Chapter 17

FUNDAMENTALS OF HEALTHCARE BENEFITS FROM THE EMPLOYER PLAN SPONSOR'S PERSPECTIVE

CRAIG STERN

PART I FUNDAMENTALS OF HEALTHCARE BENEFITS FROM THE EMPLOYER PLAN SPONSOR'S PERSPECTIVE

INTRODUCTION

Healthcare benefits are designed to meet the needs of beneficiaries. Benefits must rest on the foundation of the organization's needs and expectations. As such, a benefit is not defined until there are analyses of demographics, utilization, and the current and future requirements of the beneficiary population. Then the healthcare resources, costs and financial projections are analyzed to determine the infrastructure that will be required to deliver the benefits. This chapter focuses on the elements of healthcare benefits.

WHAT IS THE NEED FOR HEALTH INSURANCE?

Individuals at different age levels must ascertain their need for healthcare services. The uncertainty of one's health and the expense of requiring hospitalization, physician care, or other health resources lead many to consider purchasing health insurance. As an economic and cultural decision, some purchase monthly benefits, while others choose only catastrophic care for unintended problems requiring hospitalization.

WHAT ARE THE TYPES OF HEALTH INSURANCE?

Individuals (*beneficiaries*) may receive health insurance protection through several vehicles. They may be covered under federal and state government sponsored plans like Medicare and Medicaid, Blue Cross/Blue Shield service organizations, or health maintenance organizations (HMOs) and preferred provider organizations (PPOs). They also may participate in group insurance plans offered by their employers, or purchase individual insurance through mass purchasing groups (e.g., credit unions, or professional or trade associations).

The decision for purchasing individual or group healthcare insurance is based on "insurability." To purchase individual insurance, a person must fill out a health questionnaire and complete a medical examination. Insurability is based on the applicant's personal health, medical history, age, habits, and income. Group health plans, on the other hand, are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA an applicant does not have to take a medical examination. Group health is based on the *law of large numbers* such that the impact of individual health risks is mitigated by insuring a large number of individuals. Group health plans must find a balance between the number of healthy versus sick people in order to mitigate the impact of high cost and utilization in the population insured.

The most popular type of health insurance in the United States is employer-sponsored group coverage. As of 2003, 159.2 million people were covered by employment-based plans, according to the Employee Benefit Research Institute. This includes non-elderly full time employees (people under age 65 who work more than 34 hours per week), and part-time employees (people who work between 21 and 34 hours per week). As of 2006, 62.2 percent of the non-elderly population had employment-based health insurance, according to EBRI reports. This compares with 62.7 percent in 2005.

WHAT IS GROUP HEALTH INSURANCE?

Group health insurance includes medical, dental, vision, prescription drug, mental health, and long-term care coverage. Beneficiaries receive full or partial reimbursement for their various expenses, which usually include hospital and surgical expenses, diagnostic x-rays, tests, and physician visits. Coverage is defined in a master contract issued to the group and relayed to beneficiaries through the Summary Plan Description (SPD).

Group health is commonly purchased by employers for their employees and retirees. Because insurance is governed by the *law of larger numbers*, large employers can purchase their own health insurance at favorable rates, or pool resources and purchase jointly as coalitions. Small employers can use similar methods by pooling their employee lives into joint purchasing groups or coalitions.

Unions commonly receive healthcare benefits through collective bargaining with employers. Typically they offer group health insurance to their members through a *trust*. The trust, or Taft-Hartley Plan, is jointly managed by the union and employers. The trust

purchases the group health policy for members who are employed by the same company, or for union members employed by different companies.

Insurance also is offered by professional, trade, retail, and chamber of commerce organizations. These groups commonly offer insurance that is specific to their business, for example, malpractice insurance. If membership in the organization is based on employment, the groups are known as multiple employer welfare arrangements (MEWA), or multiple employer trusts (MET). If they offer health insurance, they are known as Association Health Plans (AHPs). In AHPs, the groups purchase the insurance policy and offer it to their members for a fee.

States and cities also can sponsor coalitions of small employers called *health insurance purchasing coalitions*, or *cooperatives*. These coalitions are formed to improve the purchasing power of their members. Their intent is to make healthcare insurance more available and affordable, where individuals are offered multiple health plans to choose from, but the employers pay only one bill. Examples of these groups are the Pac Advantage in California and HealthPass in New York City. There is an opportunity for multiple state cooperatives to join together and jointly purchase health insurance. By pooling their resources, they receive lower costs and can promote value-based purchasing through requirements on quality or quality incentives for better care. This is commonly known as *pay for performance (P4P)*.

