

# CHAPTER 5

## PRESCRIPTION INSURANCE

Author: Carriann Smith, BS, PharmD

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.<sup>1,2</sup> 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.<sup>1,2</sup>

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.<sup>1,2</sup> 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.<sup>1,2</sup>

### 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.<sup>3</sup> 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.<sup>3</sup>

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.<sup>3</sup> 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**.<sup>4</sup>

## **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.<sup>4</sup> 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.<sup>4</sup> PAs may also be used to limit the use of high risk medications or institute other quality measures set by different quality organizations.<sup>4</sup>

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.<sup>4</sup>

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.<sup>4</sup> **Figure 5-1**, identifies common types of prior authorizations that may be utilized.<sup>4,5</sup>

Types of Prior Authorization	
Indication	<ul style="list-style-type: none"> <li>• Off-label</li> <li>• One indication vs. another</li> </ul>
Prescriber Coverage for Particular Medication	<ul style="list-style-type: none"> <li>• Specialist vs. Primary Care Physican</li> </ul>
Quantities outside FDA-Approval	<ul style="list-style-type: none"> <li>• Duration of therapy</li> <li>• Days supply</li> <li>• Maximum daily dose limits</li> </ul>
Non-step Therapy	<ul style="list-style-type: none"> <li>• Utilizing second-line, more complex, and/or more expensive options/alternatives before first line options</li> </ul>
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.<sup>4</sup> Patients may also request an exception when an insurance plan executes a change to their formulary and their medication is no longer covered.<sup>16</sup>

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.<sup>5</sup> In the event that coverage exceptions or PAs are denied, patients may complete an appeal to request further evaluation or re-evaluation of their original exception.<sup>5</sup> 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.<sup>6,7</sup>

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

Figure 5-2. Components of an insurance card

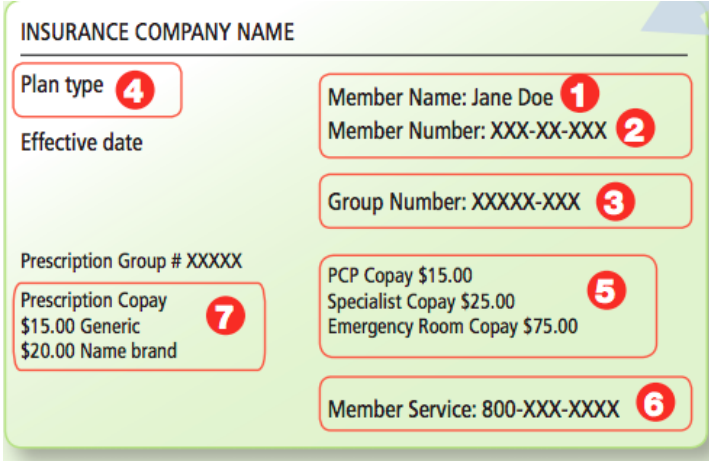



Figure 5-3. Sample insurance card<sup>6</sup>

 <b>ABC INSURANCE</b> <small>PARTNERS</small>		PPO	
1)	Policy Number 356M59557	3)	Office Visit Copay: \$15 Specialist: \$15
2)	Group Number 1234567	4)	Emergency Room: \$150 Urgent Care: \$50 Rx: \$10/20/40
	Group Name XYZ COMPANY	<b>Network Coinsurance:</b>	
	Member Name SUSAN J. SAMPLE	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

**Figure 5-4.** Sample insurance card<sup>7</sup>

**SUBMITTING CLAIMS**

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 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.<sup>8</sup> 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.<sup>9,10</sup> There are various resources available for such patients. Families with children can go to [InsureKidsNow.org](http://InsureKidsNow.org) to check if their child is eligible for Children's Health Insurance Program (CHIP).<sup>11</sup> 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.<sup>11</sup>

Patients with Medicare Part D may qualify for low-income subsidy or "Extra Help" and can apply online at [Socialsecurity.gov/extrahelp](http://Socialsecurity.gov/extrahelp).<sup>17</sup> 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).<sup>5,9,10</sup> 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.

## **MEDICARE PART D PLAN SELECTION**

One way to practice the terminology used in the previous chapter and this chapter is to look at the Medicare plan finder. This tool helps Medicare beneficiaries compare plans and demonstrates some of the differences between types of payer-provider relationships and types of prescription coverage. Medicare Part D is the prescription drug benefit for all Medicare beneficiaries. Even for patients with Medicare and Medicaid, Medicare Part D is the first payer. This section will discuss specifically how to assist patients with comparing options.

