National Practices in Formulary Management

David B. Nash, MD, MBA

Last summer, the AMCP released their report entitled "Common Practices in Formulary Management Systems," consisting of a survey of six PBMs and two health plans that together are responsible for administering benefits to more than 176 million people in the U.S. Although I cannot discuss every detail of this important survey, I'd like to summarize the highlights.

The survey consisted of a series of six questions covering topics such as the composition of the P&T committee, types of formulary structures, cost-containment measures, categories and classes of drugs excluded from coverage, and a description of the appeals process in each of the eight organizations.

Not surprisingly, the survey found that the composition of the typical P&T committee averages about 63% physicians, 32% percent pharmacists, and 5% other types of health care professionals.

One question in particular piqued my interest: what is the distribution of covered lives under various formularies? Allow me to describe each of the formulary structures and the percentage of covered people in each of the health plans using those particular tools.

Eighteen percent of the covered individuals fell into the category of a closed formulary system, defined by the AMCP as a structure that limits and requires justification for the use of drugs not listed on the formulary independent of those excluded through other benefit designs. Thirty-three percent of the covered individuals in these firms belonged to an open preferred formulary structure, which encourages the use of certain drugs through the use of incentives (e.g., academic detailing, usage criteria). Thirty-eight percent of the covered individuals were under an open passive formulary, a structure that includes drugs that are only passively promoted through the use of educational materials and very few "soft" promotional materials. The remaining 14% were not part of a formulary structure. They did not require prior authorization and had no drug utilization review.

What is the lesson from these statistics? In my view, it is clear that we have a long way to go. These national private sector firms representing millions of covered lives are not tackling the tough issues of appropriate long-term utilization of pharmaceutical resources. I'd like to see P&T committees address the difficult question of the closed versus open formulary with a stronger commitment to limiting the accelerating cost of drugs.

The AMCP report noted that many managed care systems have been criticized for imposing a waiting-period before some newly approved drugs are reviewed by their respective P&T committees. As a result, respondents in this survey were asked how many of them were in health plans that have waiting-period requirements. According to the survey, only 1% of covered lives are in plans that have a waiting-period requirement greater than six months for newly approved drugs. The percentage of covered lives that are in plans having a waiting period of less than six months is only 6%. The take-home message, at least according to this survey, is that these managed-care systems get drugs onto the P&T committee agenda rapidly and make decisions with appropriate speed.

On a related matter, respondents were asked how many covered lives are in health plans that have an internal process whereby members may appeal denials of drug coverage or non-formulary drug requests, or request reimbursement for excluded drugs. The report surprised me when it stated, "since most states mandate that health plan members have access to an appeals process, respondents were asked to verify the seemingly low number of covered lives reportedly having access to an appeals process. Three of the four PBMs reported that they lacked specific information to report on the various appeals processes in place in their client health plans." I gather from this that the nation's largest PBMs do not have the data necessary to answer a health plan member and his physician when they request a non-formulary drug.

Maybe we are asking the wrong sector of the health care system. Perhaps the individual health plans could answer this question more directly. The AMCP report does show that 50% of covered individuals in health plans have an internal appeals process for excluded drugs, 20% have an internal appeals process for non-formulary requests, and only 10% of covered people in health plans have an external review of their appeals process. This controversial area is sure to be an important component of any congressionally mandated Medicare drug benefit in the future.

I applaud the AMCP's effort to categorize and describe formulary management practice in the private sector. They appropriately admit at the conclusion of this report that six PBMs and two managed care organizations, despite the 176 million covered lives, do not necessarily reflect formulary practice across the entire nation. Although I recognize the limitations of the AMCP report, I believe these descriptions are indicative of common private sector practice.

P&T committee members must remain vigilant in their responsibility to fairly and equitably allocate resources for the pharmaceutical benefits that all health plan members enjoy. We need more research to document comparable practice in smaller PBMs and plans that are a more accurate reflection of our national experience.

As usual, I am very interested in your views. Your can reach me at david.nash@mail.tju.edu. You can contact the AMCP at www.amcp.org. ■