HOW DO COMPANIES BUY HEALTH INSURANCE?

The diversity and complexity of the various health insurance options available in the marketplace is usually beyond the scope of employers, including the larger ones. Therefore, most companies use intermediaries to help them develop a plan, research their options, and negotiate competitive bids. These intermediaries may be insurance agents (who represent insurance companies), *brokers* (who represent employers), health benefit consultants, or third party administrators (TPAs). These intermediaries work with the *underwriters* at insurance companies to define the employer's or group's acceptability for insurance based on risk. *Risk* in insurance terms is the chance that the claims will exceed the expected level. Underwriters evaluate companies by developing risk profiles that consider the composition of the employer or group according to age, sex, prior claim experience, and the plan design. The risk will define the premium level that will be paid.

WHY AND UNDER WHAT CIRCUMSTANCES WOULD AN EMPLOYER SELF-FUND GROUP HEALTH INSURANCE?

Some large employers decide that funding their own health insurance is less expensive than purchasing it from an insurance company. As well, the employer may determine that the benefit plan that they desire is not available at a reasonable cost or that the risk for loss is less than that determined by the insurance company's underwriter. Whether for cost or breadth of benefit offering, an employer or group that decides to self-fund must make several critical decisions. A self-funded program avoids the overhead costs of an insurance company, but

they must decide whether to pay claims internally or outsource this function. Typically, self-funded programs contract with a TPA or insurance company to handle the benefit administrative functions. These functions are directed to the payment of claims in an expeditious manner, to managing the resolution of claims problems and reporting on benefit utilization.

WHO REGULATES HEALTH INSURANCE?

Benefits provided under insurance contracts are governed by state laws as defined by the McCarran-Ferguson Act of 1948. Health plans are covered under the rules and regulations of the Department of Insurance (DOI) for the state in which the employer is licensed. The DOI publishes a *Health & Safety Code* that lists rules and regulations. Self-funded health plans, that is, employers that fund health plans themselves, are covered under ERISA that preempts state laws (see below).

WHAT IS ERISA AND HOW DOES IT APPLY TO GROUP HEALTH INSURANCE?

Federal law does not require employers to provide medical coverage for their employees. However, once a health plan is established, there are federal laws that regulate the entities. These include: the Employee Retirement Income Security Act of 1974 (ERISA); the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Mental Health Parity Act of 1996 (MPHA); the Newborn's and Mothers' Health Protection Act of 1996 (NMPHA); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); the Pregnancy Discrimination Act (PDA; 1987 amendment to the Civil Rights Act of 1964); the Age Discrimination in Employment Act of 1967 (ADEA); Omnibus Budget Reconciliation Act of 1993 (OBRA '93); the Women's Health and Cancer Rights Act of 1998 (WHCRA); and Family and Medical Leave Act of 1993 (FMLA).

ERISA was written to protect employee pensions, not medical insurance plans. The law includes a definition of "welfare plans" that broadly includes health plans within its scope. ERISA requires that plans must meet certain requirements:

- Plans must have a written document defining the plan.
- Plans must be administered according to the document.
- The document must be understandable to the average employee, and copies of the plan (the SPD) must be given to employees.
- The document must describe covered benefits, and clearly define the conditions for denying coverage of a service.
- The document must indicate who administers the plan and how the benefit is funded.
- Annual financial reports must be provided to the government, and summaries (*summary annual reports [SARs]*) must be given to participants.

COBRA is another piece of legislation that implicates medical insurance. COBRA requires coverage under the employer's medical plan after termination of employment provided that the employee pays the full cost of the coverage.

WHAT ARE BLUE CROSS/BLUE SHIELD PLANS AND HOW DO THEY DIFFER FROM PRIVATE INSURERS?

Blue Cross associations were established in the 1930s under the auspices of the American Hospital Association. Blue Shield associations were established in the 1940s under the auspices of the American Medical Association. Blue Cross organizations guaranteed payment in full to hospitals for services, while Blue Shield organizations provided a similar guarantee to physicians. The close association between hospitals and physicians with the Blues prompted the providers to offer discounts on fees. Later, many Blue Cross and Blue Shield organizations associated to form Blue Cross/Blue Shield (*the Blues*) associations.

