states must meet minimum standards, Medicaid benefits do vary between states based upon individual state budgets and overall population need.

Individuals who are over 65, disabled for 24 months or longer, have End Stage Renal Disease (ESRD) and/or ALS (amyotrophic lateral sclerosis or Lou Gehrig's disease) qualify for another government program called Medicare.¹¹ It is important to note that individuals may qualify for both Medicaid and Medicare. See Table 1 describing the different types of Medicare programs available to patients.¹¹

Table 1:

| |
|-------------------|
| Types of Medicare |
|-------------------|

| | |
|--|---|
| <p>Medicare Part A & B ("Original Medicare")</p> | <p>Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After the member pays a deductible, Medicare pays its share of the Medicare-approved amount, and the member pays their share (coinsurance and deductibles).</p> |
| <p>Medicare Part C ("Medicare Advantage")</p> | <p>Medicare health plan that contracts with Medicare and uses managed care arrangements with providers to provide Part A and Part B benefits to Medicare patient. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Patient choose either Medicare Advantage or Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.</p> |
| <p>Medicare Part D</p> | <p>A separate program that helps pay for prescription medications for people with Medicare. All Medicare Part D plans are offered through private insurance or prescription benefit companies, there is no "original" Medicare Part D plans offered by the federal government. There are two ways to get Medicare prescription drug coverage: through a stand alone Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes medication coverage.</p> |

Other examples of government-funded programs include coverage through the federal Department of Defense for military members and their families and coverage for veterans through

the Veterans' Administration (VA).¹¹ Government funded coverage may also be referred to as public health coverage.

Managed Care Organizations:

There are three basic forms or categories of managed care health insurance plans: 1. fee-for-service, 2. health maintenance organizations, and 3. preferred provider organizations.^{2,3}

Traditional fee-for-service plans are often the most expensive coverage options but in exchange offer patients the most flexibility when choosing health care providers.³ Health maintenance organizations (HMOs) offer lower co-payments for patients than traditional fee-for-service plans. Although HMOs cover most costs for preventative care, patients are only allowed to use a limited number of health care providers and facilities, except in emergency situations.^{3,12} HMOs require their patients to select a primary care provider in order to receive coverage.^{3,12,13} Additionally, HMOs may require referrals from a single primary care provider, also known as a gatekeeper, to see providers outside of the plan's network.¹² Point-of-service options may also be offered by some HMOs and allow patients to receive care outside the preferred network, but at a higher, out-of-pocket cost through higher premiums.¹²

Preferred provider organizations (PPOs), offer lower co-pays than traditional fee-for-service plans, and provide more flexibility to patients when selecting health care providers or facilities.¹² PPOs typically provide the most coverage for providers within network, but still allow patients to receive care out-of-network at higher costs and usually do not require referrals for such care.^{13,14} Unlike HMOs, PPOs do not require patients to choose a primary care provider.^{12,13}

Comparing and selecting health insurance plans

Ultimately, selecting a health care insurance plan requires evaluation by the individual seeking coverage. The individual should first understand the types of coverage available to them such as private or public. Based on the type of coverage, different forms of reimbursement

(HMO, PPO, fee for service) may impact a patient's choice.^{12,13,14} A patient's current health status, health behaviors, and financial situation should be considered when selecting insurance plans. Acceptance of risk should also be taken into consideration.¹³ What does this mean? Similar to the way warranty plans work for appliances, paying for more insurance coverage means they are avoiding the risk that they may have to pay out of pocket for unplanned medical expenses. Alternatively, if patients do not wish to pay for coverage they may not need then they may want to reduce the amount of coverage they select. Patients not expecting to go to the doctor may select a plan with lower monthly premiums but less coverage.^{6,8} However, if a patient is healthy but wants to make sure they do not have to pay much if they do need healthcare services may choose to pay higher premiums under a private insurance plan to ensure better coverage.

