The Department of Defense Pharmacy Benefit Management Program

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Prescription drug prices are frequently both politically and personally salient issues. The Department of Defense (DoD) offers a robust prescription benefit to 8.8 million beneficiaries. This benefit has evolved to meet changes in technology and patient requirements. The PharmacoEconomic Center (PEC) was established as the first pharmacy benefit manager entity in 1992, primarily in response to rapidly rising DoD pharmacy program expenditures. In its short history, the PEC has dramatically improved patient safety and decreased costs. To accelerate the efficiency and effectiveness the enterprise-wide pharmacy benefit manager has already achieved, DoD should increase the funding, staff, and authority of the PEC.

Introduction

The dramatic increase in pharmaceutical expenditures over the past 30 years is well documented.1–3 During the period of 1985–1999, national prescription expenditure growth was 13% annually, compared with 5% annual growth in overall health care expenditures.1 Rapid technological advances have increased the number of newer and more expensive drugs.4 The treatment shift in the United States from inpatient to outpatient hospital care is also a major factor in escalating pharmaceutical expenditures.1–3 During the period of 1985–1999, national prescription expenditure growth was 13% annually, compared with 5% annual growth in overall health care expenditures.1 Rapid technological advances have increased the number of newer and more expensive drugs.4 The treatment shift in the United States from inpatient to outpatient hospital care is also a major factor in escalating pharmaceutical expenditures.1–3

The use of pharmacoeconomics and prior authorization protocols, therapeutic guidelines, formulary management, disease management, negotiation of drug pricing with the pharmaceutical industry, and off-label use of drug products are essential components of a successful PBM.7

Description

The Department of Defense (DoD) currently provides pharmacy benefits to >8.8 million beneficiaries.10 The intricate task of efficiently managing costs and utilization for eligible recipients of all age groups, across three service branches (Army, Air Force, and Navy) and at points of service throughout the world, is still in progress. The DoD PBM primarily consists of the PharmacoEconomic Center (PEC) and the Pharmacy Data Transaction Service (PDTS). PEC staff members perform cost-effectiveness analyses, gather and disseminate education and information, administer the DoD Formulary through the pharmacy and therapeutics (P&T) committee process, negotiate national pharmaceutical contracts, and formulate clinical practice guidelines.11

History

Before 1992, military pharmacy was characterized as fragmented and localized. The number of military treatment facilities (MTFs) worldwide exceeded 800.3 Prescriptions were obtained for no charge at the MTF or reimbursed by the Civilian Health and Medical Program for the Uniformed Services for retail pharmacy purchases. Medication formularies were primarily simple lists and reflected local therapeutic requirements. Pharmacy administrators and hospital leadership made autonomous formulary decisions. Not only were there differences between the MTF and retail pharmacy formularies, but also the individual MTF formularies varied greatly. Beneficiaries were left with an inconsistent and undefined pharmacy benefit.3

This fragmented approach led to continued large increases in DoD pharmaceutical costs. The DoD established the PEC in response to this trend.12 A team of pharmacists, physicians, and logisticians formed the first arm of the DoD PBM in 1992.13 Initial goals were to decrease costs, to provide optimum care, to provide pharmacotherapy cost-effectiveness education, and to provide a consistent pharmacy benefit.12

The PEC’s first effort at creating a consistent pharmacy benefit was the Tri-Service Formulary (TSF). Published in 1993, the TSF required all MTFs to include 120 products in their formularies.3 Although the DoD primarily operates as a staff-model health maintenance organization, there are minimal incentives for providers or beneficiaries to utilize the formulary medications, compared with similar private-sector health maintenance organization models.4,12 Compliant providers were not rewarded for prescribing according to the guidelines, and patients were not charged copays for non-TSF medications.

The role of the PEC expanded in 1995, as advisor to the newly created DoD Pharmacy Board of Directors.3 The PEC replaced the TSF with the Basic Core Formulary (BCF) in 1998. The BCF is a more robust list with minimum requirements for MTFs and is managed by the DoD P&T committee. Several therapeutic classes are closed, limiting MTFs to dispensing nonformulary agents in these classes by exception only.3

The DoD made substantial progress in negotiating with phar-
maceutical manufacturers in the 1990s. The well-rounded PEC staff performed cost-effectiveness analyses and large purchase-power projections to leverage national contracts, primarily through the Defense Supply Center in Philadelphia. Several contracts have been awarded in collaboration with the Department of Veterans Affairs. These programs saved DoD more than $310 million during the period of 1999–2002.14 Although the DoD made progress in the PBM purchasing component, communication between points of pharmacy service remained fragmented. This problem was illuminated in a 1998 General Accounting Office report. There are currently 587 Army, Air Force, and Navy MTFs around the world. The actual number of military pharmacy points of service is >700, because of remote clinics and deployed locations. The retail pharmacy network expanded to >40,000 civilian pharmacies in 1995, when TRICARE replaced the Civilian Health and Medical Program for the Uniformed Services. A mail-order program was also implemented in 1995. The DoD prescription benefit became robust, but these service outlets were not interconnected. This combination created significant problems in areas of patient safety and cost. Hundreds of unknown, harmful, drug interactions threatened beneficiary safety, whereas duplicate medication dispensing at different points of service drove up costs.