Blues plans contract directly with physicians, hospitals, and other healthcare providers to establish the charges for services to their members. When a member goes to a healthcare provider, the bill for charges is sent to the Blues for payment. The Blues offer health plans similar to private insurers but often at deeper discounted prices. Typically, the Blues offer base medical plans with supplemental major medical plans if employers wish to purchase more coverage. They also offer many types of managed care plans, for example, HMO, PPO, or point-of-service plan (POS).

Private insurers offer supplemental insurance to the plans offered by the Blues. As for-profit organizations, they pay premium taxes (about 2.5%) to the state. In contrast, many of the Blues are still non-profit organizations and pay no premium tax to the state. As a non-profit organization, the Blues (many are now for-profit) receive exclusive rights to hospital discounts granted by the state; however, in return for these rights, the Blues allow state regulation of their rates and eligibility criteria for individual contracts. As a result, many of the Blues have experienced higher costs without being able to raise premium rates or to deny coverage for certain pre-existing conditions similar to private health plans. Their response has been to raise group health premiums for employers to cover the shortfall in individual contracts. This has lead employers to seek alternative options to lower costs consistent with their actual cost trend (or inflation).

HOW DO EMPLOYERS DESIGN HEALTH CARE PLANS?

Employers use group health insurance as employee benefits, or even as a competitive strategy to hire desired employees. The economic climate often determines the level of benefits that employers can afford. They may also consider their corporate culture, and the demographics of their employee population. Given these baseline fundamentals, employers frequently follow one of five general strategies for health benefit design:

- *Managed Competition:* Employees are offered choices between multiple health plans with the goal of driving employees to the most cost-effective plan.
- *Total Compensation:* Employee benefits are negotiated as a single package together with base salary and incentive pay with the goal of driving employees to consider their total take-home compensation. The result is to drive employees to consumer-

driven health plans (CDHPs) that shift more cost to employees by requiring them to make value judgments about the most cost-effective plan for them.

- *Paternalistic:* Employees are fully covered, or require a modest employee contribution with the goal of making the employee the dependent of the employer. The employer utilizes PPOs to control costs.
- *Flexible/Market Driven:* The most common of strategies where employees are offered several options of PPO, HMO, and CDHP with the goal of allowing employers to maintain a competitive hiring and employee retention position in the marketplace by responding to employee needs.
- *Consumer Driven:* These strategies (i.e., CDHPs) move more of the benefit expense to the employee with the goal of making them a more informed consumer supported by financial incentives, information, and comparisons between available options.

WHAT TYPES OF HEALTH PLANS ARE AVAILABLE?

Group health plans fall into the two broad categories of traditional or managed care. Traditional group health is a basic medical plus major medical plan (also known as *base-plus* or *first-dollar* plan), or a comprehensive medical plan (also known as *comprehensive*).

The base-plus plan is a two-part health insurance plan composed of basic medical coverage (hospitalization, surgery, physicians' visits, diagnostic laboratory tests, and X-rays) and a major medical which covers other expenses. The base-plus has limits on the services, e.g., number of hospital days covered, but there are no deductibles or coinsurance for the employee to pay. Employees are compensated for the total expense from the first-dollar of expenses.

The major medical is broader and, as a result, while there are fewer limits, the employee is required to pay more of the expense through deductibles and coinsurance until a maximum out-of-pocket (MOOP) expense is reached. After that threshold is reached, the employer reimburses expenses in full.

A comprehensive plan provides coverage for most healthcare expenses using a standard reimbursement formula based on a deductible and a coinsurance paid by the employee for all covered expenses until a MOOP is reached, after which the employer pays all expenses in full.

Managed care is a healthcare delivery system where the plan or insurer influences the type of medical care delivered. Managed care actively "manages" both the medical and financial aspects of patient care by providing comprehensive plans for predetermined prices. The onus is on the plan to determine the most cost-effective and efficient methods to deliver the required care.

WHAT TYPES OF SERVICES ARE COVERED BY HEALTH PLANS?

