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TRICARE Pharmacy Benefit Program Formulary Management Analysis  
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By

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### Abstract

The Military Healthcare System's (MHS) is struggling with how to provide and sustain the current pharmacy benefit. In order to provide a safe, cost-effective pharmacy benefit, many companies, including the Department of Defense (DoD), have contracted with Pharmacy Benefit Managers (PBMs). Though methods of cost containment have been implemented in the MHS, the cost of sustaining the pharmacy benefit continues to rise. A policy analysis of the DoD's Pharmacy Benefit Policy was conducted and three alternatives were suggested using Bardach's Eight Steps of Policy Analysis. The three alternatives are as follows: (1) Take no action or (2) increase tier co-payments and index annually or (3) implement health savings accounts (HSAs). Minor changes to the current Pharmacy Benefit Policy may ensure its continuation into the future.

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## Introduction

During the last thirty years, national healthcare expenditures consistently exceeded the overall economic growth in the United States (Shi & Singh, 2004). It is projected that by the year 2011, the costs associated with healthcare will account for approximately 18% of the Gross Domestic Product (National Coalition on Healthcare, 2005; Mercola, 2002; Shi & Singh, 2004). Government officials, third-party insurers, healthcare providers, and large businesses, including the Department of Defense (DoD), are grappling with how to provide quality healthcare, while simultaneously controlling costs. Since the year 2000, the 45% rise in healthcare costs has forced employers to increase the amount their employees contribute to their health benefits (Express Scripts, 2005). Employee spending on healthcare insurance has increased 126 % in four years, while benefits are reduced and employee cost shares have increased to 63% for individuals and 58 % for families (Funk, 2005; National Coalition on Healthcare, 2005). Healthcare spending in the Department of Defense is also on the rise. This increase led the civilian leadership in the Office of the Secretary of Defense (OSD) to review TRICARE, its healthcare benefits program.

Currently, there are over nine million beneficiaries eligible for TRICARE benefits (Wolak, 2005). Beneficiaries include active duty and retired military personnel and their family members. According to Shi & Singh (2004), TRICARE beneficiaries may choose from the following three health plans: (a) Prime (b) Extra and (c) Standard. TRICARE Prime is similar to a traditional Health Maintenance Organization (HMO). Beneficiaries are assigned a primary care manager (PCM), who coordinates all care associated with their individual health needs. Although Prime enrollees may choose a civilian PCM from

a group of local physicians who accept TRICARE (network physicians), the majority of care is delivered in a military treatment facility (MTF). According to Shi and Singh (2004), Prime is the most cost effective health plan. TRICARE Extra is a preferred provider type plan. Beneficiaries may choose care from a participating group of civilian doctors for a discounted fee. The difference between Prime and Extra is that beneficiaries selecting to use Extra may choose their care provider from a larger pool of healthcare providers, without following specific enrollment rules associated with the TRICARE Prime HMO model. TRICARE Standard is a traditional fee for service type plan. Beneficiaries choosing Standard have the most options when it comes to healthcare providers, but they also pay the highest cost shares out of the three plans. TRICARE was implemented over ten years ago in an attempt to contain the costs associated with military healthcare. Unfortunately, that has not occurred and the costs of providing the TRICARE benefit are projected to rise from \$30 billion to \$33 billion in Fiscal Year 2006 (Chu & Winkenwerder, 2005; Wolak, 2005).

The continued increase in healthcare spending has led many organizations to look for methods of controlling costs. Shi and Singh discuss several cost containment strategies which include price controls, demand-side incentives, and utilization controls (2004). Examples of price controls include the prospective payment system (PPS) and diagnosis related groups (DRGs). The prospective payment system was introduced in 1983. It changed the way hospitals were reimbursed for Medicare patients. In the past, hospitals discharged patients and billed for every expense incurred during the patient's hospitalization. Today, the prospective payment system bases payment on diagnosis related groups. Hospitals now receive a "flat rate for the DRG, regardless of the actual

services provided” (American Hospital Directory, 2005, p. 1). The DRG is based on the patient’s principal diagnosis or ICD-9 code. The ICD-9 code is a numeric system of coding over 13, 000 diagnoses and 5,000 procedures.

Demand-side incentives are also a method used to control costs. Demand-side incentives are costs incurred by patients, which allow consumers to make informed decisions regarding their benefits package. According to Robinson (2005), demand-side medical benefits, allows the consumer to choose programs that require higher cost-shares but also offer more options regarding patient preference in providers and procedures.

Utilization management is another method of controlling access to healthcare by using primary care managers as coordinators of healthcare. Primary care managers act as gatekeepers, because patients must first see them before they can be referred for diagnostic procedures and specialty care. This controls costs because it reduces the number of unnecessary laboratory tests and referrals to high cost specialty appointments.

Another method of controlling costs in healthcare organizations is to actively manage the pharmacy benefit. According to Express Scripts (2005), the cost of prescription drugs is rising at a meteoric pace. In 2003, drug costs accounted for 11% of total healthcare spending. Therefore, managing the pharmacy benefit is an essential component of containing healthcare costs. Although cost containment strategies, such as the ones previously discussed, have been suggested in the healthcare arena, the cost of healthcare in both the civilian and government sectors continues to rise.

#### *Conditions that Prompted the Study*

Most healthcare benefits programs are faced with the challenge of providing safe, clinically effective pharmaceuticals, while controlling costs (Berger & Teutsch, 2005).