Less coverage may be defined in different ways. Less coverage may mean that the insurance plan covers fewer expenses. Or it may mean that the insurance company covers the same number of expenses but the patient must pay more out of pocket.^{6,8} Paying a higher cost share may mean a patient pays 30% instead of 20% of the medical cost, for example.^{6,8} Insurance plans may also have different coverage for different levels of care, referring to the location of where care was received.⁶ For instance, a patient with a fever and flu symptoms would likely pay much more for a visit to the ED than an urgent care. The same visit would cost even less at a physician's office.

In choosing a plan, patients should be aware of networks. Based on the plan they choose, the patient may have little to no coverage at certain providers who are out of network.^{12,13,14} If there is a certain provider or service needed, the patient should make sure it is covered under the plan. By limiting the number of providers that a patient can receive care from allows the insurance company to reduce expenses and pass that savings on to the patient.^{12,13,14} For example, seeing a primary care physician for a physical may be covered, whereas seeing a renal specialist for the same physical may not be covered. This also helps direct patients to the most appropriate provider for their care need.

Some plans may offer tax-exempt Health Savings Accounts (HSAs) or Flexible Spending Accounts (FSAs).¹⁵ These accounts enable patients to deposit and save money, tax-free, within the special HAS or FSA to help pay for incurred future medical expenses. Typically, a percentage of a patient's paycheck will be directly pulled and deposited into the accounts.¹⁵ This is a great way to save money and manage healthcare costs. Since the accounts are commonly used with high-deductible policies, patients typically pay higher costs upfront and track their expenses more carefully.¹⁵

It is important to find out if the plan includes prescription drug coverage especially if the patient is currently taking prescription medications. Patients should consider a health insurance's formulary when selecting plans, to better determine their prescription coverage needs and/or costs.^{16,17,18} For example, medications or brands not on the formulary can be much more expensive or may not be covered by the plan at all. Sometimes the plan will place formulary restrictions on certain medications and only cover them after the patient has completed a step therapy or other type of prior authorization, discussed later within the chapter, to prove the medication is medically necessary.^{16,17,18}

Ultimately, premiums, deductibles, and benefits must be weighed and balanced accordingly. Patients who need high cost prescriptions may purchase a different plan than a person who primarily needs support for wellness and emergency care.

PRESCRIPTION INSURANCE BASICS

When patients are choosing health insurance, the prescription benefits are usually part of the health insurance package. Medicare Part D is the exception. In this section, more detail will be provided on the prescription benefits portion. While prescription benefits are only a part of the health insurance package, they may be the most utilized 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 often hired to help design, manage, and maintain formularies for insurance companies.^{19,20} 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.^{19,20}

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.^{19,20} 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.^{19,20}

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 utilized in one of two ways.¹⁶ 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.¹⁶

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.¹⁶ 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 more in depth later within the book.¹⁶

Ins and Outs of Prior Authorizations

By utilizing medications that have established efficacy and safety, health insurance plans can better optimize patient outcomes. Thus, health insurance plans implement prior authorizations, also known as a PA. A PA requires physicians to provide explanations and/or documentations to justify the use of a specific medication for a patient.¹⁷ Insurances can then utilize this information to determine whether or not they will approve or deny coverage of the medication. Thus, a PA helps ensure medications are administered according to recommended therapeutic guidelines and better control overall costs for health insurance plans.¹⁷ PA's may also be used to limit the use of high risk medications or institute other quality measures set by different quality organizations.¹⁷

For example, a patient presents a prescription for Crestor[®] to their community pharmacy, who then submits a claim to the patient's health insurance plan. Unfortunately, the brand name medication is not covered by their insurance plan, resulting in a rejected or unpaid claim. 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 then 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.¹⁷

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 providers is allowed to prescribe that medication.¹⁷ Figure 3, below, identifies common types of prior authorizations that may be utilized.^{17,18}

Figure 3:

| Types of Prior Authorizations | |
|--|---|
| Indication: | - Off-label - One Indication vs. Another |
| Prescriber Coverage for Particular Medications: | - 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 | |

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, rather than three 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 upon individual patient cases to determine whether or not coverage exceptions will be made.¹⁷ Patients may also request an exception when an insurance plan executes a change to their formulary, because now their medication is no longer covered.¹⁷

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 upon prescriber recommendations for the patient's overall health.¹⁸ In the event that coverage exceptions or prior authorizations are denied, patients may complete an appeal to request further evaluation or re-evaluation of their original exception.¹⁸ 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.