Covered expenses are eligible for payment under group health plans, although employees may be required to pay whole or part of the expense. Covered expenses vary by plan, but usually include professional services of physicians and osteopaths, hospital charges for

semiprivate rooms, surgical charges and anesthesia, nursing services, home health care, diagnostic x-ray or radium treatments, blood transfusions, oxygen, prescription drugs, ambulance services, durable medical equipment (DME), artificial limbs and prostheses, casts, and wheelchairs. Outpatient services are covered for emergency treatment, surgery, and services rendered in outpatient labs or x-ray departments. Mental health may be included or insured separately (*carve out*) with a separate premium. Hospice care is covered by Medicare Part A but may not be covered by traditional plans because this type of care does not cure illness. Traditional plans must cover palliative care to include hospice coverage for their beneficiaries. More controversial are alternative therapies (i.e., herbal remedies, acupuncture, etc.), which are covered by only some plans. A common criterion for coverage for acute, outpatient, and emergency treatment is that they are all regulated by applicable licensing agencies so that there is oversight of safety and compliance with state laws.

Experimental treatments have traditionally not been a covered benefit. The problem lies in the definition of "experimental" used in the benefit language. Where does treatment become non-experimental? How is a treatment tested to determine if it has any value and if it is safe? These questions lie at the root of the problem, and have lead to the difficulty in covering experimental treatments.

WHAT ARE THE ELEMENTS OF CONSUMER-DRIVEN HEALTH PLANS?

Traditional health plans are based on providing *defined benefits* (DB) for employees. These benefits are listed in the SPD given to employees to define what is covered on their health plan. When services are rendered, the employee receives an *Explanation of Benefits (EOB)* to define which services were covered in their plan, and a rationale for the cost share that is the employee's responsibility. With the rising cost of healthcare services, emphasis has shifted from providing defined benefits, to making a *defined contribution* (DC) to the employee. The defined contribution shifts the responsibility for payment and selection of healthcare services from the employer to the employee, according to the Employee Benefit Research Institute. DC assumes that an employee will spend their own money more wisely than if they are spending their employer's money. DC forces employees to shop for healthcare the same as they do for other goods and services.

There are several types of DC benefit plans; namely, health reimbursement accounts (HRAs), medical savings accounts (MSAs), health savings accounts (HSAs), and consumer-driven dental care. An HRA is paid solely by the employer, where the employee is reimbursed for medical expenses up to a maximum dollar amount for a defined period of time. Any unused portion is carried forward to the next period to increase the maximum dollar amount in that period. In an MSA, the employer gives a fixed dollar amount and the employee sets up their own account. Medical expenses are drawn from the MSA and any balances can build over time. An HSA is a tax-exempt trust that is established for the exclusive purpose of paying qualified medical expenses for the beneficiary. An individual may establish an HSA as long as the health plan

includes a high-deductible feature (usually $1,000 annual MOOP for an individual). In DC, the employee decides which type of plan is best for his/her needs. The selection of the DC plan is based on one of at least three models:

- The employer gives the employee a fixed dollar amount (*voucher*) that the employee may use to buy whichever health plan they choose.
- The employer identifies a group of health plans with varying services and costs for which the employer has pledged to pay a fixed premium amount. Any surpluses are paid to the employee and any balance of payment must be borne by the employee.
- The employer can construct a medical savings account with a financial entity or an HMO, which then tracks the utilization and pays cost from the account.

CONCLUSION

The subject of medical insurance is complex and Part I of this chapter only scratches the surface. It is not sufficient to define the needs of a population and contract a provider network. Regulatory, legislative, tax, and financial implications must be considered as well. The dynamic nature of insurance as populations change, and the role of different financial and delivery models as design experiments is at the heart of the issue. The employer-based group health model is one such experiment that is now undergoing radical change to consumer-based models. The marketplace will eventually decide which of these models will remain.

PART 2 Measuring Health Plan Performance

INTRODUCTION

Managed care is based on aligning insurance models and delivery systems to provide medical care that meets the expectations of patients and payers. The alignment of the various stakeholders in the medical system requires that there be methods to test performance, financial controls, and fiscal intermediaries (e.g., TPAs, pharmacy benefit managers [PBMs]) to ensure compliance with benefit designs. This section focuses on the use of audits, contracts, and market intelligence to provide oversight and management of these systems.

AUDITS

All organizations are obligated to establish financial controls on their operations to protect the interests of their owners, shareholders, and employees. They also are obligated to ensure that when they contract services to outside vendors, their benefits and health plan

objectives are administered in a fashion that is consistent with their plan obligations. A contract defines the obligations of both parties when an outsourced vendor is used.

How do we test compliance with contracts, contractors, and internal control systems? Are claims administration policies sufficient to ensure a high level of accuracy in claims payments? When should we audit? What do we audit?

