Financial risk management of pharmacy benefits

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Abstract: Financial risk management of pharmacy benefits in integrated health systems is explained. A managed care organization should assume financial risk for pharmacy benefits only if it can manage the risk. Horizontally integrated organizations often do not have much control over the management of drug utilization and costs. Vertically integrated organizations have the greatest ability to manage pharmacy financial risk; virtual integration may also be compatible. Contracts can be established in which the provider is incentivized or placed at partial or full risk. The main concerns that health plans have with respect to pharmacy capitation are formulary management and the question of who should receive rebates from manufacturers. The components needed to manage pharmacy financial risk depend on the type of contract negotiated. Health-system pharmacists are uniquely positioned to take advantage of opportunities opening up through pharmacy risk contracting. Functions most organizations must provide when assuming pharmacy financial risk can be divided into internal and external categories. Internally performed functions include formulary management, clinical pharmacy services and utilization management, and utilization reports for physicians. Functions that can be outsourced include claims processing and administration, provider- and customer-support services, and rebates. Organizations that integrate the pharmacy benefit across the health care continuum will be more effective in controlling costs and improving outcomes than organizations that handle this benefit as separate from others. Patient care should not focus on payment mechanisms and unit costs but on developing superior processes and systems that improve health care.

Index terms: Capitation; Clinical pharmacists; Clinical pharmacy; Contract services; Costs; Drug use; Economics; Integrated health care; Managed care systems; Pharmaceutical services; Pharmacy, institutional; Pharmacy benefit management companies; Pharmacy, community; Reimbursement

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As managed health care evolves and the consolidation of health care entities continues, there will be greater pressure on organizations to move toward integrating health care. Health care in the United States has traditionally been provided through hospitals, physicians, and pharmacies that have been largely compartmentalized. This compartmentalization has been one of the major contributors to the fragmentation of care and the escalation of health care expenditures. Given the continued growth of managed care and redistribution of financial risk to providers through capitation, organizations have been moving toward integrated delivery systems.

This article describes financial risk management of pharmacy benefits in an integrated health system. Southern California's Friendly Hills HealthCare Network will be briefly discussed as an example of a highly evolved integrated delivery system.

Background

Friendly Hills Medical Group started as a small medical group in 1968. By 1996, Friendly Hills was serving 400,000 individuals in prepaid health plans in Southern California. It has 400 health care professionals, operates 41 health care centers, and owns a 274-bed hospital. Of the 3500 Friendly Hills employees, approximately 220 work in the group's 31 outpatient pharmacies, 1 inpatient pharmacy, and 1 drug distribution pharmacy. Friendly Hills is not a health plan but a group-model health care provider that contracts with health plans for the provision of care. Unlike an independent practice association, which loosely links physi-
icians contractually, the Friendly Hills Medical Group is a multispecialty group of physicians that exclusively contracts with the Friendly Hills HealthCare Network to provide professional services. Friendly Hills accepts global capitation (capitation for both hospital and professional services) for 97% of the enrollees it serves. It also assumes financial risk for prescription drug benefits for a majority of its 400,000 members, including capitation for pharmaceutical services for about 75% of its enrollees.

Prescription drug benefits are one of the few areas in health care in which health plans have continued to maintain and manage financial risk rather than share it with providers. Health plans and pharmacy benefit management companies (PBMs) have been carving out prescription drug benefits (i.e., handling them separately from other health care services). However, without integration of pharmaceutical and medical services, there is an overwhelming focus on unit costs and fragmentation in how pharmaceutical care is delivered.

Although increases in medical expenditures have flattened out in recent years, managed care expenditures have continued to rise at double-digit rates. Health plans realize that they alone cannot control inappropriate use of and spending on prescription drugs and have begun to shift the financial risk for drug expenditures to medical providers. But pharmaceutical products and services have not been integrated into the general services of health care providers, so they remain an uncontrolled component of health care costs. The savings that can be generated from pharmacy benefit management can represent a disproportionately large share of an organization’s profitability.

