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DEFENSE HEALTH CARE

Need for Top-to-Bottom Redesign of Pharmacy Programs

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Defense Health Care: Need for Top-to-Bottom Redesign of Pharmacy Programs

Mr. Chairman and Members of the Subcommittee:

We are happy to be here today to discuss our report on the Department of Defense's (DOD) $1.3 billion pharmacy programs and efforts under way to redesign DOD's pharmacy benefit.[1] As you may know, DOD and its managed care support contractors provide prescription drug benefits to about 8.1 million active-duty personnel, their families, and retired beneficiaries. The pharmaceuticals are dispensed through three programs: 591 military treatment facility (MTF) outpatient pharmacies, 5 TRICARE managed care support contractors' retail pharmacies, and a national contractor's mail-order service.[2] Without question, pharmacy is the health care benefit most in demand by beneficiaries.

During the past several years, the Congress has grown concerned about the costs and quality of DOD's pharmacy benefit, and beneficiaries have complained that some prescribed medications are no longer available at MTF pharmacies because of cost-cutting. As a result, the fiscal year 1998 National Defense Authorization Act (P.L. 105-85) required that we review DOD's pharmacy programs, focusing on (1) the adequacy of the information that DOD and its contractors have to manage the pharmacy benefit; (2) the merits and feasibility of DOD and its contractors applying commercial best practices, including a uniform formulary,[3] in managing its pharmacy programs; (3) the merits and limitations of recent mail-order and retail pharmacy initiatives to secure discounted DOD drug prices; and (4) the potential effects MTFs' funding and formulary management decisions may have on beneficiaries' access to pharmacies and TRICARE contractors' costs.

In summary, we found that the significant problems DOD is experiencing delivering its pharmacy benefit result largely from the way DOD manages its three pharmacy programs. Rather than viewing the programs as integral parts of a single pharmacy system, DOD manages the programs as separate

[1] Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness (GAO/HEHS-98-176, June 12, 1998).

[2] TRICARE represents a redesign of the DOD health system during an era of military downsizing and budgetary concerns. Under TRICARE, beneficiary health care is coordinated and managed on a regional basis using MTFs, supplemented by managed care support contractors. TRICARE contractors administer three types of health plans—health maintenance organization (TRICARE Prime), preferred provider network (TRICARE Extra), and fee-for-service (TRICARE Standard).

[3] A formulary is a list of prescription drugs, grouped by therapeutic class, that a health plan prefers its physicians and beneficiaries to use. Drugs are chosen for a formulary for medical value and also price.

entities, not taking into account, for example, the merits of establishing a uniform DOD formulary and integrated databases or the effects that initiatives, such as implementing a separate mail-service pharmacy program, will have on the other programs. Unless DOD begins to manage the various components of the pharmacy programs as a single system, the problems we identified will continue and potentially worsen. Specifically, we found the following:

- Despite ongoing efforts to improve its pharmacy benefit programs, DOD and its contractors lack basic prescription drug cost and beneficiary use information as well as integrated pharmacy patient databases needed to effectively manage military beneficiaries' pharmaceutical care.
- Without cost and use information and integrated databases, coupled with formularies that differ among its pharmacy programs, DOD is unable to apply proven pharmacy benefit management (PBM) commercial best practices that could save hundreds of millions of dollars each year.
- Last year's DOD mail-order and retail pharmacy initiatives aimed at achieving savings by using discounted DOD drug prices could cause financial and patient safety problems for TRICARE contractors because these initiatives divorce contractors' medical care management from their pharmaceutical care, and this integration is important in maintaining the beneficiary population's good health.
- MTFs' efforts to hold down costs by restricting the drugs available on formularies could reduce beneficiaries' access to prescription drugs and according to contractors has increased their retail pharmacy costs. Such efforts can be particularly hard financially on retirees aged 65 and over, who have no prescription drug coverage under Medicare.