The Centers for Medicare and Medicaid Services (CMS) hosts a website to allow consumers to compare Medicare Part D plans. The online tool is referred to as the "Plan Finder" and is accessed at [medicare.gov/find-a-plan](http://medicare.gov/find-a-plan). Information is maintained in this tool by CMS based on information they receive from the insurance companies offering Medicare Part D plans. Patients, caregivers, and advocates can search for details on different insurance plans by

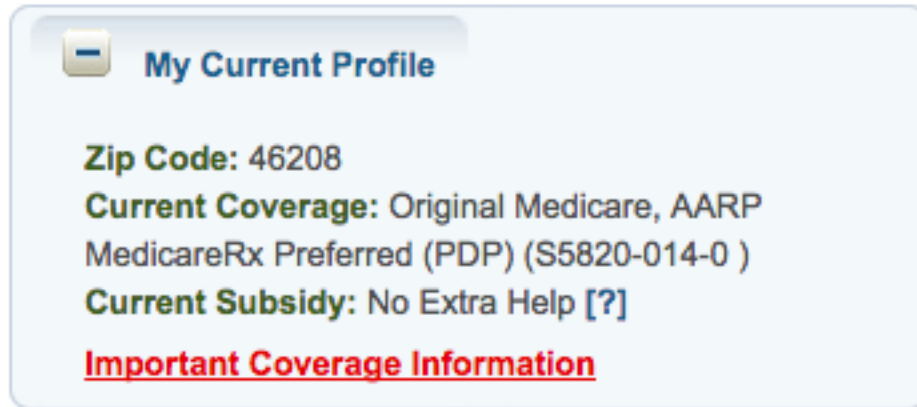


entering information about the patient. The tool will bring up a list of plans sorted in ascending order by price, like airline flights or rental cars.

Let's assume a male pharmacy student, Doug, is helping his Medicare-aged grandmother, Rita. When Doug pulls up the Medicare website at [www.Medicare.gov](http://www.Medicare.gov), he first has to decide whether to do a general search or a personalized search. If the person entering information has access to a patient's Medicare card and their location, as Doug does, then it is best to do a personalized search. This personalized search will allow Doug to verify Medicare's records regarding Rita's coverage and any federal low income assistance benefits she receives. If you do not have access to the information needed for a personal search, a general search can be performed by answering as many guided questions as possible to focus the search to reflect the patient's current coverage.

Doug selects the personalized search option and enters: Rita's zip code, Medicare number (from her red, white and blue Medicare card), last name, effective date for Part A (also found on her card), and her date of birth. When done, he selects "Find Plans." Because her zip code spans multiple counties, it will ask him which county she resides in. If her zip code did not include multiple counties, then it would not show a county selection. This is because insurance companies offering Medicare plans make network arrangements with pharmacies, doctors and hospitals. The county a person resides in will likely impact which plans and pharmacies are available for them.

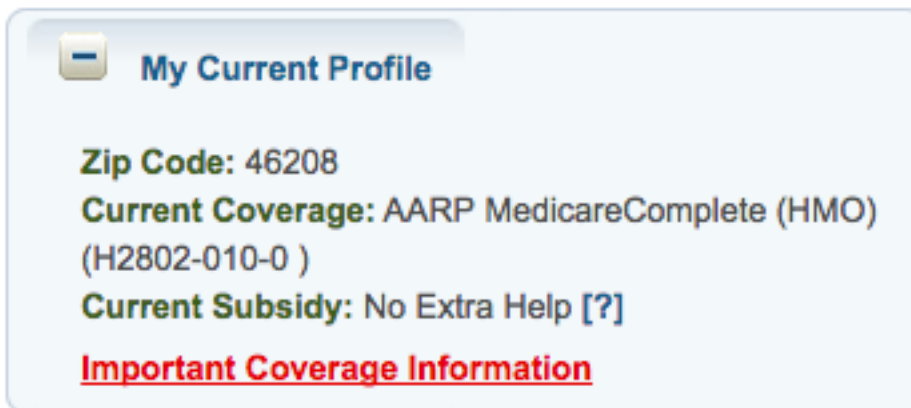
Once this is complete, it is time to enter the patient's medication list. At the "Enter Your Drugs" screen you will see a review of the patient zip code and current coverage in the upper right corner. It should look similar to [Figure 5-5](#).