Feasibility of assuming risk for drug benefits

Before a managed care organization assumes financial risk for pharmacy benefits, it must evaluate the feasibility of doing so. One of the basic principles of capitation in managed care is to assume financial risk only for factors that are manageable. Even in today’s managed care environment, the physician still controls 70–80% of all health care spending. Without an alignment of physician financial incentives to drive appropriate use of products, pharmacy financial risk strategies are likely to fail. The type of organizational integration also greatly affects the ability to manage pharmacy risk.

Horizontal integration. Hospital corporations such as Columbia/HCA, Tenet HealthCare, and Sutter Health are examples of horizontally integrated organizations, as are drugstore chains such as Walgreen, American Drug Stores, and Thrifty Payless. Horizontally integrated organizations that do not have equity positions or partnerships with medical groups, independent practice associations, or individual physicians will not have much control over drug utilization and costs and should be extremely cautious about entering into pharmacy risk contracts. Unless physician financial incentives are aligned with those of the horizontally integrated organizations assuming pharmacy financial risk, very little influence can be exerted on those writing the prescriptions and coordinating care.

Vertical integration. Organizations that are highly vertically integrated have the greatest ability to manage pharmacy financial risk. An example is Kaiser Permanente of Southern California. Kaiser’s vertical integration involves incorporating a full continuum of health care provider services with a health plan and providing primary care, specialty care, hospital care, and pharmacy benefits.

Another example is Friendly Hills. Friendly Hills has evolved into a vertically integrated system that does not have the health plan component, but it does enter into globally capitated contracts and provides a full continuum of care. Friendly Hills is able to manage pharmacy risk through its medical group relationship, its ownership of outpatient pharmacies, and its clinical pharmacy expertise. The advantages of vertical integration include unified ownership with common goals and strategies, a culture of cooperation, negotiating leverage, clinical integration, and administrative efficiencies.

Virtual integration. Many health plans and provider organizations are moving away from vertical integration and forming “virtually integrated” companies. This is evidenced by health plans that have sold or are selling off their staff-model operations, such as FHP, CIGNA, Aetna U.S. HealthCare, Foundation Health, and Prudential. In virtual integration, organizations become assemblers of care, developing contractual relationships that form “virtual” organizations. Virtually integrated health plans, such as PacifiCare and Health Net, do not have the same ability to control prescription drug costs as do vertically integrated organizations, but they are not stuck with the huge overhead costs inherent in a vertically integrated system. And because of class-of-trade distinctions, they are able to leverage product prices through rebates and discounts to levels similar to those in vertical systems.

Although Friendly Hills is highly vertically integrated, it, like many other medical provider organizations and physician practice management companies, has some virtual integration characteristics. Friendly Hills evaluates services and contracts out those that are too costly to perform internally. The advantages of virtual integration include the ability to respond rapidly to market changes, contractual relationships that allow for market pricing, coordination of care delivery through negotiated payments and performance guarantees, and a stronger profit incentive.

Key issues in pharmacy risk contracting

Pharmacy risk management begins on the contract
end. Without a clear understanding of the implications of pharmacy benefit risk taking, an organization can experience significant deficits in its bottom line. Before entering into a pharmacy risk agreement, the organization must review historical utilization and expenditure data for the defined patient population. If the provider that the health plan is negotiating with is not aware of historical data—particularly, utilization for the past year—the health plan can use leverage to negotiate beneficial terms and rates. It is also important to know what expenditures are being allocated to the pharmacy risk pool, what is included in the pharmacy benefit plan design, and the demographics of the plan members. As with other types of managed care contracts, pharmacy financial risk can be divided in innumerable ways. Contracts can be established in which the provider is “incentivized,” placed at partial risk, or placed at full risk.

