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HEARING ON FEHBP's Prescription Drug Benefits: Deal or No Deal?

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Mr. Chairman and distinguished members of the committee, thank you for the opportunity to discuss the evolution of the Department of Defense (DoD) TRICARE Pharmacy Program.

Overview of the DoD Pharmacy Benefit

DoD, through TRICARE, provides a pharmacy benefit to all eligible Uniformed Services members, their family members, and all retirees and their family members, including beneficiaries ages 65 and over. The benefit covers over 9 million individuals through three outpatient venues of distribution: 1) military treatment facility (MTF) pharmacies; 2) Retail Pharmacies including a 60,800 TRICARE Retail Pharmacy (TRRx) network as well as other non-network retail pharmacies; and 3) a TRICARE Mail Order Pharmacy (TMOP) program. In Fiscal Year (FY) 2008, 71% of eligible beneficiaries (6.9 million) used the pharmacy benefit. In that year, more than 122 million prescriptions were filled at an expense of $6.9 billion in the context of a $31.5 billion Defense Health Program Operation & Maintenance budget.

Legislative Framework

The National Defense Authorization Act (NDAA) for FY 2000 established the parameters for the DoD Pharmacy Benefits program. This federal law required the Secretary of Defense to establish an effective, efficient, and integrated pharmacy benefits program. Under this program, the Secretary must ensure the availability of pharmaceutical agents for all therapeutic classes, establish a uniform formulary based on clinical effectiveness and cost-effectiveness, and assure the availability of clinically appropriate pharmaceutical agents to members and retired members of the Uniformed Services and their family members. By law, the Uniform Formulary may not exclude access to any medication used in the ambulatory care setting and must make all Food and Drug Administration (FDA) approved prescription medications available to beneficiaries

, even those medications designated as “nonformulary,” a key difference from civilian pharmacy benefit plans. These drugs are all available at a nominal copayment. The Secretary of Defense implemented the current TRICARE Pharmacy Benefit regulations, a key component of the TRICARE program, effective May 3, 2004.

Benefit Structure

The law stipulated a three-tier cost-sharing structure and limited the amount of the highest copayment category—the nonformulary or third tier category—to 20% for active duty family members and 25% for retirees and their family members of the costs of drugs in the third tier. The first tier is comprised of generic drugs for the most part and the second tier is comprised of preferred brand name drugs. Although the law allows established copayments to be adjusted periodically based on experience with the uniform formulary, changes in economic circumstances, and other appropriate factors, the copayment structure has not changed since 2001. Legislation in FY 2007, FY 2008, and renewed in FY 2009 froze all TRICARE copayments in the retail pharmacy network.

Expenditures

DoD’s pharmacy program expenditures grew significantly from $1.6 billion in 2000 to $6.9 billion in 2008 but have begun to plateau. The primary driver for DoD’s increase in pharmacy expenditures was the implementation of the TRICARE Senior Pharmacy Program as promulgated in the NDAA for FY 2001. This legislation expanded pharmacy coverage for beneficiaries ages 65 and over, providing them access to the retail pharmacies and TMOP. Prior to the enactment of this legislation, this beneficiary category had only limited access to MTF pharmacies. With the maturation of the TRICARE Senior Pharmacy Program for DoD’s 1.5 million Medicare-eligible population, retail costs rose dramatically. This escalation in pharmacy expenditures was further compounded by other cost drivers such as drug price inflation, increased

utilization, and an increased number of beneficiaries. Many commercial health plans have seen their pharmacy spending increased by some of these same drivers.

Before the NDAA for FY 2008 DoD had very limited discounts available for medications dispensed through the retail venue. Although military pharmacies and the TMOP both had access to significant federal pricing discounts under the Veterans Health Care Act, the retail venue did not. With the passage of the NDAA for FY 2008 legislation, the TRICARE network retail venue is now also covered by federal pricing discounts. DoD is in the process of implementing procedures to collect refunds from manufacturers. The total amount of refunds expected in Fiscal Year 2010 is more than one billion dollars (counting both appropriated funds and accrual funding for DoD beneficiaries).

Pharmacy Benefit Management Tools

Pharmacy benefit management in the commercial arena uses a number of tools to control costs. Among them are the use of formulary management—which provides the ability to drive utilization to formulary medications by restricting access to more expensive medications that are not proven to be more clinically effective; the implementation of timely adjustments to cost-shares; and mandating the use of less expensive venues, such as mail order, by restricting access to more expensive venues. In addition, commercial pharmacy benefit managers' ability to restrict access to nonformulary medications or render some medications unavailable to beneficiaries is a powerful leveraging tool with the pharmaceutical industry. Although DoD has a longstanding mandatory generic substitution policy, this policy does not mitigate the use of brand name products that have no generic equivalent. Additionally, since medications are available at low cost-share differentials ($3 for generics versus $9 for brand names), there is little incentive for the patient or provider to choose a less expensive brand drug over a clinically equivalent higher costing drug.