This delicate balancing act is becoming increasingly difficult due to the rising costs of pharmaceuticals, increasing utilization rates due to expanded benefits, and increasing use of costly brand name pharmaceuticals (Bailey & Ferro, 1998; Funk, September, 2005). Many health benefit programs rely on pharmacy benefit managers to assist them with containing costs. Cost containment has been difficult due to consumers demanding access to brand name pharmaceuticals that they see advertised. Consumers do not want costs to interfere with their access to medications. For example, when TRICARE moved Viagra to nonformulary status, the copayment for the drug increased from \$9 to \$22. The *Army Times* published a question from a concerned beneficiary regarding the change (Hamby, August, 29, 2005). The beneficiary stated that he was “concerned about the new twenty two dollar price category ...” He claimed that the new pricing strategy was a “stealth” approach to general price increases. After reading the article and attending several briefings regarding the increasing costs of sustaining the TRICARE pharmacy benefit, this author decided to analyze the policy entitled: TRICARE Pharmacy Benefit Program Formulary Management.

#### *Statement of problem*

The DoD is spending an increasing amount of money every year on the Defense Health Program (DHP). As the cost of healthcare in the military health system continues to increase, the leaders in the Department of Defense are actively seeking out new methods of controlling costs. A major contributor to the increasing cost of the DHP is the rising cost associated with providing pharmacy benefits to the nine-plus million TRICARE beneficiaries. In an effort to support the cost containment effort in the DoD, the Health Affairs Policy 04-032: TRICARE Pharmacy Benefit Formulary Management

(Winkenwerder, 2004) will be analyzed in an attempt to offer alternatives to the current system.

### *Literature Review*

Pharmacy Benefit Management (PBM), “encompasses all of the functions required to administer and manage a prescription drug benefit program” (Pharmacy Benefit Management Institute, Inc., 1998, p. 3). Over 50% of the U.S. population is covered by PBMs (Pharmacy Benefit Management Institute, 1998). Pharmacy benefit management is utilized by health benefit providers as a method of controlling prescription drug costs through utilization management (PBM Institute, 1998). Controlling drug costs is necessary because of the rapid increase in consumer spending on prescription drugs. According to Charatan (2001), prescription drug expenses will increase by 12%, which will cause healthcare spending overall in the United States to more than double by the year 2010.

“Americans consume about 3 billion prescriptions on average, and people over 65 spend about \$2,300 a year on medications” (National Coalition on Healthcare, 2005). The impending increase in the elderly population due to the aging of the Baby Boomer generation will cause the prescription drug spending to dramatically increase in the next twenty years. Mercola (2005) suggests that prescription drug spending will continue to grow at double digit rates and will account for 14% of the total health costs by 2011.

Several HMOs are using a version of PBM to aid them in controlling costs. Aetna, Foundation Healthcare, and PacifiCare, “...own subsidiaries that are PBMs or provide internal pharmacy benefit management services...” (Pharmacy Benefit Management Institute, 1998, p. 1). Cigna and Prudential are examples of HMOs that use internal

resources to provide utilization management, but contract out claim processing to external organizations (Pharmacy Benefit Management Institute, 1998). Many national HMOs sign with national PBMs such as Diversified Pharmaceutical Services, Cigna, PCS Health Systems, and Express Scripts to name a few. Today, the largest national PBM is Diversified Pharmaceutical Services. The company's success is directly tied to its relationship with United Health Care, one of the largest health maintenance organizations in the U.S. Currently, the Tricare Management Activity, the manager of the TRICARE health plans, has contracted its Mail Order and Retail Pharmacy programs out to Express Scripts. Express Scripts currently provides services for over four million members in 41% of the HMOs in the U.S.

Providing safe, effective, and affordable prescription drugs is the goal of every PBM. Several methods are used by the PBM to provide the drug benefit, but the methods that are most often used are; formulary management, tiered co-payments, therapeutic interchange, and reference pricing (Odedina, et al., 2002; Atlantic Information Services (AIS) Pharmacy Benefit, 2005; Schachtner, et al., 2002; Coalition Working Group, 2000). The Coalition Working Group, a group of national organizations that represents healthcare workers, government, and business leaders, published guidance regarding the essential components of a drug formulary system in 2000. They define a formulary as a list of medications that is continuously updated by pharmacists and physicians. The Coalition Working Group (2000) defines a drug formulary system as:

“An ongoing process whereby a healthcare organization through its physicians, pharmacists, and other health care professionals, established policies on the use of drug products and therapies, and identifies drug products and therapies that are

the most medically appropriate and cost effective to best serve the health interests of a given patient population” (p.1)

The Coalition believes that a sound formulary system will help leaders balance healthcare quality and costs. Novartis (2004) reports that based on the 2004 Class Utilization and Evaluation (CUE) Data Collection Survey, the majority of managed care plans (91.3%) were using a, “...formulary to define the benefit provided to enrollees” (p. 7).

The Coalition also recommends that a formulary system be based on evidence regarding drug effectiveness, economic considerations based on evaluation of drugs in terms of their safety and efficacy, and impact on total health care costs. The system should also allow patients to access nonformulary medications if medically necessary. The formulary should be reviewed on a regular basis by a Pharmacy and Therapeutics (P&T) Committee. This committee will evaluate and select drugs for the formulary based on scientific evidence of efficacy as well as cost-effectiveness. The P&T committee should also develop guidelines for providers to inform them of the products, usage, and committee decision (Coalition Working Group, 2000).

