Managed Healthcare Executive

Closed formularies hold the line on costs

One of a number of strategies in use

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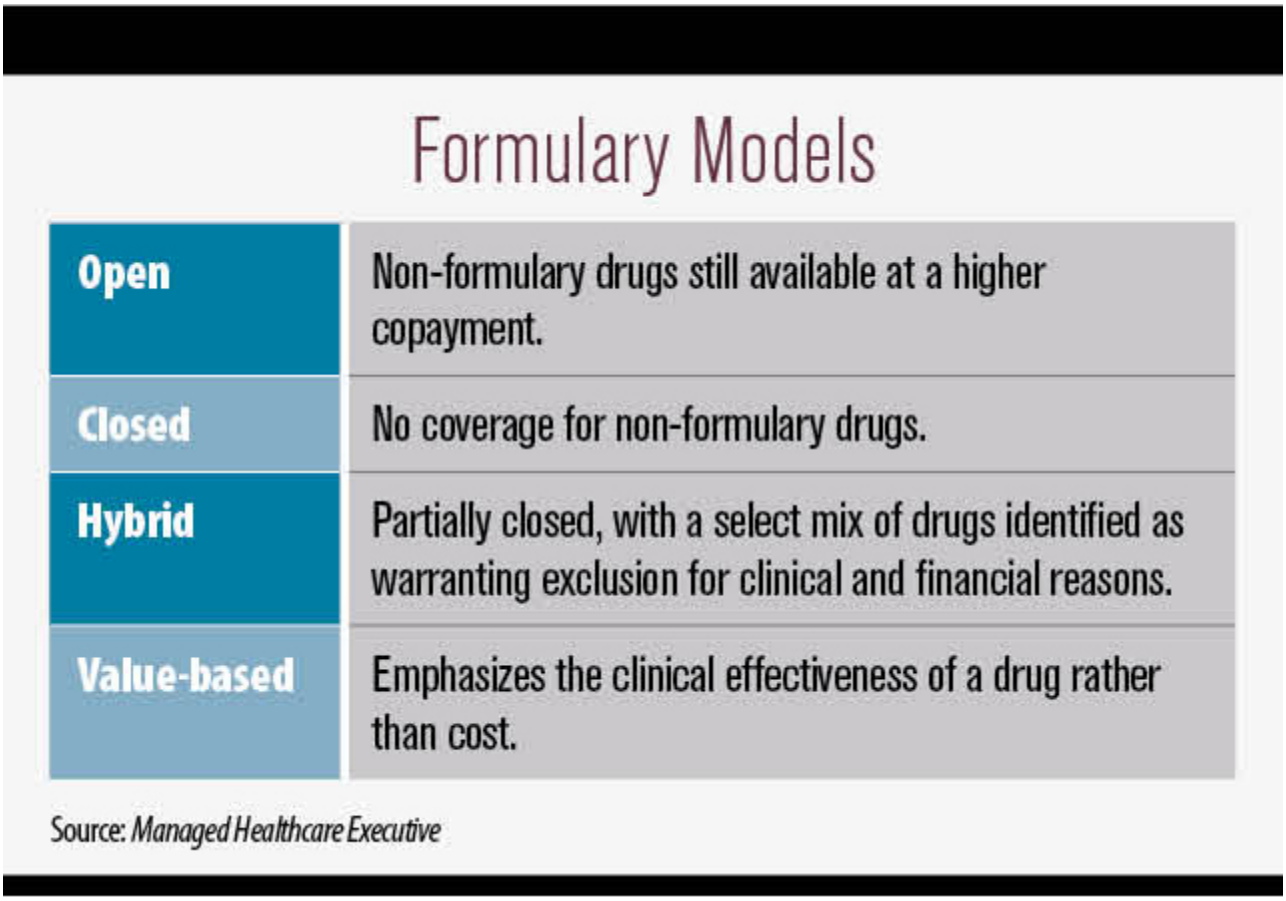
By Mari Edlin

Health plans struggling to rein in pharmacy costs are using mail service, disease management programs, financial incentives for generics, member cost sharing, and, increasingly, limited and closed formularies.

In an open formulary, non-formulary drugs are still available but require a higher copayment. Closed formularies, on the other hand, do not cover non-formulary drugs except for medical necessity. In the middle are formularies that offer components of both open and closed models.



To many, the idea of a closed formulary infers that it might have fewer available drugs. But Mary Jo Carden, director of regulatory affairs for the Academy of Managed Care Pharmacy (AMCP), says that isn't necessarily the case; instead, it could include more drugs at a lower copayment.