Explanations of Benefits

Explanations of benefits are sent to patients by the insurance company to explain their health insurance coverage. These explanations of benefits (EOBs) outline what claims were covered, the negotiated contracted price for the medication, the amount owed by the patient, the

amount paid by the insurance company and the reason for any claim rejections, where the insurance company refuses to cover a particular medication and/or therapy. The following case will review a sample EOB.

CASE 2 – READING AN EXPLANATION OF BENEFITS

This case will allow the reader to consider the differences between private individual insurance options.

Following completion of this case the learner will be able to:

1. Identify the components of an explanation of benefit (EOB).
2. Discuss the information provided regarding the claims listed on the EOB.²¹

| Medical Services Detail | Your Provider Billed | Member Benefit | | | Amount Your Provider May Bill You | | | | | Reason Code (See below) | |
|--|-----------------------|----------------|----------------|----------------|-----------------------------------|------------|-------------|-----------------|----------|-------------------------|--|
| | | Allowed Amount | Member Savings | Your Plan Paid | Copayment | Deductible | Coinsurance | Other Liability | TOTAL | | |
| Claim #: 01-102510-046-40 | | | | | | | | | | | |
| Provider: JOHN SMITH Date(s): 11/21/2011-11/21/2011 | \$875.00 | \$600.00 | \$275.00 | \$0.00 | \$0.00 | \$600.00 | \$0.00 | \$0.00 | \$600.00 | | |
| | Service: MEDICAL CARE | | | | | | | | | | |
| Provider: JOHN SMITH Date(s): 11/21/2011-11/21/2011 | \$150.00 | \$100.00 | \$50.00 | \$0.00 | \$0.00 | \$100.00 | \$0.00 | \$0.00 | \$100.00 | | |
| | Service: LABORATORY | | | | | | | | | | |
| Provider: JOHN SMITH Date(s): 11/21/2011-11/21/2011 | \$50.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$50.00 | \$50.00 | ENB | |
| | Service: SUPPLIES | | | | | | | | | | |
| Total for Claim # 01-102510-046-40 | \$1,075.00 | \$700.00 | \$325.00 | \$0.00 | \$0.00 | \$700.00 | \$0.00 | \$50.00 | \$750.00 | | |

1. For the first charge what is the dollar difference between the allowed amount and the amount the provider billed? What is allowable amount referring to?

Answer: \$275, This is the maximum amount that the insurance company allows the provider to bill for the claim.

2. Which of the three charges was not covered by the insurance company?

Answer: The third charge, you can tell because the allowed amount was 0 and because there is a reason code. Different insurance companies use different reason codes so you would have to look elsewhere on the EOB for an explanation for the denial.

3. Has this person met their deductible? How can you tell?

Answer: No they have not. You can tell by looking in the deductible column and seeing the full allowed amount listed there.

CASE 3- PRESCRIPTION COVERAGE OPTIONS

A patient brings a prescription to your pharmacy for a preferred brand product. You process the prescription. The cash price of the prescription is \$125.

Your pharmacy is an in network provider for the PPO which negotiates the price to \$100. The patient pays \$10 for tier 1 lowest cost generics, \$15 for tier 2 non-preferred generics, \$20 for tier 3 preferred brand, \$45 for tier 4 non-preferred brand, \$100 for specialty pharmaceuticals; once the deductible is met.

Your pharmacy is also in network for patients with an HMO. The negotiated price is \$80 and there is no deductible for medications. For patients with the HMO they pay 20% of the cost of the medication and the HMO pays the rest as long as the medication is on formulary.

Assuming there is only one HMO and one PPO plan in the area. Answer the following questions.