DOD currently is seeking to acquire the technology that will enable it to integrate its pharmacy databases by March 2000. Also, as mandated by the fiscal year 1999 Strom Thurmond National Defense Authorization Act (P.L. 105-261), DOD is developing a plan for redesigning its pharmacy programs and initiating a two-site pharmacy redesign program for Medicare-eligible beneficiaries. We have not yet been given a copy or access to this plan and thus cannot comment on it.

Background

In operating a system of military health care delivery, DOD has twin missions: care and treatment of military personnel where and when they need it and cost-effective and accessible health care benefits for active-duty families and retired military personnel and their families. The largest

DOD pharmacy program is the outpatient pharmacies operated in the "direct care system" of Air Force, Army, and Navy MTFs. In fiscal year 1997, these pharmacies dispensed about 55 million prescriptions at an estimated cost of $1 billion. MTFs get most of their prescription drug supplies through the Defense Supply Center in Philadelphia. This DOD agency negotiates discounted drug prices through distribution and pricing agreements (DAPA) with over 200 drug manufacturers. DAPA prices are between 24 and 70 percent less than average wholesale prices.

The MTF direct care system is supplemented by 5 TRICARE managed care support contractors, which, among other services, provide retail pharmacy benefits to eligible beneficiaries. DOD's national mail-order pharmacy program contractor is another way DOD augments MTF pharmacy services. This program delivers 30- to 90-day supplies of medications taken for longer-term, chronic health problems to eligible beneficiaries' homes. In 1997, DOD's contractor-supported retail and mail-order pharmacy programs cost about $245 million.

In contrast, in the private sector, PBMs administer prescription drug coverage on behalf of health plan sponsors. PBMs are a type of managed care firm whose objective is to provide high-quality prescription drug services at the lowest possible cost. PBMs offer their customers such services as (1) formulary development and management, (2) retail pharmacy networks and mail service, (3) drug rebate negotiation with manufacturers, (4) generic substitution, (5) therapeutic interchange programs, (6) claims processing, and (7) drug utilization review. PBMs' ability to control pharmacy benefit costs for customers has led to their increasing involvement in private sector plans, including the Federal Employees' Health Benefits Program (FEHBP).

DOD and the Contractors Lack Information Needed to Effectively Manage Pharmacy Programs

DOD lacks the comprehensive prescription drug cost and use data that PBMs and their health plan sponsors routinely track and analyze to manage pharmacy benefits and control costs. MTF pharmacy cost and use data are unreliable at both local and headquarters levels, and the limited data TRICARE contractors do provide are not merged with MTF data or used to manage pharmacy benefits. For example, we had to piece together data from multiple sources to estimate DOD's fiscal year 1997 total pharmacy costs--$1.3 billion—because summary cost data were not available.

A root cause of the problem is that existing pharmacy patient databases at the MTFs, regional TRICARE contractors, and the national mail-order

pharmacy contractor are not integrated. Although most military beneficiaries regularly obtain prescription drugs from multiple dispensing outlets across DOD's three programs, no centralized computer database exists with each patient's complete medication history. Millions of dollars in unneeded costs from overutilization and patient safety problems from adverse reactions to prescription drugs are likely occurring because DOD and its contractors lack the databases needed to support automated prospective drug utilization review systems to review prescriptions before they are dispensed. PBMs widely use such systems to reduce inappropriate prescription drug use that can cause adverse reactions leading to illness, hospitalization, and even death. In addition, automated drug utilization systems are used to better identify patterns of fraud, abuse, or other inappropriate or medically unnecessary care.