As an example, Premera Blue Cross, based in Seattle, Washington, defines its closed formulary in its pharmacy benefit coverage guidelines "as one that routinely covers only formulary (preferred) drugs. A non-formulary drug may be covered when its use has been determined to be medically necessary after a review of the individual clinical case circumstances."

Jeff Eichholz, senior director of formulary solutions for Express Scripts, a pharmacy benefits manager (PBM) headquartered in St. Louis, Missouri, says there is no standard definition of a closed formulary because there are different degrees of "closed."

Managed Healthcare Executive editorial advisor David Calabrese, vice president and chief pharmacy officer for Catamaran, a Chicago-based PBM, agrees with Eichholz, pointing out that a formulary could be partially closed, with a select mix of drugs that are identified as warranting exclusion for clinical and financial reasons.

Clinically appropriate benefit

Express Scripts sees more traditional three-tier formularies than closed ones in its book of business. But, it has watched its closed formulary offerings evolve from two tiers--preferred generics and preferred brands without any additional coverage--to three tiers, limiting the number of drugs in particular categories.

Eichholz notes that PBM's current formularies adopt principles from both open and closed models by using additional tiers but shifting more cost share to members if they choose drugs on higher tiers.

"Drugs on our formularies are appropriate for 95% of our population," he explains. While some plans are using a strict closed formulary to lower costs, he notes that they still offer a clinically appropriate benefit and do not limit clinical effectiveness because "It's not appropriate to limit choices if a drug has clinical impact."

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Restrictions are primarily placed on categories with a wide range of available generics, such as high cholesterol and hypertension, and not on classes with limited treatment options, says Eichholz. "It depends on the therapy class in determining the rate of exceptions," he says. Even if there are only two tiers, Express Scripts provides drug choices across all categories.

"You have to balance clinical advantages with the downstream implications of reducing costs by using preferred drugs," says Eichholz, who notes that high-cost specialty drugs are the main culprit for the rising costs of drugs.

It's a give-and-take situation in which Express Scripts has the ability to add new, more effective and higher-cost drugs but can offset those costs by narrowing the choices in other categories, he notes. "We need to balance choice, access and cost. If we broaden access, we will have to shift costs to consumers."

To Eichholz, if a formulary meets member needs, reduces costs and avoids disruption, it is successful.

Calabrese notes that an aging population, price inflation and the end of the patent cliff serve as other impetuses for designing a closed formulary. He says that, in light of financial pressure on payors, closed formularies are delivering measurable costs savings and are making a comeback in formulary management.

Even so, notes Calabrese, most formularies today are open, using tiers and copayments to manage the benefit. With the development of patient-centered medical homes and accountable care organizations that place more financial risk on providers, a closed formulary plays a less significant role, he says.

Related: Cigna will modify its formulary structure for generics in Florida

Michael Nugent, managing director, healthcare practice for Navigant, a PBM based in New York City, believes that closed formularies are making a comeback not just to reduce drug costs, but also to help decrease the total cost of care, referring to potentially higher utilization of services in the future if drug selection is only based on cost.

"As providers assume more risk and earn extra reimbursement through pay-for-performance programs, they are more concerned about the total cost of care and how to manage it," says Nugent. "Closed formularies can be successful as part of a broader care model; they cannot be managed in a silo."

The value formulary

Catamaran offers a partially closed formulary, known as its Value Formulary, which excludes branded drugs that do not provide any clear clinical advantage over less costly brand or generic drugs.

Catamaran's Value Formulary is partially closed with more than 140 drugs excluded from coverage. The list of exclusions includes 14 specialty products that have clinically comparable, less costly therapeutic alternatives. It does, however, include Harvoni for hepatitis C, specialty products for multiple sclerosis and rheumatoid arthritis and growth hormones.

Conversely, its national, traditional three-tier formulary is an "open" formulary design without product exclusions.

Calabrese says that 90% of drugs on the Value Formulary, which is Catamaran's standard offering, are products covered by coupons.

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"Given today's budgetary challenges facing payers, the market is much more accepting of a more aggressively designed, streamlined formulary offering, as long as such an offering is developed in a high-clinical quality, high-integrity manner which still provides an ample array of options by drug class for providers to choose from," he says.

Closed formularies: not without challenges

Designing a closed formulary is not without challenges. High on Eichholz's list is explaining to members how to access alternatives and what drugs are available; avoiding member disruption; and preventing members from switching to another plan that offers more choice.

Calabrese agrees that members need to be educated, especially if they find themselves on a drug that is excluded from the formulary.

"Plans need an active outreach program," he says.

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