Methods associated with controlling pharmacy costs include formulary management techniques such as prior authorization and tiered co-payments. Formularies that require prior authorization obligate the physicians to obtain prior authorization for prescription drugs outside of formularies. The providers usually must be able to demonstrate medical necessity prior to the patient receiving a non-preferred drug. In addition, cost sharing is a system in which beneficiaries must pay a “flat dollar amount or a percentage co-payment collected at the point of distribution” (Novartis, 2004, p. 13). Tiered co-payments “provide financial incentives for members to use the most cost-

effective alternatives, and still offers members a choice of medications... which provides significant savings without negative effects on clinical outcomes” (Express Scripts, 2004).

A single-tier co-payment is based on a single cost share for both brand and generic drugs. A two-tiered system means that there is a higher cost share for second-tier drugs. The first tier usually contains generics. Generic medications have the same therapeutic effects as their brand name equivalents (European Generic Medicines Association, 2005). Generics and brand name pharmaceuticals differ in two ways. Generics may contain different non-active ingredients from brand names, such as food coloring, while brand names are more expensive than generics. The second tier usually contains brand name drugs (Novartis, 2004). Brand name medications are owned by the drug companies that develop the new drug. The company gives the drug a “brand name” by obtaining ownership rights (a patent) to the name (Barrlabs, 2005). This means that during the twenty years the drug is patented, other drug companies can not profit by selling generic versions of the drug. The third and fourth-tier structures continue to stratify the drugs into categories that correspond to increasing copays. Although the tiered approach to pharmacy benefit management is one of the most popular methods of cost-containment, there are several others that are mentioned in the literature to include step therapy, therapeutic interchange, and reference pricing.

Step therapy is based on the extensive use of generic rather than brand name medications. Providers are encouraged to use a first-line medication, usually a generic, before moving to a second-line drug, usually a brand name drug (Aetna, 2001-2005). Therapeutic interchange is defined by Schachtner et al (2002) as the use of a “less

expensive, equally efficacious, chemically different compound in the same pharmacologic class of the prescribed agent” (p. 529). According to AIS (2005), reference pricing is another method of containing pharmacy costs. This method is based on groups of pharmaceuticals with therapeutic similarities. Drugs are placed in four different co-payment levels based on their reference prices. The higher the reference price the higher the co-payment made by the beneficiaries.

If so many healthcare organizations are implementing the above mentioned cost-containment strategies, why are pharmacy costs increasing at such a rapid rate? Express Scripts asserts that the increases in pharmaceutical costs are due to several reasons that include inflation and therapeutic mix. According to Express Scripts (2005), the six percent overall inflation rate for prescription drugs was due to a number of factors including the introduction of a high cost Human Immunodeficiency Virus drug, higher cost of anticonvulsants due to increased generic competition, and the introduction of new generics on the market due to patent expirations of brand name drugs. Factors which describe a change in the therapeutic mix include a change in the market shares of individual drugs, the addition of new strengths of existing drugs, and changes in the market share of each class. Civilian and military healthcare costs are affected by many of the same issues, but there are several issues specific to the military.

Factors that contribute to the spiraling costs of healthcare and pharmacy costs in the Military Health System include the following: (1) implementation of TRICARE for Life the healthcare benefit for retirees over 65 years old, (2) benefit expansion for the Reserve Component and their family members, (3) increasing utilization among retirees

younger than 65 years of age, (4) and co-payments that have not been increased (Chu & Winkenwerder, 2005).

The cost of providing pharmaceuticals to TRICARE beneficiaries was over five billion dollars in Fiscal Year 2005 (Winkenwerder, 2005). Officials in the Military Health System are currently reviewing methods of containing pharmacy costs. The current method of cost containment uses a three tiered co-pay structure, which will be discussed during the “Assembling Some Evidence” section of this Policy Analysis. The increase in pharmacy costs in the DoD is the focus of this policy analysis.

### *Purpose*

A thorough analysis of the Health Affairs Policy 04-032: TRICARE Pharmacy Benefit Formulary Management will address the strategies for cost containment found in the management of the TRICARE pharmacy benefit, consider whether or not the strategies have been effective, and if not, suggest alternatives to the program.

### Methods and Procedures

In his book, The Eight-Step Path to Public Policy Analysis (1996), Eugene Bardach discusses a research technique that may be used in policy analysis. Reliability and content validity are obtained in this qualitative research by conducting an extensive literature review and obtaining information from well-established journal, books, and internet sites. Ethical considerations are addressed by evaluating each alternative’s projected outcomes as equitable or not equitable. There are eight essential steps that must be used when analyzing policy. The steps are listed below:

1. Defining the Problem is the first and most important step in the policy analysis process. According to Bardach (1996), defining the problem determines the reason for

conducting the analysis and provides directions for the data gathering process. In order for the policy analyst to complete this step, he/she must review all raw materials available. Raw material is taken from the literature and public debate surrounding the issue. Defining the problem is best thought in terms of deficit and excess. Bardach makes use of the following example to make his point: “There are too many homeless people in the United States” (1996, p. 6). The definition of a problem should include a quantitative example of the problem. For example, in the above mentioned example regarding “too many homeless people”, Bardach suggests defining what number is too many.