Management of the DoD pharmacy benefit has unique challenges for benefit delivery. Under the Act, DoD may not, for example, mandate the use of the less expensive mail order venue, but instead must focus its efforts on educating beneficiaries about the convenience and cost savings of mail order to encourage beneficiaries to use it. These efforts have had unprecedented success, and TMOP use has continued to increase over the years. Further increases in TMOP use however, could be realized.

Carved In Pharmacy Benefit

Prior to 2004, the DoD purchased care pharmacy benefit, i.e., the retail and mail order pharmacy programs, were part of the five regional TRICARE Managed Care Support Contracts (MCSCs). This type of pharmacy benefit management structure created significant challenges:

- Federal discounts in the retail pharmacy venue were not accessible because management of the retail benefit was not under direct government control.
- With a fragmented "book of business" and market share, DoD had less leverage with pharmaceutical manufacturers for favorable pricing.
- Lack of portability of the benefit, i.e., access to the pharmacy benefit could not cross the five regional contract lines.
- Lack of visibility to beneficiaries of the five separate formularies managed by the MCSCs as to what was included and lack of standardization, led to an unequal benefit across the five regions.
- Absence of standard policy application across the regions; i.e., in some regions, the mandatory generic policy was strictly followed, in other regions, it was not.
- Lack of visibility of pharmacy expenditures in the purchased care portion of the pharmacy benefit made it difficult for TRICARE to track and analyze these costs.
- Duplicative administrative services and fees by five MCSCs added to the costs and complexity of administering the program.

Carved Out Pharmacy Benefit

From 2001 to 2002, overall DoD pharmacy expenditures rose 48%, primarily due to the addition of the age 65 and over population to the benefit. The MCSCs reported an 88% increase in DoD retail pharmacy costs alone. Under the carved in structure, the MCSCs could not access DoD's federal discounts in the retail or mail order venues. The result of this decentralized management structure was a disparate, non-transparent, non-portable and increasingly costly benefit.

A significant factor in DoD's consideration in redesigning the pharmacy benefit management structure, was the subject of access to federal discounts in the network retail pharmacy venue used by DoD beneficiaries. Promulgated through the Veteran's Health Care Act, federal discounts could be obtained only if DoD carved the pharmacy benefit out of the MCSCs and placed it directly under the control of a DoD Pharmacy Benefit Management (PBM) office. DoD's goal was to consolidate the pharmacy benefit under one structure to maximize leverage with the pharmaceutical industry and to streamline the management structure and practices.

The decision to carve out the retail pharmacy benefit from the MCSCs was made in 2002 and in 2004 TRICARE implemented its Retail Pharmacy contract. TRICARE had implemented its Mail Order Pharmacy contract in 2003. Even without broad access to federal discounts initially, overall cost increases slowed from an annual rate of 48% in 2002 to 22% in 2004 and in retail slowed from 88% in 2002 to 31% in 2004. Upon carve out, $50 million in savings (year one alone) were immediately recognized based on consistent, uniform and appropriate management of the mandatory generic policy. Between March 2004 and June 2007, the generic dispensing rate for TRRx increased from 43.6% to 58.6%. Placing the benefit under centralized management with a Uniform Formulary afforded DoD the leverage it needed for favorable negotiations with the

pharmaceutical industry. Through April 2008, Uniform Formulary decisions had been implemented in 32 drug classes representing 53% of FY 2007 total DoD drug expenditures. The 32 drug classes representing 343 drugs were reviewed at 12 quarterly meetings of the DoD Pharmacy and Therapeutics Committee and the Beneficiary Advisory Panel, resulting in the classification of 85 drugs (24.8%) in tier 3, 92 drugs (26.8%) in tier 2, and 166 drugs (48.4%) in tier 1. The Government Accountability Office reported in April 2008 that DoD avoided over $447 million in drug costs for FY 2006 and $916 million in FY 2007 due to the Uniform formulary process. An additional $60 million in rebates from drug companies was obtained in FY 2007 through the Voluntary Agreements for TRICARE Retail Pharmacy Refunds (UF VARR) program for prescriptions filled at community retail pharmacies. This is a total of $976 million in cost avoidance for DoD in FY 2007.