1. How much would the patient pay for the prescription if they did not have any insurance coverage?

Answer: \$125

2. How much would the patient pay for the prescription if they have a CDHP/PPO and hadn't met their deductible?

Answer: \$100

3. How much would the patient pay for the prescription if they have a PPO plan if the patient met their deductible?

Answer: \$20

4. When you process the prescription to the HMO, there is a rejection notice that the medication was not on formulary. What would you do?

Answer: Identify if a prior authorization or step therapy is required. Determine if another product would be equally safe and effective. Discuss this with the patient and possibly the prescriber depending on the store process. The prescriber will have to complete the prior authorization if one is needed.

5. If the medication was on formulary with the HMO, what would the cost of the medication be?

Answer: \$16

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 4 below defines common components of an Insurance Card, whereas figures 5 and 6 are examples of what an Insurance Card may look like.^{22,23}


Components of an Insurance Card

| | |
|------------------------------|---|
| Member Identification Number | <ul style="list-style-type: none"> - Used to identify the individual covered or 'holding' the insurance - Numbers may be similar for others covered under the original card holder |
| Group Number | <ul style="list-style-type: none"> - Used to track specific benefits of the insurance plan - Also helps identify the individual covered under the insurance plan |
| BIN Number | <ul style="list-style-type: none"> - Unique six digit number that identify the third party processor - Third party processors may contract with multiple companies, which utilize the same BIN number |
| PCN Number | <ul style="list-style-type: none"> - Help identify different plans via utilization of numbers or letters |
| Plan Type | <ul style="list-style-type: none"> - May have either HMO, PPO, HAS, Open, or other words/labels to describe the type of network the insurance plan maintains |
| Phone Numbers | <ul style="list-style-type: none"> - Help lines, information, questions, etc. - Typically listed on the back of the card |
| Effective Date | <ul style="list-style-type: none"> - Date the coverage became active |

Insurance Cards:^{22,23}

INSURANCE COMPANY NAME

| | |
|---|--|
| Plan Type | Member Name: XXXXXX XXX Member ID: XXX-XX-XXX |
| Effective Date | Group: XXXXX-XXX |
| Prescription Copay | PCP Copay \$\$ Specialist Copay \$\$\$ Emergency Room Copay \$\$\$\$ |
| Prescription Copay \$ Generic \$\$\$ Name Brand | Help Desk: XXX-XXX-XXXX Pharmacy Help Desk: XXX-XXX-XXXX |

| | | |
|---|-----------------|-----------------------------|
|  ABC INSURANCE <small>PARTNERS</small> | | PPO |
| 1) Policy Number | 356M59557 | 3) Office Visit Copay: \$15 |
| 2) Group Number | 1234567 | 4) Specialist: \$15 |
| Group Name | XYZ COMPANY | Emergency Room: \$150 |
| Member Name | SUSAN J. SAMPLE | Urgent Care: \$50 |
| | | Rx: \$10/20/40 |
| | | Network Coinsurance: |
| | | 5) In 90%/10% |
| | | 6) Out 80%/20% |
| | | Med/Rx Deductible Applies |

1. Policy number
2. Group number
3. Copay amounts
4. Coinsurance amounts
5. In network
6. Out of network

So now what? How are claims submitted?

Pharmacy claims are generally transmitted at the point of sale. Generally, 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 then 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 both 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. In some situations, patients may decide

to pay cash or a discount price (using eligible discount cards or coupons). However, 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. It is important to note that 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. Generally, most prior authorizations are completed within 72 hours.

Fees for Not Having Health Insurance

As set in the PPACA, individuals may be subject to penalties should they not have health insurance coverage. Individuals who can afford health insurance but choose not to purchase coverage are required to pay a fee called the Individual Shared Responsibility Payment, also known as a penalty, fine, or individual mandate.^{17,24} Individuals without coverage are required to pay the fee for any month they, their spouse, or their tax dependents do not have health insurance coverage that qualifies as minimum essential coverage.²⁴ Payments are required upon filing for federal tax returns for the year coverage was not held.²⁴ Fees are calculated per person as a percentage of an individual's household income. HealthCare.gov provides resources to estimate mandated fees.