Audits are the standard approach for testing systems and validating the results when the systems are applied. Their purpose is to provide accountability for managers and officials to their governing boards. All managers and officials that are entrusted with the handling of public or corporate resources "are responsible for applying those resources efficiently, economically, and effectively to achieve the purposes for which the resources were furnished" (Government Auditing Standards, 1.13.b). As a result, the term *audit* refers to both financial and performance audits. *Financial audits* provide independent reports directed to an entity's financial performance. They identify if the financial information is presented fairly and if its internal controls comply with laws and regulations. *Performance audits* provide an assessment of the performance of organizations, programs, activities or functions of an entity. They improve accountability, oversight, and are used as a basis for decision-making or corrective actions.

FINANCIAL AUDITS

Financial audits include financial statements (balance sheets, income statements, cash flow) as defined by a strict accounting perspective. These audits include determinations of: 1) whether the information is presented in accordance with established criteria; 2) whether the entity has adhered to financial compliance requirements; and 3) whether the internal controls over financial reporting and safeguarding of assets is suitably designed and implemented to achieve the objectives. These criteria are detailed in financial audit criteria established by the American Institute of Certified Public Accountants (AICPA).

Audits that are commonly performed in healthcare systems fall under the *attestation standards* developed by the AICPA in the AT Section of the *Statements on Standards for Attestation Engagements*. Attestation standards focus on contract compliance and reviews of systems to determine if they meet adequate standards. Opinions are given on the adequacy of these controls.

Attestation audits (also called *engagements*) require a standard for comparison. For example, the methods for paying incurred services (e.g., pharmacy claims) needs to be clarified and codified. The pharmacy vendor or fiscal intermediary has standards for payment. The goal of the engagement is to achieve clarity such that all concerns are addressed. This may include re-pricing of claims, testing of eligibility for benefits, and validation of prior authorization controls for payment of non-benefit claims. The role of the auditor in this regard is to provide an independent opinion of the veracity of claim administration and to push for more clarity and transparency of systems.

PERFORMANCE AUDITS

Performance audits are "objective and systematic examinations of evidence for the purpose of providing an independent assessment of performance" of an organization, program, activity, or function (Government Auditing Standards). The goal of these audits is to provide accountability and to assist decision makers with the information that they need for oversight of their operations. Performance audits have three elements: economy, efficiency, and program audits.

Economy and *efficiency* in this context include determinations of: 1) the appropriate use of resources (people, funds); 2) the causes of any inefficient processes; and 3) compliance with rules and regulations. *Program audits* apply to determinations of: 1) the extent to which the desired results of programs, functions, or activities are achieved; 2) the effectiveness of organizations and their programs; and 3) compliance with rules or standards relating to specific programs, functions, or activities.

Ultimately, the goal of performance audits is to provide information. Managed care organizations and their many contractors have both regulatory and business requirements for oversight. Performance audits provide the information necessary for effective oversight.

ELEMENTS OF A VENDOR CONTRACT

Because attestation audits focus on contract compliance, it is often necessary to define a model contract. How can an entity be sure that critical elements are included in contracts? As with any vendor contract, there are specific elements that must be included to ensure that the entity is receiving the services and pricing that are consistent with their business requirements. A PBM, TPA, or fiscal intermediary (FI) contract is no different. Provider contracts are frequently boilerplate and allow for minimal customization. The entity, as the client, must decide which elements are important and how to measure the performance of the vendor.

What elements should be considered in any contract? A contract with an intermediary (used collectively for all PBMs, TPAs and FIs that administer pharmacy benefits) must consider the fundamental service portfolio that is offered and how it fits with desired service requirements. Intermediary service portfolios can be distilled into the following:

- Pharmacy and specialty injectable claim administration
- Pharmacy benefit administration
- Pharmacy network contracting and oversight, including mail service, internet and specialty providers
- Formulary construction and management (drug utilization review), and prior authorization support
- Rebate collection and management
- Data and reporting
- Value-added programs (e.g., disease management)

To administer a contract, the intermediary must have their incentives aligned with those of their client. Of particular concern is that pricing methodologies are well defined and transparent, services are delivered on a timely basis for both members and administrative issues, and that the network of providers is delivering optimal services as defined in the contract.

As the fiduciary, the managed care entity or employer defines the benefit. The intermediary administers the benefit in compliance with all applicable rules and regulations. To ensure compliance with the benefit, the intermediary contract includes measurable parameters for all critical performance elements. All service and chargeable elements have performance and service guarantees, as well as financial penalties for non-performance to ensure contract compliance.