Incentivized contracts. Incentivized contracts generally do not contain downside risk (i.e., the risk of a financial loss due to the utilization of more resources than budgeted). Usually, incentivized contracts are intended to reward cost-effective prescribing behavior. In some cases, a health plan may attach a set of criteria that must be met in order for a provider to receive the full reward. Examples of these criteria include formulary drug compliance levels, generic drug compliance levels, utilization rates, and expenditure targets. Incentivized contracts may contain downside risk with or without upside benefits (i.e., sharing of surpluses generated when costs are less than budgeted).

Partial-risk versus full-risk contracts. Risk sharing is generally based on the establishment of a fund called a risk pool. Amounts are allocated to the risk pool during the year on the basis of a predetermined budget. Actual expenses are then deducted from the pool. The amount due to or owed by the provider is determined from the surplus or deficit in the pool at the end of the contract period. In a partial-risk pharmacy contract, the surplus or deficit is divided between health plan and provider on the basis of a negotiated percentage. In a full-risk agreement, the provider receives or owes the entire surplus or deficit. In any type of risk arrangement, it is important to define what is being allocated to the risk pool.

Capitation with management and administration of benefits. Capitation is a form of full risk in which the provider is paid a fixed amount, generally calculated per member per month. In a capitated contract, it is usually the provider that manages and administers the pharmacy benefit. Capitated contracts can be established in which the health plan administers the benefit and charges the provider for all claims and administrative expenses. This is not the preferred method of benefit administration. The control of benefit delivery is a very important factor, because whoever administers the benefit has influence over product selection, utilization, and costs.

Many health plans are concerned about having capitated contracts with providers for pharmacy benefits. Unlike medical or hospital services that are generally restricted to a limited network of providers, many health plan pharmacy networks contain a majority of the pharmacy providers in a given geographic area. One of the concerns from the perspective of a health plan is patient access to pharmaceutical services. In capitated pharmacy contracts, the inconsistency that may occur in the development of different pharmacy provider networks by different capitated providers may negatively affect a health plan trying to sell a product or a member trying to use a service. Health plans are likewise concerned about inconsistencies in how pharmacy benefits are delivered to members, out-of-area claims procedures, and the process of resolving complaints from members about services.

The main concerns that health plans have with respect to pharmacy capitation are formulary management and the question of who should receive rebates. Whoever controls product selection and drug utilization can demand and receive rebates and discounts from pharmaceutical manufacturers. Rebates used to be an unexpected additional source of revenue to both health plans and PBMs. In today’s health care market, rebates are an integral part of the revenue expected by health plans and PBMs. Without rebates, many health plans would immediately find ways to shift more financial risk to providers of care.

Organizational ability to manage and administer pharmacy benefits

The components needed to manage pharmacy risk depend on the type of contract negotiated. In incentivized, partial-risk, or full-risk arrangements in which the health plan administers the benefit, the provision of clinical pharmacy services is the primary tool that a provider organization can use to manage appropriate drug utilization. Health-system pharmacists are uniquely positioned to take advantage of the opportunities that are opening up through pharmacy risk contracting. Compared with other provider organizations, hospitals have a pharmacy manpower advantage. No other health care setting has as much pharmacy staffing per patient as a hospital. And as automation begins to play a larger role in dispensing functions, health-system pharmacists will be freed to expand their clinical functions.

Many health-system pharmacists have the clinical skills that are needed to practice in a managed care setting. Because these pharmacists use their clinical skills daily—adjusting dosages, interacting with physicians and other health care professionals, and fielding drug information questions—many of them may need only minor refinements in their clinical knowledge base. However, to function efficiently in the managed care environment, pharmacists need additional train-
ing in the business area, specifically, in financial risk management and capitation.