Exemptions for the Individual Shared Responsibility payment may be available for qualifying individuals. An individual must meet one of the following criteria, (see Figure 7 below), to be exempt, which prevents them from holding minimum health insurance coverage.¹⁷

Figure 7

- Have no affordable coverage options due to the fact that the minimum required costs for the annual premiums rises more than 8 percent above the household income¹⁷
- Have a gap in health coverage lasting less than 3 consecutive months¹⁷
- Qualify for an exemption for at least one various other reason, such as having a hardship that prevents an individual from obtaining coverage or belonging to a group explicitly exempt from the health insurance coverage requirement¹⁷

Simply holding insurance coverage may not enable an individual to avoid penalties.

Under the PPACA, health insurance coverage must meet minimum comprehensive benefit standards.⁴ Figure 8 below outlines these essential health benefit standards.²⁵

| Essential Health Benefits | |
|---|---|
| Ambulatory Patient Services (outpatient care, non-hospital admittance) | Mental Health/Substance Use Disorder Services (Counseling, Psychotherapy, etc.) |
| Emergency Services | Laboratory Services |
| Hospitalizations (Surgery, Overnight Stays, etc.) | Pregnancy, Maternity, and Newborn Care |
| Prescription Drugs | Rehabilitative/habilitative Services/Devices (Help Gain or Recover Mental/Physical Skills) |
| Pediatric Services (Oral, Vision, etc.) | Preventive/Wellness Services and Chronic Disease Management |

All marketplace plans meet minimum standards.^{4,24,25} Most plans obtained through employer, government, or state programs also meet minimum standards.²⁴ Providers should advise patients who wish to purchase insurance outside of these programs to double check that all coverage requirements are being met. HealthCare.gov can be utilized to help identify whether or not a plan meets minimum standards.

Lower Cost Support/Assistance

Inability to afford medications is a major cause of non-adherence.¹ Uninsured patients, those lacking prescription and/or health insurance entirely, in need of assistance paying for their medications have several options. For example, 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. The online tool and medical app GoodRx is a good resource to compare prices of medications and identify potential discounts for patients.

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 by utilizing discount cards. Although most discount cards have similar formatting and claims information, discount cards are *not* insurance cards. Offered by a variety of companies, discount cards offer savings that are dependent upon the specific medication. Unfortunately, most discount cards cannot be combined with insurance coverage. Thus, discount cards may hold the most utility for consumers should a particular medication not be covered under their insurance. In this case, the discount card may then be used in place of the insurance card. Similarly, most medication coupons that can be obtained online work the same way as a discount card and hold the same limitations, but actually resemble a regular merchandise coupon. Medication coupons often are specific to one medication, whereas discount cards can often be applied to any medication. Advertising claims for both discount cards and medication coupons are often very misleading, as most consumers do not realize the implications regarding their use.

Manufacturer assistance cards, also known as co-pay assistance cards, can be found through manufacturer websites. Unlike discount cards or coupons, most manufacturer assistance cards can be utilized in *combination* with an individual's health insurance coverage. Although benefits vary between medication manufacturers, most manufacturer assistance cards offer either a one time or twelve month savings program. However, manufactures will often set a maximum annual savings limit. Additionally, 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 physician offices may provide manufacturer assistance cards or are willing to help patients locate them.

Uninsured patients are not the only patients who may need assistance. Underinsured patients, those who have minimal, non-complete health and/or prescription insurance coverage, often have just as much difficulty affording medications and in need of assistance.^{10,11} Fortunately, 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).²⁶ 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.²⁶

Patients with Medicare Part D may qualify for low-income subsidy or "extra help" and can apply online at Socialsecurity.gov/extrahelp.¹⁸ 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).^{10,11,18} 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.

CASE 4 – MEDICARE PART D WITH LOW INCOME SUBSIDY (LIS)

This case will allow the reader to become familiar identifying financial assistance for patients with Medicare.