**Figure 5-5.** Zip code and current coverage listing for MedicareRx Preferred

Rita has Original Medicare A and B and a Part D plan and AARP MedicareRx Preferred, a stand-alone prescription drug plan (PDP). She does not have a low income subsidy from the federal government (referred to as Extra Help).

If Rita had Medicare Advantage, her profile box would look like **Figure 5-6**. Medicare Advantage is also referred to as “Medicare health plans,” which combines Medicare Part D with private coverage for Medicare Parts A and B.



**Figure 5-6.** Zip code and current coverage listing for Medicare Complete

This patient has an AARP MedicareComplete plan, an HMO plan as indicated in parentheses

after the name. If you were unsure if this plan had prescription drug coverage included, you could double check by calling the company, checking their website, or by looking in the annual CMS publication *Medicare and You*. This book is mailed to all Medicare beneficiaries each year and is specific to the state they live in. Patients should be encouraged to retain this volume each year.

Now Doug is ready to enter Rita's medications, careful to enter the medications exactly as brand or generic and the correct dosing. Once that is complete, he will select her preferred pharmacy. The tool will ask which type of Medicare Part D plans are of interest.

Doug can compare three options: stand-alone prescription drug plans with Original Medicare, Medicare health plans with drug coverage, or Medicare health plans (Medicare Advantage) without drug coverage. An easy way to remember is that health plan means medical benefits, like doctors and hospitals, as opposed to a drug benefit or Part D alone. Since Rita already has Original Medicare and a prescription drug plan, that is what she wants to compare. If Doug were to compare Medicare Advantage plans, he would need to pay attention to the medical benefits and their network coverage, such as in-network physicians as well as the prescription coverage details. In this search he will focus on prescription benefits.

A list of all the available plans will show up in the next screen in order of lowest estimated annual cost, though this can be changed. The lowest estimated annual cost is an estimate of the total cost the patient will pay for their Part D coverage. This includes premiums, the monthly fee to maintain coverage, and the costs of their medications. The medication costs include the amount the patient has to pay before they meet their deductibles and any co-pay or co-insurance amounts paid until they reach their out-of-pocket maximum. Doug selects two plans to compare with Rita's current plan in a side-by-side comparison.

The results of this comparison are provided in [Figure 5-7](#). The first column lists her current plan. Please note the current plan may not always be in the same place and may change on future searches.

A		B		C	
<b>Fixed Costs</b>					
Monthly Drug Plan Premium [?]	\$38.80	Monthly Drug Plan Premium [?]	\$31.50	Monthly Drug Plan Premium [?]	\$60.70
Monthly Health Plan Premium [?]	N/A	Monthly Health Plan Premium [?]	N/A	Monthly Health Plan Premium [?]	N/A
Annual Drug Deductible [?]	\$200.00	Annual Drug Deductible [?]	\$360.00	Annual Drug Deductible [?]	\$0.00
Medicare costs at a glance		Medicare costs at a glance		Medicare costs at a glance	
<b>Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs</b>					
Cost at Blackburn Health CTR Phrm		Cost at CVS Pharmacy		Cost at Blackburn Health CTR Phrm	
Enrollment Today [?]	\$4,752.12	Enrollment Today [?]	\$1,226.81	Enrollment Today [?]	\$4,839.72
Cost at CVS Pharmacy		Cost at Blackburn Health CTR Phrm		Cost at CVS Pharmacy	
Enrollment Today [?]	\$1,389.32	Enrollment Today [?]	\$1,234.80	Enrollment Today [?]	\$1,499.40
Cost at mail order pharmacy		Cost at mail order pharmacy		Cost at mail order pharmacy	
Enrollment Today	\$1,993.17	Enrollment Today	\$1,878.28	Enrollment Today	\$1,848.39
Lower your drug costs		Lower your drug costs		Lower your drug costs	

Figure 5-7. Plan comparison

Doug reviews this screen with Rita. He explains that the first row is the monthly drug plan premium she will pay for her stand-alone prescription drug coverage. In the next row, monthly health plan premium is N/A because Rita does not have Medicare Advantage. Therefore, there is no health plan premium listed because Medicare does not list the original Medicare premium here. The third row is the annual deductible which will take effect at the beginning of her coverage for that year. Some plans charge a deductible and others don't. This amount can also vary. Plans are structured as basic or enhanced plans, which is why the plans are not standardized.