2. The next step in Bardach’s method of policy analysis is to assemble some evidence. Evidence as defined by Bardach, “is the information that affects the existing beliefs of important people about significant features of the problems you are studying and how it might be solved or mitigated” (p.13). If an analyst wants to affect the beliefs and decision-making processes of important people, then the data that is converted to evidence must be reliable and valid. The evidence is used for the following three reasons: (1) to define the problem, (2) to determine the features of policy, (3) and to review similar policies that have worked in other settings. Bardach implores the policy analyst to think about what he or she wants to determine and why, prior to collecting information. This allows the analyst to not waste time on information that has no value to the analysis. Bardach further defines valuable information as information that helps the analyst develop acceptable outcomes that are usually better than the original decision.

3. The next step of the policy analysis is constructing alternatives. Alternatives are also defined as policy options or strategies of intervention that solve a problem. The

process of constructing alternatives starts by constructing an exhaustive list of alternatives based on political climate and the views of all the stakeholders.

4. Selecting the criteria for judging projected outcomes is based on the judgment of the analyst on why the alternative is desirable. Outcomes can be measured in terms of efficiency and equality. According to Bardach (1996), a policy is efficient if it “maximizes net benefits” (p. 26). The overall goal of determining the efficiency of a policy is to determine whether or not it may be utilized to solve the identified problem. For example, the cost effectiveness of a pharmacy program equates to the efficiencies built into the program to deliver a benefit. Equality in a policy is indicative of fairness and justice on how the policy is administered to the eligible population. Another method of analyzing the outcomes of a policy is to evaluate the legality of the policy. Policies must not, “violate constitutional, statutory, or common law rights” (p. 31).

5. For every alternative suggested, outcomes must be projected. According to Bardach (1996), many analysts prefer to skip this step because it requires clarification concerning what can realistically be achieved. Projecting realistic outcomes is outside the comfort zone of many analysts. Bardach (1996) insists that most analysts prefer optimism over realism. Policy analysts must be realistic in projecting and evaluating outcomes because policy affects real people and their lives. Bardach mentions that policy analysts have a moral burden to be realistic and to ask themselves who will be affected if the projected outcomes are incorrect.

6. Determining the tradeoffs is a step that occurs prior to choosing an alternative. According to Bardach (1996), a tradeoff between money and a good or service received by consumers is the most common.

7. Make a decision. Choose an alternative based on the completed policy analysis.
8. The final step in the process is telling your story. This step communicates the decision making process concisely and with the reader's needs and interest in mind. The analyst tells the audience why a particular alternative was selected.

## Policy Analysis

### *Define the Problem*

The cost of providing the pharmacy benefit to the more than nine million TRICARE beneficiaries is over \$5 billion annually and is expected to continue to increase (Winkenwerder, 2005). The DoD implemented several strategies aimed at decreasing healthcare costs in the Military Health System including the implementation of the prospective payment system, consolidation of TRICARE healthcare regions, and the implementation of the Pharmacy Benefit Management Program.

The Prospective Payment System is currently being implemented in Military Treatment Facilities (MTFs). In the past, military hospitals were funded based on historical workload. This funding method was based on the amount of resources consumed in the provision of patient care. The Prospective Payment System ensures that the DoD, "bases its healthcare portion of the Defense Health Program (DHP) budget on outputs, not inputs" (Chu & Winkenwerder, 2005). The government's MTFs must now develop business plans and budgets based on actual outputs, which promote internal efficiency in individual MTFs (Chu & Winkenwerder, 2005). The consolidation of TRICARE healthcare regions from twelve to three streamlined the administration of healthcare, therefore reducing overhead costs. The implementation of the Pharmacy Benefit Management Program was designed to manage the full spectrum of pharmacy

benefits in the MTFs, the network retail pharmacies, and in the mail order pharmacy system. The analysis of the TRICARE Pharmacy Benefit Program: Formulary Management will provide a discussion on how the program intends to achieve cost savings and whether it should be modified by adding additional steps in order to both provide the pharmacy benefit as well as contain costs.

#### *Assemble Some Evidence*

The Military Health System's (MHS) Prescription Drug Benefit Program was mandated by Congress. Title 10, Subtitle A, Part Two, Chapter 55, section 1074g describes the Pharmacy Benefit Program to which all DoD beneficiaries are entitled. The legislation mandates that the MHS utilize a Uniform Formulary of pharmaceutical agents, and establish a Beneficiary Advisory Panel (BAP) and a DoD Pharmacy and Therapeutics (P&T) Committee. As a result of this legislation, the Health Affairs (HA) Policy 04-032: TRICARE Pharmacy Benefit Program Formulary Management was developed to implement the legislative guidance.

The Uniform Formulary is defined by TRICARE as a list of medications that the DoD approved for distribution in the Military Health System (TRICARE Management Activity Administration, November 8, 2005). The list is kept updated through the use of a well-established P&T Committee review process which ensures that TRICARE beneficiaries always have access to effective high quality medications (TRICARE Website, August 9, 2005). The BAP is comprised of representatives of active duty families, retirees, civilian pharmacists and physicians, and others that support the TRICARE health benefit through healthcare contracts (TRICARE Management Activity Administration, November 8, 2005). The Panel meets on a regular basis in order to

review and comment on the development of the Uniform Formulary. This allows beneficiaries to make known their views on what drugs the DoD P&T Committee recommended for inclusion and exclusion in the Uniform Formulary.