In DOD's programs, for example, the lack of such systems has allowed beneficiary prescription drug stockpiling to become so pervasive among MTF pharmacies that pharmacists commonly refer to the problem as "polypharmacy"—or the practice of visiting multiple pharmacies to accumulate more prescription drugs than needed. Three cases illustrate this phenomenon:

- A patient and his wife tried to fill prescriptions worth $400 at an Air Force base pharmacy. Somewhat suspicious, the pharmacist called the out-of-state base that wrote the prescriptions and found that the couple had gotten a 90-day supply of each drug from that pharmacy 3 days earlier and, checking further, that they had gotten 90-day supplies of the drugs at a third base pharmacy that morning. The pharmacist refused to fill the prescriptions.
- Upon her husband's death from chronic lung disease, a widow returned several boxes of inhalant drugs and supplies to an Army base's pharmacy. Obtained from several MTF pharmacies over a 2-year period, the drugs were valued at about $5,000. In responding to why she and her husband obtained drugs that were not used, the widow pointed out that her husband was entitled to them, he feared his benefits might be curtailed, and so they stocked up.
- At another Air Force base, a young patient's mother obtained 260 prescriptions in 15 months from several on-base doctors. The prescriptions were filled at the base hospital and clinic pharmacies. In effect, she amassed a 5-year supply of inhalant asthma drugs (Proventil and Ventolin) and inhalation devices. When an investigation was conducted as a result of the mother's aggressive behavior toward pharmacy staff, the base hospital pharmacy staff had to manually

compile the patient's medication profile from the hospital and clinic pharmacies to determine the extent of the mother's drug stockpiling.

Since we issued our report, DOD has stepped up its efforts to plan, acquire, and install an estimated $5 million pharmacy patient data system by March 2000 that will support automated drug utilization reviews on a limited basis. At the same time, DOD continues to study alternative information technology approaches to implement a comprehensive pharmacy patient management system, and it may have a cost estimate and timeline for completing such an overhaul later this summer. Last year, DOD pharmacy officials estimated the 10-year cost of a similar comprehensive system to be $43 million but that such a system would save $424 million over the same period and substantially reduce patient safety risks.

Applying Commercial Best Practices Could Reduce Costs and Enhance Care Quality

In addition to integrated databases, PBMs use other practices to control costs and provide quality service. For example, PBMs offer health plan sponsors uniform formularies for beneficiaries as well as help in designing standard beneficiary eligibility criteria and cost-sharing to provide incentives for physicians to prescribe and beneficiaries to use formulary drugs. Features such as copayments for nonformulary drugs, for example, can create the incentives or disincentives crucial to balancing the health plan's financial soundness with beneficiaries' freedom to choose pharmacies and drugs. While DOD's goal is to provide uniform pharmacy benefits, its programs operate under a complicated and confusing array of policies, regulations, and contractual requirements governing key benefit design elements such as eligibility, drug coverage, and cost-sharing. For example, DOD's formularies vary depending on where the beneficiary gets the drugs. As a result, beneficiaries experience drug coverage and availability uncertainties and unnecessary costs. The lack of a uniform formulary drives up costs in other ways such as causing cost-shifting among MTFs when pharmacy patients "shop around" for prescriptions.

And, although all military beneficiaries obtain drugs from MTFs free of charge, the national mail-order and TRICARE contractors' programs require copayments regardless of whether the drugs are formulary or generic. Finally, most of DOD's 1.4 million Medicare-eligible beneficiaries lack a systemwide prescription drug benefit and thus have a serious coverage gap because Medicare does not cover outpatient prescriptions. Such problems prevent other PBM practices from being fully and systematically applied in DOD's pharmacy programs.

Establishing a uniform formulary with incentives for physicians to prescribe and beneficiaries to use formulary drugs could help reduce current benefit variability and increase cost-effectiveness. With an incentive-based formulary, DOD and its contractors could provide nonformulary drugs but require beneficiaries to make higher copayments than for formulary or generic drugs. Also, like private sector plans and PBMs, DOD could negotiate deeper price discounts from drug companies seeking formulary approval for their products. But, for systemwide effectiveness, such a formulary may require MTF prescription drug copayments that DOD believes it lacks authority to impose. Nonetheless, the existing pharmacy benefit variation combined with nonintegrated databases prevents DOD from (1) controlling costs through formulary management; (2) fully analyzing drug use to curb inappropriate use and introduce less costly generic and therapeutic substitutes; and (3) identifying and, as appropriate, educating physicians who prescribe too many or nonformulary drugs. Such approaches have enabled private sector health plans to reduce their costs by an estimated 10 to 20 percent. On this basis, a uniform, incentive-based formulary could save an estimated $61 million to $107 million annually, and other PBM practices could save another $99 million to $197 million annually.