Hospitals generally focus on inpatient formularies and unit costs. Although this may be an important strategy in reducing inpatient drug expenditures, it may ultimately result in higher total pharmacy costs. As hospitals form alliances with physicians and assume risk for pharmacy benefits, lowering overall costs and improving patient care become the new objectives. Since approximately 80% of all drug expenditures are incurred outside the hospital, using an inpatient formulary to guide product use for outpatients does not make sense unless the two formularies are unified. This may mean choosing drugs that are more expensive on the inpatient side because of the lack of direct or bid contracts for those specific agents. But it may also mean substantially lowering costs on the ambulatory care side. With a unified formulary, hospital and outpatient pharmacy inventories decrease as the need to carry multiple products in the same therapeutic drug categories diminishes. Patient care becomes more standardized, and malpractice litigation declines.2

Creating a single formulary that is managed from both the inpatient and outpatient settings is one of the steps needed to integrate patient care. Health-system pharmacists who are involved in a unified formulary selection and management process gain a greater understanding of the continuum of patient care. Suddenly, patient care does not end when the patient is discharged from the hospital.

Internal and external PBM functions

When an organization elects capitated reimbursement for pharmaceutical services, it must determine which components to buy, lease, build, or outsource.3 The level of integration, the amount of internal departmental resources, and the availability of clinical services are all factors that must be considered. For most organizations, it will make sense to outsource at least some functions to a PBM or a third-party administrator (TPA). Some of the functions a PBM can provide are drug development and maintenance of employer relationships, underwriting, benefit plan design, formulary development and management, manufacturer contracting and rebates, administration of benefits, claims administration, integration of clinical and financial data, and utilization reporting and management. In contrast, TPAs primarily perform claims administration services and utilization and financial reporting. In hospitals, most of the clinical and drug-utilization-management functions can be performed internally. Other functions, such as pharmacy network development, claims processing, utilization reporting, and provider and customer services, should be outsourced.

Internally provided functions. Formulary development and management. A formulary that encompasses cost-effective and therapeutically sound product choices should be developed internally in cooperation with the prescribers in the organization. Achieving such consensus during formulary development will ensure the greatest rate of compliance. Drug products should not be selected solely on the basis of costs or contractual relationships but should be developed by using objective-based criteria6 and outcomes management information. Although a greater share of drug rebates can be gained through a PBM formulary (when using a PBM for pharmaceutical contract management), rebates represent a fraction of the total costs and savings an organization can generate through utilization management and appropriate product selection. Rebates should not be the primary factor in determining whether a drug is included on a formulary.

Clinical pharmacy services and utilization management. Clinical pharmacy services must be designed to support physicians in their delivery of patient care. Often, tight controls on utilization, such as prior authorizations and highly restrictive formularies, degrade patient care. Such controls may lead to delays in treatment and negative perceptions by patients about the quality of care.2 A negative perception of care adversely affects both the health plan and individual providers.

Utilization reports and education for physicians. Pharmacists can be very effective in managing pharmacy benefits by providing reports and education to physicians about their prescribing. Utilization reports can be generated by a PBM or a TPA. Customized reports can be generated by an internal information department through the downloading of claims data and creation of a data repository. All reports should be analyzed by pharmacists to verify their integrity and validity before they are distributed to the prescribing physicians. The reports provide important feedback to physicians about their prescribing habits. Pharmacists providing physician education through group or one-on-one sessions should refer to the utilization reports.

Outpatient pharmacy ownership. Pharmacy costs can be controlled at the provider level, the TPA level, and the outpatient pharmacy level. The pharmacy provider level is one control point that is often ignored by health plans and provider organizations that are virtually integrated. Although steep discounts can be negotiated with pharmacy providers, it may make sense for some organizations to open or use their own outpatient pharmacies. In addition to the financial benefits of outpatient pharmacy ownership, outpatient pharmacists can play a major role in integrating patient care. Outpatient pharmacists who are employed by organizations that take on and manage pharmacy risk can intervene regarding inappropriate medications and dosages, provide feedback and education to prescribers, and play an integral role in disease management programs.

