Commentary
Purchasing Community Perspective

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AdvancePCS provides pharmacy benefit management services for more than 75 million members, as well as a variety of other products and services.

In 1970, when few people had prescription drug coverage, approximately 80% of the costs of drugs were paid out-of-pocket by patients[1]; by 2001, the out-of-pocket cost paid by an individual on average was about 27%, according to AdvancePCS data (on file; Scottsdale, Ariz). However, health care costs have been increasing, and employers struggle to pay for these increases. In 2001, 1.4 million people lost their health care coverage,[2] in part due to employers being unable to afford the increased premium costs. Two major drivers of increasing health care costs in 2001 were hospital costs and pharmaceuticals. Pharmaceuticals constituted, on average, about 13% of overall health care costs, although some of our clients reported those costs to be as high as 25% (data on file, AdvancePCS).

Because our client base is broad, our clinical formulary allows wide access to drugs. Our open formulary has more than 1000 drugs. Appropriate use of pharmaceuticals is one of the most cost-effective ways to provide care. One tool we use to develop our formulary is our Pharmacy and Therapeutics (P&T) Committee process. Our P&T committee is independent; none of the voting members are AdvancePCS employees. They are physicians, clinical pharmacologists, pharmacists, and other health care professionals from across the country who evaluate the clinical merit of a drug. We share only clinical, not cost, information with them and ask them to recommend whether or not a drug should be added to the formulary.

A pharmaceutical management trend we have noted among our clients is the use of prior authorization; 20% of our clients use this tool (data on file, AdvancePCS, 2001). While prior authorization is useful, there may be other ways to get the same effect with less administrative burden, such as therapy.

Approximately 10% of our clients presently use step therapy, in which drugs are used in a particular sequence (data on file, AdvancePCS, 2001). We are seeing increasing use of this tool by our clients.

A third trend we have seen is the shift from a closed formulary design, which was more prevalent in years past, to a tiered-benefit design. Less than 5% of our own clients use a closed formulary (data on file, AdvancePCS). How much are people paying in these tiers? Across all our clients and across all tiers, the average copayment for a 30-day prescription in 2001 was $14.54 (data on file, AdvancePCS). The third-tier average copayment was $29.78 for a 30-day supply of a branded nonpreferred drug at a retail pharmacy, the second-tier average was a $16.06 copayment for a branded preferred drug, and the first-tier average copayment was $7.54 for a generic preferred drug (data on file, AdvancePCS, 2001). This trend to the 3-tier system has decreased the need for prior authorization in many cases.

One of our clients, with several million members, has shifted to a 4-tier design and has markedly decreased prior authorization. With a 4-tier system, lifestyle drugs are put in the fourth tier as well as drugs that this client would not have covered previously. An alternative to the tier system that is being used by some clients is a percent coinsurance for all branded drugs (e.g., 30%), with no preferred or nonpreferred brands.

All antipsychotics and antidepressants are on our national formulary. In general, most clients do not use therapeutic interchange (a voluntary switch to another agent, with the physician's and the patient's permissions) for antidepressants or antipsychotics. Among our clients for whom we provide utilization management services, no client presently requires the use of one particular type of branded antidepressant before another. One requires that generic fluoxetine be tried before the brand-name version. No client presently requires

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step therapy or prior authorization for any antipsychotic medication.

Both drug costs and the number of prescriptions being written (utilization) are increasing. There is a therapeutic shift toward using higher dosages, instituting a longer duration of therapy, and more frequent use of combination therapy versus more frequent use of monotherapy in the past. Payers continue to struggle to keep access to health care providers and drugs as open as possible because they have to compete in their own marketplace and want to be seen as the insurer or employer of choice.

REFERENCES

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