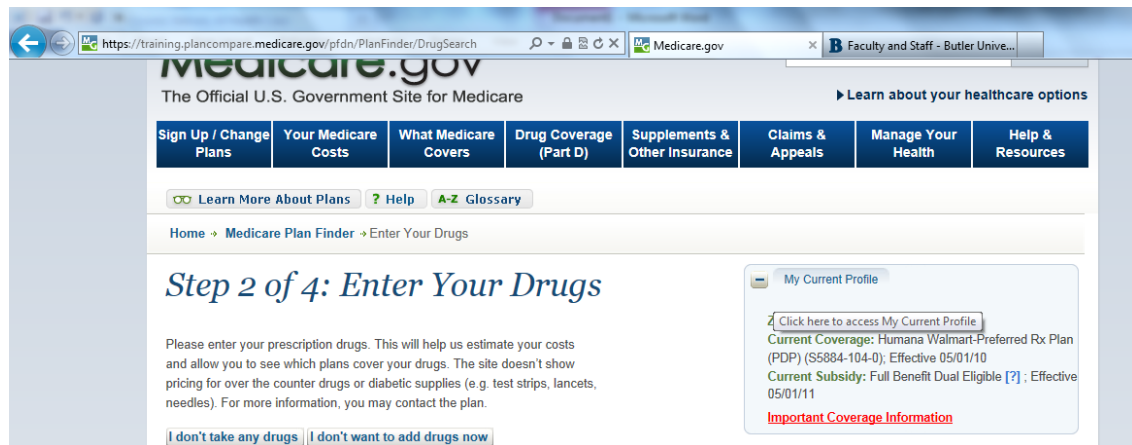
Paula Persimmon

Zip Code: 19103

Medicare Number: 111223333D

Medicare Part B effective date: March 1, 2004

Date of birth: March 15, 1950



1. What type of Part D coverage does Paula currently have?

Answer: A stand alone prescription drug plan or PDP. It is important to be able to recognize what type of coverage an individual currently has. Make sure you know that this means she has original Medicare and a stand alone plan and not Medicare Advantage. Just to reiterate Medicare Advantage (MA) plans are also called Medicare Health plans and stand alone plans are also called Prescription Drug Plans. (PDP) When a Medicare Advantage plans offers medication coverage wrapped in, it would be called an Medicare Advantage Prescription Drug Plan (MA-PD)

2. What subsidy category does she fall into?

Answer: Paula is a full benefit dual eligible so she has full Medicaid and Medicare. She would be automatically enrolled into Extra Help and a Medicare Part D plan. Patients may have both Medicare and Medicaid. If you qualify for full Medicaid you would be enrolled into extra help and a Medicare Part D plan. Medicare would provide your medication coverage unless you

happened to be on a medication that was excluded by law for coverage under Medicare and it happened to be covered by Medicaid in your state. (This is very rare)

If Paula did not qualify for full Medicaid, you could help her apply for Extra Help from the federal government. Use this link to get information about the Extra Help subsidy with Medicare Part D.

<http://www.socialsecurity.gov/prescriptionhelp/>

3. What is the estimated value of Extra Help? Answer: \$4000 It is important to remember that this is federal assistance that come from federal tax dollars. It however is not unlimited so individuals who qualify for full extra help can only get premium assistance up to the dollar amount set by each state. This is referred to as the LIS benchmark amount. There is partial and full Extra help.

4.Can you apply for extra help online?

Answer: Yes This is important because it is a very simple application and this would be a way pharmacists could help Medicare patients to receive help with the cost of their medications.

5.If Paula had additional income that did not allow her to qualify for Medicaid or Extra Help, and she

had medications that she could not pay during the coverage gap, what other options would be available for a brand name medication?

Answer: She could apply for a manufacturer assistance program. Access to medication in this way would be based on the criteria and availability set by the manufacturer. There may also be a state pharmaceutical assistance program (SPAP) that may help with the cost of her premium to leave more money to be spent on medications.