Mail-Order Program and Retail Pharmacy Proposal Further Fragment Health Care Services and Raise Costs

In April 1998, DOD replaced the TRICARE contractors' mail-order pharmacy services with a separate, national contract to help control the contractors' rising prescription drug costs. Mail-order is easy and convenient for beneficiaries to use and can help control DOD's costs because prescription drugs are purchased at DAPA prices previously available only to MTF pharmacies. The TRICARE contractors now pay for the mail-order contractor's costs. Also, when the next round of TRICARE managed care support contracts phases in, DOD plans to carve out and provide under one national contract the TRICARE contractors' retail pharmacy services. These initiatives, however, may further fragment health care services and raise costs, as the following illustrate:

- While the TRICARE contractors continue providing retail pharmacy services, neither they nor the mail-order pharmacy contractor will have a complete computerized history of each patient's retail and mail-order medications. This presents potential health risks for patients.
- Having two separate national contractors—one for mail-order and one for retail pharmacy services—would further fragment DOD health care services and divorce TRICARE contractors' medical care management from pharmaceutical care. Contractors would be unable to adequately

manage patients' medical care since the prescription drugs are important in maintaining the beneficiary population's good health and it would be difficult for contractors to isolate the pharmacy benefit from the remaining medical benefit.
- Savings from DAPA prices could be short-term because drug companies may be motivated to raise DAPA prices to avoid losses from an expanded DOD discounted market. Although these marketplace adjustments are difficult to project because of the many factors that influence drug prices, expanding the size of the market that could have access to DAPA prices could put upward pressure on DAPA prices.

An alternative would allow TRICARE contractors to continue providing beneficiaries with retail pharmacy services, while providing DOD the data it needs to obtain DAPA prices from the drug companies. This approach would keep pharmaceutical and medical care administration together under existing contracts. And such an approach may offer savings in addition to those achievable by integrating patient databases to support drug utilization review and applying other commercial best practices in MTF, TRICARE retail, and national mail-order pharmacy programs.

Another alternative would be that, once MTFs and TRICARE contractors integrate their pharmacy patient databases, they also could institute electronic billing and reimbursement. With electronic billing and reimbursement, MTFs could continue and possibly increase the volume of pharmacy services they provide to TRICARE contractors' beneficiaries. By reimbursing MTFs, TRICARE contractors potentially could save money by directing their beneficiaries to the MTFs to obtain medications at DAPA drug prices, rather than using retail pharmacies.

MTF Funding and Formulary Management Decisions Can Limit Beneficiary Access to Drugs and Affect Other Pharmacy Costs

Following DOD's downsizing efforts in the early 1990s, which reduced medical personnel and the number of MTF pharmacies, remaining MTFs began experiencing funding reductions that made the pharmacy benefit an attractive target for cost-cutting. At the same time, the demand for prescription drugs began increasing. Also, policy changes required that beneficiaries be treated alike in dispensing formulary drugs. To control costs, MTFs dropped certain prescription drugs from their formularies and chose not to add others. This prevented beneficiaries from obtaining certain drugs at MTFs. Examples follow:

- In 1997, to include Allegra, a widely advertised, nonsedating antihistamine, on their formularies, two Air Force pharmacies in Kansas

and Florida cut dispensing to 30 tablets instead of the full 60 tablets for a 1-month supply. One pharmacy chief told us this should save about $60,000 each year. Both facilities justified restricting Allegra, estimated by MTF officials to cost 25 to 50 times more than other antihistamines with major sedative side-effects, on the basis that it was unwarranted for overnight use. Similarly, an Air Force medical center in Texas dropped Allegra from its formulary because it was costing too much of the medical center's $28 million pharmacy budget to make it available for all beneficiaries. Instead, this MTF pharmacy carried Allegra as a nonformulary drug obtainable only under special-order, primarily for military pilots.