The DoD P&T Committee is composed of pharmacists, doctors, and representatives from each of the Services and the Veterans Administration. The Committee meets quarterly to make recommendations to the TRICARE Management Activity Director regarding what drugs should be designated as formulary or non-formulary (TRICARE Management Activity Administration, 2005). According to Dr. Winkenwerder (2004), the P&T Committee is responsible for formulary management in the Military Health System. “The Uniform Formulary process involves the review of different classifications of FDA-approved medications on the basis of their clinical and costs effectiveness” (TRICARE Management Activity Administration Office, 2005, p.1). Medications are classified as formulary generic (tier one), formulary brand name (tier two), or non-formulary (tier three) in order to determine the appropriate cost share. Non-formulary medications are not contained in MTF formularies and may only be obtained if they are deemed medically necessary (Winkenwerder, 2004, TMA Administration, October 24, 2005). Medical necessity will be further defined later in the Policy Analysis.

In HA Policy 04-032 (2004), Dr. Winkenwerder designates the development of the Uniform Formulary as well as the Basic Core Formulary (BCF), the Extended Core Formulary (ECF), and the MTF Formulary. The BCF is a subset of the Uniform Formulary and must be on hand in every MTF pharmacy. It is considered the minimum amount of medications required to adequately support the primary care practice in each MTF. The BCF only applies to MTF formularies and does not affect the mail order or

retail pharmacy programs. The Extended Core Formulary (ECF) is designed to meet more specialized scopes of practice than drugs on the BCF. The DoD P&T Committee determines which drug classes are to be included on the BCF and the ECF. MTF Commanders and their local P&T Committee's may determine other drugs to include in their MTF's pharmacy, as long as the drugs are also contained on the Uniform Formulary. Although TRICARE beneficiaries may obtain their prescription drugs from the MTFs, they may also obtain them from the mail order and retail pharmacy programs. A discussion of the TRICARE Pharmacy Benefit is necessary at this time to understand the various aspects of the program.

The TRICARE Pharmacy Benefit includes pharmaceuticals dispensed at the MTFs, the Mail Order Pharmacy Program, the Retail Pharmacy Program, and non-network retail pharmacies. Beneficiaries may obtain up to a 90 day supply of medication from the MTF pharmacy at no cost if the medications are on the MTF formulary (TRICARE Administration Office, October 24, 2005). The TRICARE Mail Order Pharmacy (TMOP) is administered by Express Scripts, Inc. (ESI), a well known Pharmacy Benefit Manager (PBM). Patients may receive a 90 day supply of their medications that they take on a regular basis. The patient may request a refill through the mail, phone, or via the internet which will be sent directly to their home (TRICARE Management Activity Administration, 2005). Beneficiaries must register with TMOP prior to being able to reorder medications through the system. The TRICARE Retail Pharmacy Program (TRRx) is also administered by ESI. This program allows beneficiaries to fill prescriptions by going to any of the over 54,000 network retail pharmacies that accept TRICARE. Beneficiaries may also obtain their prescriptions from

non-network retail pharmacies but this is the most costly method of obtaining medications.

The three tiered method of formulary management is used to deliver the TRICARE Pharmacy Benefit. As discussed previously, tier one medications are classified as generic, tier two medications are classified as brand name, and tier three medications are classified as non-formulary. “The co-payment depends on where the beneficiary chooses to fill their prescription” (TRICARE Management Activity Administration, 2005, p. 1). If the beneficiary gets the prescription filled in the MTF, there is no co-payment applicable to tier one and tier two medications. The beneficiary can only obtain non-formulary drugs through an MTF if it is considered medically necessary. Medications are designated as medically necessary by the physician when one or more of the following criteria is met: (1) use of a drug contained in the formulary is medically contraindicated, (2) the patient suffered side effects from the formulary medication in the past, (3) an alternative medication on the formulary failed to gain the desired therapeutic effect, (4) the patient positively responded to non-formulary medication and changing to a formulary alternative would cause unnecessary risk to the patient, or (5) there is no formulary alternative (TRICARE Management Activity, August 8, 2005). If the medication is not medically necessary, beneficiaries may obtain the non-formulary medication through the TRICARE Mail Order Pharmacy (TMOP) or the TRICARE Retail Pharmacy (TRRx), but will have to pay a co-payment.

Medications classified as formulary status may be obtained at the MTF Pharmacy but also may be obtained through the TMOP or the TRRx. The co-payment for a 90 day supply of medications obtained through TMOP and TRRx is \$3 for a tier one (generic)

medication, \$9 for a tier two (brand-name) medication, and \$22 for a nonformulary medication. When the Director, TRICARE Management Activity moves a medication to nonformulary status, some beneficiaries are angered by the decision. The patients can no longer obtain the medication from the MTF free of charge, and they must pay the \$22 cost-share associated with the medications non-formulary status. One beneficiary expressed his concerns in the Army Times (August 29, 2005). As previously discussed, the beneficiary who wrote the letter to the Army Times regarding the movement of Viagra to nonformulary status was incensed. Although there are at least two other medications that are the therapeutic equivalent to Viagra on the formulary, which he may obtain through the MTF at no cost, the beneficiary believes that by switching the drug to non-formulary status, TRICARE is using an underhanded approach to increasing prices. Based on an extensive literature review, this analyst discovered that TRICARE is using a well-established, well-documented tiered method of managing the pharmacy benefit. According to the Kaiser Family Foundation (2004), the three tiered co-payment structure is now the most widely used pharmaceutical cost-sharing formula. Why then is the MHS pharmacy budget increasing at such a rapid rate? This question is being asked by the TRICARE leadership, and they are currently researching alternatives that will allow them to sustain the benefit while controlling costs. This analyst will suggest alternatives to the current pharmacy benefit policy that the TRICARE leadership may want to consider in their quest for providing a high quality, cost effective benefit to the over nine billion TRICARE beneficiaries.