GLOSSARY OF TERMS

Annual Limit

Total benefits that an insurance company will pay over a certain period of time for individuals enrolled under a plan

Beneficiary

The person who benefits from an insurance policy

Benefits

Items, services, or payments that are covered in full or part by the insurance company for the beneficiary

Claim

A formal request, made by a health care provider or facility that provided a health service, for payment from an insurance company

Coinsurance

A percentage fee paid by an individual for health care services

Copayment/Copay

Flat fees that must be paid by an individual for particular services, like a visit to a primary care physician

Covered Expense

Expenses that are covered or eligible for coverage under a health insurance plan

Deductibles

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

Dependent

Any individuals, such as a spouse or children, covered under a health insurance plan held by another individual

Fee-for-Service Plans

Offer the most flexibility to beneficiaries, but at the highest costs

Flexible Spending Account (FSA)

An account that an individual can deposit money into, which can then be utilized to help pay for out-of-pocket health care costs not covered under their health insurance plan

Formulary

List of particular medications available for coverage by insurance companies that have been demonstrated to be safe, effective, and provide 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^{27,28}

Health Maintenance Organizations

Offer lower co-payments, limit provider and facility choices, and often require referrals for out-of-network care

Health Savings Account (HAS)

A savings account that enables individuals to save 'tax-free' money, which can be used for health care expenses

Individual Shared Responsibility Payment

Also known as a fee, penalty, fine, or individual mandate required as payment for not holding health insurance coverage

Lifetime Limit

Set monetary amount that will be covered under during an enrollees lifetime

Member

Individual enrolled under a particular health insurance plan

Network

Group of health care 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

Point-of-Service

Option offered by certain HMOs that enable out-of-network care at higher costs to the patient

Preferred Provider Organizations

Offer lower co-payments, provide more flexibility in provider and facility choices, and do not typically require referrals for out-of-network care that is available to beneficiaries at a higher cost

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

Referral

Provider direction of a patient to another provider or specialist for care or services

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

CONCLUSIONS: WHY THIS IS IMPORTANT:

As the health care system adopts accountable care measures, pharmacists will become a primary asset to other professionals and, especially, to their patients. New opportunities, positions, and expansions to current job descriptions will arise as pharmacists begin forming a bridge between health care settings, prevent medication errors, and manage chronic diseases. Provider status has already begun re-defining pharmacists' roles across the United States, and as pressure rises, remaining states, like Indiana, may once again experience major changes, within not only the health care system, but also the world of pharmacy. The question then becomes, where will outpatient pharmacists lie? And what role will they play in overall patient care and outcomes?

Outpatient pharmacists commonly serve as a primary contact patients have with the health care system, especially in medically underserved areas. Often times, pharmacists are available after traditional office hours of primary care physician offices, urgent care clinics, and free establishments. Additionally, as more patients acquire health insurance, primary care will become less accessible for acute treatment. For example, many offices will begin serving more patients without expanding their appointment availabilities, which can create difficulties scheduling office visits for acute illnesses. Thus, patients within the community are often limited on immediate avenues for medical advice. Luckily, outpatient pharmacists can be an accessible source for information.

Furthermore, outpatient pharmacists can help individuals traverse the medical and insurance lingo regarding plan selection, prior authorization requirements and departmental insurance. They can also help explain differences between insurance cards and discount card

utilization, which can help patient's find the most cost effective options available. Many patients, although literate, may lack health literacy, and full understanding of their health insurance, which can serve as a primary source of frustration that outpatient pharmacists can help eliminate. This will ultimately help patients make educated decisions regarding insurance selection and utility based upon their individual health.

Ultimately, our goal is to provide some guidance for current and future pharmacists as they embark on a new journey through an ever-changing health care system. Patient care will continue to become of utmost importance. Chapter 2 will provide an additional perspective on patient centered care focused on cost, quality, and access. Pharmacists can help improve patient centered care through education of the interactions patients face, while accessing the quality of care patients need and want, in addition to helping manage the cost of that care. Additionally, pharmacists can expand their knowledge about patient payer interactions and become a more valuable asset to, not only their patients, but also their community.

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