MARKET INTELLIGENCE: ELEMENTS OF A REQUEST FOR INFORMATION OR A REQUEST FOR PROPOSAL

The process of assessing the performance of current benefits and providers requires an evaluation of the current marketplace. This type of market intelligence ensures that contracts and pricing reflect current market realities. Market intelligence also allows payers and employers to benchmark their benefits and contracts with other similar entities. There are several methods for assessing the market, two of which are request for information (RFI) and request for proposal (RFP).

The RFI is an informal request for information. The payor or employer is trying to determine market benchmarks for pricing, access, contracts, vendor performance, or the competitive elements of various value-added programs. The answers to an RFI are nonbinding and are not used as a basis for contracting.

An RFP is a formal request to determine the current marketplace for access, service and price. In a competitive market the vendors offer their best pricing and service as well as an offer that is consistent with the RFP questions. All benefit elements and service needs should be considered for inclusion in an RFP. There are also standard elements that should be included, namely:

- Short description of the vendor, their business model, and disclosure of any conflicts of interest with the client or their customers
- Service portfolio required with guarantees and penalties
- Benefit design and member eligibility requirements
- Reporting and data requirements
- Pricing guarantees required on a pass through claim basis to validate manufacturer pricing
- Value-add programs of interest, including performance measurement and return on investment (ROI)

The critical element is that the RFP must clearly define and guarantee the member access, service requirements (member and administrative) and pricing that are non-negotiable. Negotiable services can be added based on interest, discretion, and perceived value; however, the value must be clearly defined.

CONCLUSION

The process of auditing and evaluating the effectiveness of managed care systems is frequently mundane, but critical. The public, patients, payors, employers, and others who use and pay for medical care expect a high degree of efficiency and consideration for their needs. Expectations are high for both payors and providers that they are engaged in ethical conduct, and that the systems for implementing the provisions of medical insurance are constantly improved. To achieve exemplary outcomes, systems must constantly be re-evaluated and motivated to greater achievements. In this context, everyone is an auditor.

SUGGESTED READING

American Institute of Certified Public Accountants, Statements on Standards for Attestation Engagements, 2002. Available at http://www.aicpa.org/Professional+Resources/Accounting+and+Auditing/Authoritative+Standards/attestation_standards.htm. Accessed 26 September 2008.

Barcia S.M., Requests for proposals: do we really need them? *Health Manag Technol*. 1999; 20(8): 24-25.

Broekemeier R.L., Brewer P.E., Johnson M.K., Audit mechanism for hospital drug distribution., *Am J Hosp Pharm*. 1980; 37(1): 85-88.

California Health Decisions, Drug Formularies, A Consumer Tool. Available at http://www.calpers.ca.gov/eip-docs/member/health/edu/pharm-kit-07.pdf. Accessed 10 July 2008.

Corchnoy B., Pharmacists as fiscal auditors save hospital millions of dollars. *Hosp Pharm*. 1987; 22(11): 1101-1104.

Cornelis W.A., Audit criteria for drug-use review. *Am J Hosp Pharm*. 1986; 43(7): 1685-1686.

Daniels N., Teagarden J.R., Sabin J.E., An ethical template for pharmacy benefits. *Health Aff.* 2003; 22(1): 125-137.

Department of Human Services, Med-Quest Division, Kapolei, HI, Request for proposals. June 2002, No. RFP-MQD-2002-007

Edlin M., Cost and utilization correlations force plans to study their drug benefits. *Manag Healthcare Exec* 2004; 14(10): 46-48.

Enright S.M., Developing the request for proposal. *Top Hosp Pharm Manage*. 1989; 9(3): 1-8.

Garner J. C., *The Health Care Answer Book,* 7th Ed. New York: Wolters Kluwer/Aspen Publisher; 2007.

Ghotbi L., Managing pharmaceutical trend: a California perspective. 20th Annual Research Meeting, The premier forum for health services research, Nashville, TN, June 27-29, 2003.

Gilderman A., Trends in Effective Formulary Development, July, 2004, Clinical Services, Prescription Solutions.

Habeger H.E., Hardy D.L., Auditing function for staff pharmacists. *Am J Hosp Pharm*. 1985; 42(5): 1038, 1040.

Hoffmann R.G., Auditing hospital pharmacies. *Osteopath Hosp Leadersh*. 1987; 31(4): 20-21.