- In 1996, a Navy hospital in Florida decided not to add Zyrtec (a new allergy drug for upper respiratory symptoms) to the formulary. While recognizing Zyrtec's therapeutic edge over other formulary drugs in the same class, MTF officials decided that the high demand for Zyrtec at other Navy MTFs made it cost-prohibitive.
- An Army hospital in Colorado regularly reviews for reduction the 50 formulary drugs on which it expends the most money. In 1997, the pharmacy spent more than $350,000 dispensing Prilosec (a widely prescribed ulcer drug). To cut costs, the pharmacy now (1) urges use of the less-costly formulary drug Prevacid; (2) requires that physicians justify Prilosec prescriptions in writing, and (3) is developing physician guidance on the best uses of Prilosec and Prevacid.

According to TRICARE contractors, many beneficiaries responded to formulary restrictions by buying their prescription drugs at contractor pharmacies, thereby increasing the volume of prescription drug purchases beyond what the contractors projected in their original bids. Blaming their cost overruns on MTF formulary changes, the contractors told us they intended to seek additional compensation from DOD. A DOD consultant concluded that the contractors' pharmacy use had risen at the same time MTFs' use had dropped somewhat. DOD and the contractors disagreed about the cause of the contractors' cost increases and continue to study the matter. Of course, if DOD and the contractors had used integrated pharmacy patient databases during the periods in question, establishing cause and effect for the contractors' allegations could have been greatly facilitated.

Conclusions, Recommendations, and Agency Actions

In our June 1998 report, we concluded that the problems DOD is experiencing in delivering its pharmacy benefit stem largely from the way it manages its $1.3 billion pharmacy programs. Although the MTF and contractor retail and mail-order pharmacy programs share patient populations and are otherwise highly interrelated, DOD has adopted a program-by-program focus rather than a systemwide view of these operations. As a result, changes made to one program inevitably affect the others, and cross-program problems such as nonintegrated databases and different formularies, eligibility, and copayment requirements are having substantial, unintended consequences for DOD and contractor costs and for beneficiaries' quality of and access to health care. Although DOD has taken steps to help improve pharmacy management, a more fundamental overhaul is needed. We believe DOD needs a top-to-bottom redesign of its pharmacy programs that effectively involves the programs' major stakeholders. Also, we believe DOD needs to commit itself to managing pharmacy programs as a system and bringing needed reforms to the system. Otherwise, DOD's pharmacy problems will continue and likely worsen.

To help DOD establish a more systemwide approach to managing its pharmacy benefit, we suggested that the Congress consider directing DOD to establish a uniform, incentive-based formulary across its pharmacy programs and, as appropriate, to use non-active-duty beneficiary copayments at MTFs as incentives for physicians to prescribe and beneficiaries to use formulary drugs. Also, we suggested that the Congress may wish to give systemwide eligibility to Medicare-eligible retirees not now eligible for such benefits. In response, language in the fiscal year 1999 Strom Thurmond National Defense Authorization Act (P.L. 105-261) directed DOD to submit this month a plan for a systemwide redesign of the military pharmacy system and implement its planned redesigned pharmacy system at two sites for Medicare-eligible beneficiaries by October 1999.

Also, we made a series of recommendations to DOD to undertake a thorough redesign of the prescription drug benefit across the MTFs' and contractors' retail and national mail-order pharmacy programs. This effort should identify and act on policy, oversight, managed care support, regulatory, and contractual changes needed to make the programs as uniform, integrated, and cost-effective as possible. Some changes may require additional legislative authorities and, as appropriate, the Secretary of Defense should seek such authorities from the Congress.