To complete a make-or-buy analysis, the financial and clinical performances of staff pharmacies must be
compared with those of contract pharmacies. Evaluating staff pharmacies as profit centers rather than cost centers and holding pharmacy staff members accountable for financial performance and productivity increase entrepreneurship and creativity to levels that are often lacking in cost-based performance systems. If a pharmacy is not profitable—even if a majority of the pharmacy’s “revenue” is coming from a calculated fee-for-service rate—it must be decided whether to close the pharmacy and contract for services. Other factors to consider in evaluating the feasibility of outpatient pharmacy ownership may include patient satisfaction, the location of existing pharmacy providers, the number and types of prescribers, the estimated prescription-capture rate, and pharmacy utilization and the financial performance of prescribers at the designated location.

**Externally provided functions.** Claims processing and administration. In today’s managed care environment, it usually makes sense to contract for claims-processing services instead of performing the tasks internally. First, claims-processing fees have been dropping. Even if an organization administers benefits for an extremely large population for which pharmaceutical services are reimbursed on a capitated basis, it may be less expensive to outsource this highly technical area. Second, there are huge capital costs associated with developing an inhouse pharmacy claims management system. The capital outlay, in combination with rapid advances in hardware, may quickly lead to a costly, obsolete system. Finally, a contracted claims administrator may respond more quickly to demands made by a pharmacy than to demands from an inhouse information department. Often, pharmacy computerized systems take a back seat to other organizational computerized systems. Because prescription drug benefits operate in a real-time, online environment, any system downtime will incapacitate the prescription-filling process and will cause service-related problems for members and pharmaceutical service providers.

Claims-processing services can be provided by a PBM or a TPA. Provider- and customer-support services. Provider- and customer-support services are areas that many organizations may decide to outsource. Online access is needed to handle calls from providers or members. If a PBM or a TPA is used to provide this service, it must be able to handle calls regarding eligibility; covered benefits; benefit plan design; copayments, deductibles, and other cost sharing; maximum allowable benefits (especially in plans for the elderly); pharmacy network availability; and complaints from members. The PBM or TPA must also have the ability to process and pay claims for out-of-area services in a timely manner. It is important to know how well the customer service department handles problems related to member services. Technical support services available to pharmacy providers should include answering questions about how to enter member information correctly during claims processing, payment calculations and maximum-allowable-cost pricing, payment cycles, and check disbursement. A technical service department must also be able to refer the caller elsewhere when it cannot answer a question.

Pharmaceutical rebates. An organization receiving capitated reimbursement can negotiate directly with pharmaceutical companies for drug rebates, tap into a contract PBM’s manufacturer rebates, or arrange for a combination of these. Directly negotiating with manufacturers for rebates is time-consuming and requires additional resources to generate reports and monitor contract performance. However, directly negotiating for rebates may give the organization more flexibility in product selection and generally yields a higher financial return than using another organization’s rebate contracts. Also, a PBM may require that its formulary be used. It is important to select a PBM that is flexible in sharing its drug rebates. TPAs generally do not provide this function.

Utilization reports. Unless an organization has an internal department with the ability to generate reports that can be used to monitor and manage drug utilization, it may be better to have a contract PBM or TPA generate the reports. PBMs and TPAs have a variety of standard reports and reporting packages to select from. For additional fees, almost all PBMs and TPAs provide customized reports.

Pharmacy provider networks. A pharmacy provider network can be quickly established through a PBM. TPAs generally do not provide this service. Although pharmacy networks can be established by a capitated provider, the difficulty and time involved in network development make this a good area to outsource. Almost all PBMs have existing contractual relationships with community pharmacies. A capitated provider organization can establish a customized panel of pharmacy providers by modifying a PBM’s pharmacy network. Contract pharmacy providers cannot be expected to display the same level of commitment to an organization’s formulary and utilization management as staff pharmacies unless reimbursement is modified to reward those who intervene when prescribing decisions are less than optimal. Cutting fee-for-service reimbursement rates will only lead to increased utilization and dispensing by contract pharmacies. To help establish an incentive system, the PBM should be asked to describe its ability to pay a variable fee or incentive linked to such factors as formulary drug compliance, generic drug utilization, and professional services.

**Conclusion**

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separately. Patient care should not focus on payment mechanisms and unit costs but rather on the development of superior processes and systems that improve health care.

References