The preferred reference for the pharmaceutical pricing structure for federal agencies is the June 2005 Congressional Budget Office (CBO) paper called “Prices for Brand-Name Drugs Under Selected Federal Programs”. Likewise, the preferred reference for pharmaceutical pricing in the commercial sector is the June 2007 CBO Report called “Prescription Drug Pricing in the Private Sector”. Both documents are extremely helpful to understanding the complex pricing structure of pharmaceuticals in both the federal and private sectors.

After the carve-out initiative, DoD was able to create beneficiary outreach programs to encourage use of the cost-effective TMOP. As a result, TMOP use increased from $106 million in annual expenditures in FY 2000 before carve-out to $347 million in 2002 after carve-out, and was just short of a billion dollars ($955 million) in FY 2008. To date, overall cost increases are down from 48% in 2002 to 6% in 2008, and retail cost increases are down from 88% in 2002 to 8% in 2008. As access to federal discounts is finally achieved in FY 2009, these cost increases will continue to diminish.

A significant benefit of the carve-out is the ability to create a central data warehouse of all outpatient prescriptions dispensed to DoD beneficiaries. This worldwide centralized data system called the Pharmacy Data Transaction Service (PDTS) not only identifies potential drug-drug interactions, but provides DoD the ability to conduct outcomes studies and research projects, some of which have produced peer reviewed articles for publication.

Best Commercial Practices

Employers overwhelmingly choose to carve out their pharmacy benefit plans. In fact, the larger the plan, the more likely it will carve out the pharmacy benefit. A survey of the Fortune 500 in 2008 by Express Scripts, Inc. found that each of the top ten companies had carved out their pharmacy benefit and that 80% of the top 100 had done so. Within the Fortune 300, fully 75% had carved out the pharmacy benefit.

A June 2007 article appearing in Drug Benefit News confirms the findings of the Express Scripts survey. According to the article: "Despite renewed efforts by health plans to recapture their pharmacy benefit plan business lost to stand-alone PBMs – and even attract new Rx management business from outside of their membership – several recent surveys indicate that most large employers and other groups continue to favor contracting with stand-alone PBMs."

In May 2007, J. P. Morgan Securities, Inc., surveyed 50 large employers and found that they continue to favor stand-alone PBMs and are not interested in carving back in the pharmacy benefit. They cited price and services as the top two benefits of carving out drug spending.

According to J. P. Morgan analyst Lisa Gill, 64% of large employers used Medco Health Solutions, Inc., Express Scripts, Inc. or Caremark (now part of CVS Corp.). In addition,

between 80% and 90% of large employers carve out the pharmacy benefit. Gill explained that employers favor stand alone PBMs based on several factors: PBMs focus 100% on managing pharmacy costs rather than entire medical costs, a perception of greater transparency around PBM costs, and the greater choice of offerings from PBMs, such as specialty pharmacy and step therapy programs.

DoD's current managed care support contractors receive the pharmacy data they need for integration into a disease management or a case management program they may be conducting. The single national contract under one Pharmacy Benefits Management office consolidated the retail benefit from the previous multiple MCSC contracts into one management entity, providing a fully portable benefit unrestricted by regional boundaries with centralized pharmacy claims processing, which reduced administrative fees by more than 70% per claim. In addition, the carve-out enabled the government to establish more favorable and guaranteed reimbursement rates for the network retail pharmacies.

Health Outcomes

DoD actively participates in disease management (DM) and appropriate polypharmacy management and believes they are the ultimate goals of successful managed health care and pharmacy benefit management for improving health outcomes. These goals remain achievable through a carved out pharmacy benefit and are independent of the various distribution processes.

DoD shares pharmacy data with the TRICARE managed care support contractors and welcomes the opportunity to continue to work with them to ensure the accurate and timely flow of data. In addition, DoD has included requirements in the next generation of TRICARE contracts and the newly awarded T-Pharm contract to formalize the processes of pharmacy data sharing and DM. The contracts require a formal Memorandum of Understanding (MOU) between the managed care support contractors and the TRICARE

pharmacy contractor for the purpose of establishing the necessary cooperation for data exchange, coordination of care for patients receiving specialty pharmacy services, third-party liability, and claims issues. The MOU will specifically address the frequency and format of pharmacy data that will be provided to the managed care support contractors by the pharmacy contractor.

Conclusion

Hand in hand with the military mission itself, the highest priority in the DoD is the protection of the health of the men and women in uniform and the provision of the best possible care to those who become ill or injured. The DoD pharmacy benefit plays a critical role in that effort. Mr. Chairman, thank you for the opportunity to discuss the DoD Pharmacy Program and our efforts to continue to provide a world class and cost effective benefit to all of our beneficiaries.