Pharmacy Benefit Managers (PBMs) are organizations that use managed care principles and techniques to administer prescription drug benefits for such sponsors as managed care companies, large employers, and government agencies. In 1999, PBMs managed more than 70 percent of prescriptions filled at retail pharmacies. PBMs typically use formularies—lists of preferred drugs within particular therapeutic classes—to influence prescribing by encouraging the use of certain drugs that are deemed to be clinically equivalent, more cost-effective, or both. The impact of formularies on access to appropriate medications is of particular importance to older Americans, who tend to fill more prescriptions, per person, than do their younger counterparts. This In Brief summarizes findings from a study by Junius Gonzales, MD, of the National Institutes for Mental Health, and colleagues that examines differences in PBM formulary recommendations for drugs commonly prescribed to older Americans.1

Gonzales and colleagues obtained formularies in 1996 from the 14 largest PBMs in the United States, which together accounted for about 150 million covered lives that year. They then analyzed data from the seven formularies that rated drugs from most to least preferred; the other formularies listed only drugs for which payment was authorized.

**Findings.** Gonzales and colleagues found substantial variation in PBM recommendations for some—but not all—of the therapeutic classes of drugs that they examined.2 In three of the seven drug classes studied, there was at least one commonly prescribed product that was not on a formulary in at least one PBM. For many drugs, there was a clear discrepancy among the PBMs about whether a product was deemed to be most or least cost-effective.

**Implications.** Gonzales and colleagues suggest that variation in PBM formulary recommendations may pose problems in clinical practice. They state that the sheer number of different PBM formularies can burden physicians who receive recommendations from a broad number of formularies. Furthermore, they assert that differences in formulary recommendations do not seem to be based entirely on independent clinical effectiveness studies, since such studies would likely result in similar recommendations across PBMs.

The authors suggest the need for continued research on issues such as: (1) quality improvement efforts that examine the mechanisms by which PBMs can affect patient outcomes, and (2) the use of cost-effectiveness data in PBM drug selection and formulary policies. In addition, they assert that it would be useful to have cost-effectiveness studies that compare a new drug with comparable treatments.

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1 Gonzales, Junius, Julie Kaufman, and Kevin Schulman. *Pharmacy Benefits Managers’ Drug Formulary Recommendations: Implications For Older Americans*. AARP Public Policy Institute, Issue Brief #2000-20 (December 2000). This paper was completed while Drs. Gonzales and Shulman were on the faculty at Georgetown University Medical Center.

2 ACE inhibitors, beta blockers, and calcium channel blockers (for treatment of hypertension); antilipidemic products (for treatment of high cholesterol); SSRIs (for treatment of depression and other psychiatric conditions); and H2 antagonists and proton pump inhibitors (for gastrointestinal conditions).