Below the first three rows in Figure 5-7 are the estimated annual costs for Rita's drug premium and drug costs (taking the deductible into consideration). This image shows the cost at two community pharmacies and the cost at the mail order pharmacy. Different pharmacies may have significantly different costs if a pharmacy is not in network. Ensure you are looking at the pricing for the pharmacy the patient wants to use and/or you consider the pharmacy location in making your recommendation. A discussion of networks can be found in Chapter

6.

**Figure 5-8** shows the summary of the prescription coverage by the three plans Doug is comparing on the “Plan Finder.” First, Doug notices that plans A and B do not have all of Rita’s medications on the plans’ formularies. He may want to check with Rita’s doctor to see if she can take a generic and whether generic would be covered. If he already knows she must have brand name, then he may want to consider the overall cost of the plans in **Figure 5-10**. The estimated cost will factor in the full cost of the medication not on formulary.

Next, Doug checks to see what types of restrictions exist on the medications that Rita takes. He sees that plan B has quantity limits on the escitalopram oxalate, so she may be limited on the number of pills she can get each month. He checks in the plan finder and sees that she is allowed 30 in 30 days, which is the frequency that she uses the medication. He also notices that the physician will have to complete a prior authorization for the Namenda for all three plan options, so he will need to follow up on that when she begins her coverage. Finally, he notices that the zolpidem tartrate requires step therapy for plan B. He makes a note to contact the insurance company to identify what therapy must be tried first.

A	B	C
<b>4 out of 5 of your drugs are covered on the plan's formulary. [?]</b>	<b>4 out of 5 of your drugs are covered on the plan's formulary. [?]</b>	<b>All of your drugs are covered on the plan's formulary. [?]</b>
<b>Alphagan P SOL 0.1%</b>	<b>Alphagan P SOL 0.1%</b>	<b>Alphagan P SOL 0.1%</b>
No restrictions	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 3: Preferred Brand	Tier 3: Preferred Brand
<b>Escitalopram Oxalate TAB 10MG</b>	<b>Escitalopram Oxalate TAB 10MG</b>	<b>Escitalopram Oxalate TAB 10MG</b>
No restrictions	<b>Quantity Limit</b>	No restrictions
Tier 2: Generic	Tier 3: Preferred Brand	Tier 2: Generic
<b>Namenda TAB 10MG</b>	<b>Namenda TAB 10MG</b>	<b>Namenda TAB 10MG</b>
Prior Authorization [?]	Prior Authorization [?]	Prior Authorization [?]
Tier 4: Non-Preferred Brand	Tier 3: Preferred Brand	<b>Quantity Limit</b>
<b>Synthroid TAB 100MCG</b>	<b>Synthroid TAB 100MCG</b>	Tier 4: Non-Preferred Brand
No restrictions	No restrictions	<b>Synthroid TAB 100MCG</b>
NOT ON FORMULARY <sup>15</sup>	NOT ON FORMULARY <sup>15</sup>	No restrictions
<b>Zolpidem Tartrate TAB 5MG</b>	<b>Zolpidem Tartrate TAB 5MG</b>	Tier 3: Preferred Brand
No restrictions	Step Therapy [?]	<b>Zolpidem Tartrate TAB 5MG</b>
Tier 2: Generic	<b>Quantity Limit</b>	No restrictions
	Tier 1: Preferred Generic	Tier 3: Preferred Brand

**Figure 5.8.** Summary of prescription drug coverage

Now that Doug has a better understanding of the pricing and coverage of these three plans, he looks at the two factors together. Plan B has the most restrictions but would allow her to use her favorite pharmacists at Blackburn Health Center or cheaply at a CVS pharmacy. Plan C does not have a deductible, which would be nice since Rita has costly heat bills in the winter. However, it has significantly higher premiums than the other plans. Mail order is more expensive than retail pharmacy for all three plans so there is no incentive for her to use mail order at this time.

Doug and Rita discuss her preferences for prioritizing premiums, deductibles, pharmacies, and restrictions. Doug remembers that there is one additional piece of information they might find helpful: each plan receives a star rating to give consumers a quality perspective on the plans they are selecting. Doug finds the star ratings on the Plan Finder: plan A is 2.5 stars, plan B is 4 stars, and plan C is 3 stars.

## CONCLUSION

In order to compare medical and prescription insurance coverage it is helpful to first consider

the type of payer-provider relationship. Then 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.

# GLOSSARY

## 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

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