*Construct the Alternatives*

Congressional and DoD leaders cannot afford to maintain the status quo. These leaders have a moral obligation, as stewards of the government's and ultimately the citizen's resources, to perform their duties with the goal of balancing benefits with costs. This analyst will review and evaluate the projected outcomes of the following three alternatives: (1) Take no action, (2) implementation of higher co-pays for TRICARE beneficiaries, and (3) the implementation of health savings accounts for all TRICARE beneficiaries, including active duty members.

Bardach recommends that the first alternative should always be to "take no action." Taking no action could be the most detrimental to TRICARE beneficiaries. If sustaining the healthcare and pharmacy benefit becomes unmanageable due to costs, the benefits may be significantly reduced or beneficiaries may have to pay increased enrollment fees, deductibles, and drug co-payments just like the workers at General Motors have recently begun to do. General Motors (GM) is on the verge of filing for bankruptcy due to a combination of sluggish auto sales and the ever increasing healthcare and pension costs (MSN Money, 2005). Historically, GM hourly employees have not had to pay monthly health insurance premiums and they have had very little out of pocket costs. Their new health benefit plan has introduced an annual premium of \$752 for families. The company was providing healthcare for over 750,000 hourly employees, retirees, and their dependents, which cost the company over \$5 billion this year (MSN Money, 2005). If healthcare and pharmacy costs continue to rise in the Military Health System (MHS), leaders in the Office of the Secretary of Defense and TRICARE may be forced to suggest increased out-of-pocket expenses for all TRICARE beneficiaries. Although the costs of providing the pharmaceutical benefit in the MHS are high, a major

overhaul of the current three tiered system may not be necessary. There are methods that fit well within the current system of managing the benefit, one of which will be described in the following paragraph.

The second alternative is to increase drug co-payments to a level that is comparable with the civilian sector. According to Hosek (2005), civilian employer based pharmacy plans charge almost twice what TRICARE charges for prescription drugs. Therefore, in order for TRICARE to be able to sustain the pharmacy benefit, pharmaceutical co-payments should be increased annually in order to keep pace with inflationary trends and increased prices set by the pharmaceutical industry. TRICARE co-pay amounts (\$3, \$9, and \$22) have not been increased in several years. Currently, civilian sector tier one drugs can range from \$5-10, tier two medications range from \$25-\$50, and tier three medications may cost the beneficiary \$50 or more (New Jersey Tooling and Manufacturing Association, 2005; Unicare, 2005). Increasing research and development costs, as well as inflation, have driven the costs of pharmaceuticals up, but this has not yet been reflected in the TRICARE co-payment structure. If raising drug co-pays is not chosen as a cost containment option, then a more radical approach to cost containment in the DoD needs to be implemented.

The third and final alternative is to implement a program in which TRICARE beneficiaries assume a more active role in paying for the pharmaceutical benefit through consumer driven healthcare vehicles like health savings accounts. Becker (2006) states, “in the same way that the retirement-planning landscape is evolving from defined-benefit pension funding to the defined-contribution world of 401(k)s, the healthcare benefits landscape is poised for a fundamental shift in who ultimately contributes to the plans and

who manages their vast assets (pg. 6).” HSAs are accounts that will be contributed to and managed by the individuals who choose them as a healthcare compensation package. According to Miller (2006), employees must purchase a high deductible health plan (\$1,000 for an individual and \$2,000 for families) and then open a HSA. Health savings accounts are tax deferred savings accounts that the employee can withdraw from at anytime to pay for healthcare expenses that are not covered by the deductible (Miller, 2006). Money left over in the HSA at the end of the year stays in the account allowing the consumer to save money for future healthcare costs. Currently, individuals can make tax-deductible contributions up to the deductible amount, but can not exceed \$2,700 for individuals and \$5,450 for families. HSA’s can be used to pay for a variety of services to include office visits, in-patient stays, eye-glasses, medically related transportation, nursing home costs, and prescription drugs (Miller 2006).

According to the National Business Coalition on Health (2004), a major contributor to the increase in pharmaceutical costs is the increased volume of pharmaceutical users. This is also an issue for the MHS. With the advent of TRICARE for Life, TRICARE Reserve Select, and the increased use of TRICARE benefits by retirees under the age of sixty five, the volume of beneficiaries using the TRICARE pharmacy benefits increased significantly during the last several years. Currently, the number of retirees and their family members accounts for almost 50% of the TRICARE beneficiary population (Wolak, 2005). Increasing utilization of the TRICARE Pharmacy benefit is not a problem that will be resolved in the near future. As with the civilian sector, the military is also going to see an increase in the retiree population and an even larger demand for healthcare and pharmacy benefits due to the aging Baby Boomer

population. With advanced age comes the onset of chronic illnesses, such as hypertension and diabetes, which will require long-term pharmaceutical intervention (Nash & Goldfarb, 2006). Therefore, we can extrapolate that from the combination of increasing utilization and an increasingly elderly population, pharmaceutical costs if left unchecked will continue to rise in both the civilian and military health systems. Implementing HSAs for all TRICARE beneficiaries could help defray government healthcare and pharmacy costs.