Specific action areas identified in our report included the following:

- Develop an approach for effectively involving affected stakeholders such as the TRICARE contractors in decisions bearing on the system. A starting point may be allowing the TRICARE contractors to be represented on the national DOD pharmacy and therapeutics committee.
- Expeditiously integrate the existing MTF, TRICARE retail, and national mail-order pharmacy patient databases and providing for automated prospective drug utilization review, rather than waiting for the planned large-scale overhaul of DOD's health care information system in 2003.
- Establish a uniform, incentive-based formulary for MTF, TRICARE retail, and national mail-order pharmacies' programs. This should include using non-active-duty beneficiary copayments at MTFs to encourage the use of formulary drugs at MTF, contractor retail, and mail-order pharmacies.
- Extend systemwide prescription drug eligibility to Medicare-eligible retirees not entitled to prescription drug benefits under the Medicare subvention demonstration and pharmacy base closure programs.
- Review national FEHBP and other private sector prescription drug benefits for lessons learned in establishing new DOD program criteria and revising prescription drug benefits. A guiding principle should be to provide DOD beneficiaries with uniform and geographically convenient access to DOD prescription drug services no matter where they reside.
- Upon integrating the existing pharmacy patient databases, institute electronic billing and claims reimbursement among MTFs and TRICARE contractors.
- Upon integrating the MTF pharmacy patient databases, institute mandatory third-party insurer billing for MTF prescription drugs provided to beneficiaries who have other health insurance for prescription drugs.
- Direct and ensure that MTF pharmacies and TRICARE contractors routinely apply accepted PBM practices such as prior authorization, early refill edits, duplicate therapy edits, and physician-approved therapeutic interchange—consistent with DOD pharmacy benefit policies.
- Postpone awarding a separate national retail pharmacy PBM contract until the subject reforms have been implemented for current TRICARE retail pharmacy programs and until cost-savings from those reforms can be compared with potential cost-savings under a separate retail pharmacy contract.

DOD and the TRICARE contractors agreed with each of the recommendations, but DOD made certain points. With respect to extending systemwide drug eligibility to Medicare-eligible retirees, DOD said that legislative authority would be required to fund such services above this population's current MTF space-available services. We believe that if our recommendations were implemented promptly and strategically, the resulting savings would help to defray such added costs. Also, implementing automated prospective drug utilization review systems; a uniform, incentive-based formulary; and other PBM best practices could save DOD and its contractors hundreds of millions of dollars annually by substantially lowering prescription drug costs. And collecting copayments for nonformulary drugs from all non-active-duty beneficiaries would save millions more, as would applying safer drug therapies to reduce general health care costs. Likewise, extending the systemwide drug benefit to Medicare-eligible retirees will result in better management of their care, and major dollar savings may be achieved with drug utilization review, which helps avoid excessive use and adverse drug reactions that can cause illness, hospitalization, and even death. In short, the financial and other health benefits to be derived from overhauling the system can be applied against the costs of a military retirees' systemwide drug benefit.

Also, DOD stated that although MTF pharmacy copayments are valid and effective, beneficiaries will resist them and perceive benefit erosion. We believe the MTF pharmacy benefit already has eroded as a result of funding reductions and formulary restrictions and that our collective recommendations will help reverse this troublesome course. Furthermore, beneficiaries' general acceptance of MTF pharmacy copayments will critically depend on DOD's bringing about and promoting marked improvements in its overall pharmacy efficiency, cost-effectiveness, and quality.

Lastly, DOD is in the process of planning its pharmacy program redesign and expects to implement the redesigned retail and mail-order pharmacy programs for Medicare-eligible beneficiaries at two yet-to-be selected sites

by October 1999. We have not yet been provided a copy of or access to DOD's plan for redesigning its pharmacy benefit. Thus, we have no comments.

Mr. Chairman, this concludes my prepared statement. We will be happy to respond to any questions you or other Subcommittee members may have. We look forward to continuing to work with the Subcommittee as it exercises its oversight of DOD's redesign of the military pharmacy system.

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