The 1998 General Accounting Office report was the impetus behind establishment of the communication arm of the DoD PBM, the PDTS. Tremendous DoD pharmacy leadership and legislative support enabled rapid creation and deployment of the PDTS, and all points of service were online by 2001. PDTS became the first database to connect multiple networks to a single managing entity. The quick electronic response provides real-time, online, transaction-processing information regarding pharmacy profiles for >8.8 million beneficiaries at any of the three points of service, i.e., MTF, retail network pharmacy, and TRICARE mail-order pharmacy. Operated by WebMD, PDTS is administered by the PEC. For the first time, the PEC and DoD have access to reliable prescription utilization information. Using online analytical processing, PDTS staff members identified >99,000 potential level 1 drug interactions between 2000 and 2003. More than 10,000 of these potentially most harmful interactions resulted in therapy changes, signifying a dramatic increase in patient safety.18

Projected Changes

The DoD PBM continues to change in response to measured incremental successes and advances in civilian practice. In 2004, the retail pharmacy benefit was separated from TRICARE and administered by a large civilian PBM. This program expands the network to >50,000 pharmacies. PEC staff members administer the help desk for this program, enabling single prior authorizations and eliminating regional registration.10 A uniform formulary (UF) replaced the BCF in 2004. The UF closely follows the public sector three-tier copay model. Patients currently pay $3 for generic drugs or $9 for brand-name drugs for a 30-day supply at retail network pharmacies or $3 for generic drugs or $9 for brand-name drugs for a 90-day supply from TRICARE mail-order pharmacy; they generally receive a 90-day supply at no charge at the MTF. Proposed copays under the UF remain the same, with $3 for generic drugs and $9 for brand-name drugs, but a $22 copay for non-UF medications is added. This three-tier structure should prompt patients to follow the cost-effectiveness recommendations of the PEC.20,21

Future Recommendations

Future progression of the DoD PBM is inevitable. As medications continue to play larger roles in disease management, surgery adjuncts and alternatives, and reduced hospital admissions and costs, growth in pharmacy expenditures will persist. One way to increase MTF compliance with the established PEC formulary is to amplify the authority of the PEC. Currently, the PEC functions in an advisory role and individual MTFs can expand their formularies through the local P&T committee process (except for the few closed classes). For example, an extensive cost-effectiveness analysis by the experienced and resourceful PEC staff could result in a decision to not add a drug to the BCF. However, an individual MTF, with perhaps a less thorough analysis or a more persuasive industry representative, could locally add the same drug to the MTF formulary. This incremental approach has negatively affected beneficiary access and overall DoD pharmacy program costs. The PEC is in the best position to run the P&T committee for the entire DoD. Local MTF P&T committees may no longer be required. If necessary, the PEC staff could be expanded to continue this task. Elimination of the local P&T committees would save the DoD both money and time and could improve beneficiary satisfaction through a true, uniform, pharmacy benefit.

The PEC invests considerable effort in education. DoD P&T committee decisions, national contracts, and clinical practice guidelines are distributed primarily through electronic channels to MTF staff members. These resources are also readily available on the PEC website. However, wide disparity among the MTFs in contract compliance is evidence that not everyone receives the correct information. National contracts are fully financially realized only if all points of service use the preferred medication. Again, expanding PEC authority to interact with primary pharmaceutical distributors is a method of improving contract compliance.

Another recommendation is to expand DoD collaboration with the Department of Veterans Affairs. These two large government agencies have cooperated to sign several national drug-purchasing contracts. This standardized process has saved both entities millions of dollars. During a recent yearlong pilot program, massive Veterans Affairs mail-order facilities undertook DoD refill programs for three large MTF service areas. Beneficiaries and pharmacy staff members approved of the project, citing convenient, reliable mail-order service and decreased MTF workload. The program was recently abandoned because of funding constraints. Although communication between the primary prescription software programs of these two organizations remains virtually nonexistent, the venture demonstrated the ability to work together. Both organizations would benefit through enhanced communication between their separate systems and continued collaboration on both contracts and services.

The DoD should continue to upgrade its pharmacy software in accordance with the best private sector programs. Currently, military beneficiaries with other health insurance are billed after the prescription is dispensed. Although reporting of other health insurance at the MTF is federally mandated, eliciting this infor-
mation from patients depends entirely on the availability of trained staff members and voluntary cooperation from patients. This process is technologically outdated and unreliable, and thousands of billable pharmacy costs are lost each year. In contrast, civilian pharmacies adjudicate third-party claims before prescription dispensing. MTF pharmacy staffs should be augmented to increase recording of other health insurance for beneficiaries, and the next generation of pharmacy software should provide online billing capabilities.

Finally, the DoD PBM needs to expand in step with the transformation of the military health system. Biological weapons pose significant threats to our military, but minimal surge capability in the pharmaceutical and vaccine industries exists to combat such attacks.25 Significant military operation increases have resulted in massive reserve component mobilizations. The pharmacy profiles for these citizen soldiers are not recorded by the PDTS during periods of civilian prescription coverage. The subsequent discovery of activated soldier medication profiles during deployment has placed significant burdens on remotely located pharmacy and logistics systems. Enhanced online analytical processing and establishment of interfaces with both federal emergency response agencies and civilian pharmacy networks should allow the DoD PBM to prepare for catastrophic emergency use and to prevent gaps in treatment attributable to profile mismanagement.

Conclusion

The DoD PBM has had significant positive effects on the cost-effective utilization of pharmaceuticals, the provision of education and communication to MTF staff members and beneficiaries worldwide, and patient outcomes in just 12 years. By devoting more resources and authority to the PEC, the DoD can expect a more uniform, safe, and fiscally responsible prescription drug benefit program in the future.

References