### *Select the Criteria*

Bardach suggests that evaluation of efficiency and equity should be utilized to select the alternative with the best projected outcomes. Efficiency is defined by Bardach as “maximizing net benefits” which may be assessed by reviewing a policy based on its cost-effectiveness and cost-benefits (1996). Aday et al. (2004) describes two types of efficiency: allocative and production. Allocative efficiency is based on attaining the “most valued” combination of outputs. Production efficiency is described as the production of an optimum level of output for a minimum cost. Equity as defined by Aday et al. (2004) addresses the fairness associated with the distribution of healthcare (procedural equity) and minimizing the disparities in the health across groups (substantive equity). This analyst will evaluate projected outcomes based on allocative efficiency and procedural equity. Allocative efficiency was selected as an evaluative criterion based on the wording of the TRICARE Pharmacy Benefit Policy (HA Policy 04-032). The most valued goal of the policy is the provision of high quality pharmaceuticals in a cost-effective manner. Procedural equity was chosen because the goal of TRICARE is to ensure that all beneficiaries have access to the pharmacy benefit. Therefore, each

beneficiary should have access to high quality medications and the system for distribution should be fair to all. Each projected outcome will be evaluated based on this policy analyst's subjective evaluation of its allocative efficiency and its procedural equity. Scoring is as follows: Score=0, inefficient/inequitable; Score=1 makes no difference; Score=2, efficient/equitable.

### *Project the Outcomes*

#### Alternative One: Take No Action

Taking no action is inefficient (score=0) but equitable (score =2). The most valued combination of outputs for a pharmacy benefit program is that it provides high quality medications in the most cost effective manner. The current pharmacy benefit is inefficient in that it is not cost effective. The program cost the government over \$5 billion in 2005 (Winkenwerder, 2005) and is expected to increase next year. The University Times (2003) states that the exorbitant costs of technology and new drug development lead to increased healthcare costs. "Consider pharmaceuticals: we spend \$.5 billion for one new drug development" (University Times, 2003, pg.3). If nothing is done to reduce the cost of healthcare, Americans may find that by the year 2020, healthcare costs will have increased from the current 15% of the GDP to 20% of the GDP or \$20 trillion. The MHS will not be insulated from these increased costs. Therefore we can infer from this trend that the MHS budget will increase to an unimaginable amount of the Defense budget by 2020 as well.

In terms of equitability, the program distributes pharmacy benefits equitably. As discussed previously, all TRICARE beneficiaries have access to quality medication contained in the Uniform formulary. They pay low or no deductibles depending on their

status (Active Duty or Retiree), and pay modest cost shares for TMOP and TRRx pharmaceuticals. The current system is almost too generous to beneficiaries in that the employer, in this case the US government, bears the majority of the financial burden for the healthcare of its employees. Several large companies, including GM are on the verge of bankruptcy, due to their years of shouldering the majority of the costs of rich benefit packages. According to Watson (2005), GM's financial troubles signal the end of comprehensive employer sponsored healthcare benefits. Corporations and government organizations will begin a more austere approach to providing healthcare to its employees. Though alternative number one: Take no action is equitable now, it may not be in the future. If nothing is done to decrease the cost of the pharmacy benefit now, civilian and military leaders will be forced to significantly reduce the benefits available to future TRICARE beneficiaries.

Alternative Two: Increase the pharmacy co-payment amount

Alternative Two is both efficient (score=2) and equitable (score=2).

Implementing a higher co-payment is efficient because it achieves the goals established by HA Policy 04-032. Patients will still have access to FDA approved medications contained in the Uniform Formulary. The cost share associated with medications obtained through TMOP and TRRX would affect all beneficiaries' selecting these methods of obtaining prescription medications. No group would be exempt. Therefore, the increased cost shares would be equitable because it would affect all TRICARE beneficiaries regardless of status (Active Duty, Family Member, and Retiree).

Pharmaceutical co-payments are being increased across the nation in an attempt to control costs. According to the Kaiser Family Foundation (2004), the average co-

payment for prescription drugs distributed from three tier formularies has risen from \$7.42 to \$10.46 for generics, from \$13 to \$21 for brand names, and from \$17 to \$33 for nonformulary drugs. Several civilian organizations have increased pharmacy co-payments as a method of reducing costs. In 2003, the California Public Employees' Retirement System voted to approve an increase in drug co-pays. Co-pays for its members enrolled in Kaiser Permanente Health Plans was increased from \$5 to \$10 for generics and from \$15-\$20 for brand names (Kaisernetwork, 2003). Hosek (2005) suggests that TRICARE would experience a considerable cost savings if co-payments were increased to a level comparable to civilian pharmacy benefit plans.

#### Alternative Three: Implement Health Savings Accounts

Implementing Health Savings Accounts (HSA) would be efficient (score=2) but inequitable (score =0). HSAs would decrease the government's pharmacy costs by increasing the individual patient's fiscal responsibility for healthcare which would motivate them to reduce unnecessary utilization and look for cost effective, high quality options (MSN Nes, 2005; Romano, 2006). Currently, only 1% of the working population has an HSA but that number is expected to increase to 13% by 2007 (Becker, 2006; Romano, 2006). Blue Cross/ Blue Shield and Kaiser are offering HSAs and using incentives to attract consumers to the program. According to Becker (2006), "consumers have opened more than one million HSAs since they were created by the Medicare Modernization Act of 2003, and are now opening more than 50,000 such accounts monthly (p. 7)." Although HSAs will indeed decrease the DoD's share of pharmacy costs and are therefore efficient, HSAs are not equitable. Individuals retiring at a higher rank or those who secure well-paying post-retirement jobs would be able to afford to put

a lot more money into the accounts than the lower ranking personnel or those with minimum wage post-retirement income. Appleby (2006) proposes that HSAs will benefit the rich and lead to workers paying for the majority of their healthcare costs. For example, those who can afford to put the maximum amount into their HSAs could afford high cost pharmaceuticals and those who could not contribute the maximum would only be able to afford the cheapest drugs, not necessarily the most effective drugs.