Huber S.L., Patry R.A., Hudson H.D., Godwin H.N., Strengthening the formulary system by implementing a drug usage guidelines program. *Hosp Formul*. 1984; 19(8): 664-668.

Josephs A., UR/Quality and Compliance Collaboration, Corporate Compliance Hillcrest Health System, Texas Medical Foundation; 2004 (provider meeting).

Kamal-Bahl S, Briesacher B., How do incentive-based formularies influence drug selection and spending for hypertension? Health Aff. 2004; 23(1): 227-236.

Keys P.W., Giudici R.A., Hirsh D.R., Gonzales S.M., Pharmacy audit: an aid to continuing education. *Am J Hosp Pharm*. 1976; 33(1): 52-55.

Landon B.E., Reschovsky J.D., Blumenthal D. *Physicians' views of formularies: implications for medi-*

care drug benefit design. Health Aff. 2004; 23(1): 218-226.

Malkin J.D., Goldman D.P., Joyce G.F., The changing face of pharmacy benefit design. *Health Aff.* 2004; 23(1): 194-199.

McGovern E.M., Campbell A., Lindsay H., et al., Quality improvement in community pharmacy practice. *Int J Pharm Pract*. 2002;10(suppl):R8.

Miller L.L., Miller J.E., Designing your health benefit plan. *Empl Benefits J*. 2003; 28(1): 41-46.

Neal T., Developing the request for proposal. *Am J Hosp Pharm*. 1982; 39(3): 475-480.

Neubrecht F., Third party pharmacy audits: can they be improved? *J Am Pharm Assoc* (Wash). 2000; 40(5): 666-669.

Neumann P.J., Evidence-based and value-based formulary guidelines. Health Aff 2004; 23(1): 124-134.

Nitkin D., Brooks L.J., Substainability auditing and reporting: the Canadian experience. J Bus Ethic. 1998; 17(13): 1499-1507.

Parmenter E.M., Health care benefit crisis: cost drivers and strategic solutions. Journal of Financial Service Professionals. 2004; 58(4): 63-79.

Pharmacists meet monthly to discuss findings of QA audits. Hospitals. 1980; 54(23) 39-40.

Pietrusko R.G., Seaman J.J., Professional practice audit. *Am Pharm*. 1980; NS20(9): 49-50.

Principles of a Sound Drug Formulary System, 2000, Coalition Working Group.

Roberts M.B. and Keith M.R., Implementing a performance evaluation system in a correctional managed care pharmacy. *Am J Health-Syst Pharm.* 2002; 59(11): 1097-1104.

Schneider P.J., Brier K.L., Caryer K.E, Administrative audits of professional services: effective residency training experience. *Am J Hosp Pharm*. 1981; 38(3): 339-342.

Specialty Pharmaceutical Management Strategies for Health Plans and Employers, Two-day national conference, March 16–17, 2004, Chicago, IL, presented by International Quality & Productivity Center.

Stern C.S., Evaluating the pharmacy benefit. Empl Benefit Plan Rev. 1994; 49(6): 22-25.

Stern C.S., How to evaluate pharmacy benefit offerings. Empl Benefit Plan Rev. 1995; 50(6): 27-30.

The Commonwealth Fund, Project HOPE/The People to People Health Foundation Inc. Jan/Feb 2004. Available at http://www.commonwealthfund.org/grants/grants_list.htm?grantee_organization=Project%20HOPE%2FThe%20People-to-People%20Health%20Foundation%2C%20Inc. Accessed 10 July 2008.

Trends in Effective Formulary Development, July, 2004, Alex Gilderman, Pharm.D., Director, Clinical Services, Prescription Solutions

Tripodi M., Avoiding pharmacy fraud through automation and audit. *Manag Care Interface*. 1998; 11(12): 97-100.

Troy T.N., Growing PBMs face tough challenge in a 'highly undifferentiated' niche. Manag Healthcare. 1998; 8(5): 30-31.0.

United States Government Accountability Office, Federal Government Audit Standards, July 2007 Revision. Available at www.gao.gov/cgi-bin/getrpt?rptno=GAO-07-731G. Accessed 26 September 2008.

West J. and Glickman S., Developing an RFP for outstanding investment management, health financial management. July 1997.

Zoloth A., Yon J.L., Woolf R., Effective decision-making in a changing healthcare environment: a P & T Committee interview. *Hosp Formul.* 1989; 24(2): 85-87, 90, 93.