### *Confront the Trade-offs*

Alternative One: take no action and let the pharmacy benefit continue as is may be fine for the beneficiaries, but not for the DoD and ultimately the taxpayer. If pharmacy costs continue to skyrocket, the generous benefit that so many currently enjoy may be at risk. Alternative Two: increase pharmacy co-pay amounts will help reduce the cost associated with sustaining the pharmacy benefit, but may cause a political firestorm because beneficiaries are used to obtaining pharmaceuticals for very low or no co-payments. The current legislation regarding the DoD Pharmacy Benefit states that co-payments can not exceed 20-25% of the average pharmaceutical costs, hence the low co-payments (\$3, \$9, and \$22). Changes to the co-payment structure will first need to be debated in the political process before they can actually occur. Politicians want to decrease pharmacy costs, but they also want to appease constituents. The trade-off for option two is that pharmacy costs would decrease, but politicians may also find that their support among voters may decrease as well. The third alternative: implement HSAs would reduce the amount of money the government would be required to pay for the pharmacy benefit. This alternative is not the most equitable solution, because it would set up a class distinction between those who earn a modest income and those in the upper

echelons of the work world who can afford to put a lot of money into their accounts. A system would be established where those with the largest HSAs would have access to the most expensive pharmaceuticals. More than likely, military beneficiaries will resist this new change and solicit support from their members of Congress in order to prevent it.

*Decide!*

Based on the scores: Alternative One (total score=2), Alternative Two (total score=4), and Alternative Three (total score=2), this analyst suggests that the leaders of the Defense Health Plan consider alternative two as a viable option to its current plan. Alternative Two is an incremental approach to a large problem. It would change the Pharmacy Benefit only slightly and could decrease the DHP's pharmacy budget considerably.

*Tell Your Story*

Pharmacy costs are rising at a rapid rate in the DHP. The current three tiered system of distribution and cost maintenance is not enough to keep costs from skyrocketing to an unmanageable level. Several methods of achieving the goal of access to quality medications in the most cost effective manner may be utilized, but something has to be done and soon. Several key leaders in the DHP have expressed concern over the rising costs (Chu & Winkenwerder, 2005; Winkenwerder, 2005), but to date nothing has been done to stem the tide. Alternative two offers a simple, incremental solution to a major problem. According to Aday, et al (2004), making incremental changes in a policy is usually the most acceptable means for those people affected by the policy. Incremental changes usually correct a problem (in this case, co-payments that are too low). TRICARE beneficiaries may initially balk at a rise in co-payment prices, but if they have access to

the same medications as before and understand the reason for the changes (inflation, increased cost of new medications), they more than likely will accept the new policy. Policy makers in Congress may also question making a change in the Pharmacy Program. However, speaking as one who appeared as witness to the House Armed Services Committee on Military Health Issues, this analyst can attest to the fact that they are also concerned with how the DHP is going to contain healthcare costs. Therefore, any method of cost containment that allows beneficiaries quality care in a cost effective manner will more than likely be supported.

#### Conclusions and Recommendations

The rising cost of pharmaceuticals is driving the cost of healthcare up in both the civilian and government sectors. Stakeholders including administrators, healthcare professionals, patients, and politicians can no longer afford to ignore the truth: a large part of America's economic resources are increasingly being spent on healthcare. As healthcare costs continue to rise, the struggle between providing quality healthcare in a cost-effective manner will continue. An increase in the use of technology in the delivery of healthcare, the growing number of elderly, and the lack of cost-containment strategies will bring the healthcare system, both civilian and military, to the brink of disaster, if something is not done soon.

The three alternatives suggested in this policy analysis were chosen based on their prevalence in the current healthcare literature. The results of taking no action, raising co-pays, and implementing health savings accounts are currently being discussed by healthcare scholars, industry leaders, and employers. The list of alternatives presented in this analysis is by no means an exhaustive one. The areas that were not discussed in this

analysis may be ripe for future exploration. Future studies could include analyses of how expanding the use of the mail order pharmacy program or implementing a federal pricing program in the TRICARE retail pharmacy program would affect the pharmacy budget (RAND, 2005; AFIS, 2005). The results of this analysis and future studies could be used to develop a quality pharmacy benefit that is both cost effective and equitable.

The leaders in the DHP, understanding their duty to the beneficiaries, as well as to the policy makers in Congress, should strive to ensure that TRICARE beneficiaries receive quality healthcare through fiscal responsibility in the distribution of that healthcare, and continue research in order to implement sound policies that will guarantee that those benefits will be available to future beneficiaries. Therefore, the leaders of the DHP should consider adopting a new co-payment structure that will decrease the amount being spent on pharmaceuticals while still maintaining the quality benefit that TRICARE beneficiaries currently enjoy.

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