

April 2008

# DOD PHARMACY PROGRAM

## Continued Efforts Needed to Reduce Growth in Spending at Retail Pharmacies

**This report has been revised April 10, 2008 to correct the highlights, first sentence under “Why GAO Did This Study.” The corrected sentence should read “Estimated to reach \$15 billion by 2015, the Department of Defense’s (DOD) prescription drug spending has been a growing concern for the federal government.” The issued version has a typo reading “\$15 million” rather than “\$15 billion.”**





Highlights of [GAO-08-327](#), a report to congressional committees

## Why GAO Did This Study

Estimated to reach \$15 billion by 2015, the Department of Defense's (DOD) prescription drug spending has been a growing concern for the federal government. The John Warner National Defense Authorization Act (NDAA) for Fiscal Year 2007 required GAO to examine DOD's pharmacy benefits program. Specifically, as discussed with the committees of jurisdiction, GAO examined DOD's prescription drug spending trends from fiscal years 2000 through 2006 and DOD's key efforts to limit its prescription drug spending. To conduct this work, GAO analyzed DOD's data on spending trends, including trends in beneficiary pharmacy use. GAO also assessed DOD's cost avoidance data and the agency's efforts to limit spending through its uniform formulary, which is a list of preferred drugs available to all beneficiaries. GAO interviewed DOD officials about these and other efforts to limit spending.

## What GAO Recommends

GAO recommends that DOD (1) monitor the impact of federal pricing arrangements for drugs dispensed at retail pharmacies along with ongoing efforts to limit pharmacy spending to determine the extent to which they reduce the growth in retail pharmacy spending and (2) identify, implement, and monitor other efforts, as needed, to reduce the growth in retail pharmacy spending. In its comments, DOD concurred with GAO's recommendations.

To view the full product, including the scope and methodology, click on [GAO-08-327](#). For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

## DOD PHARMACY PROGRAM

### Continued Efforts Needed to Reduce Growth in Spending at Retail Pharmacies

#### What GAO Found

Collectively, DOD's drug spending at retail pharmacies, military treatment facilities (MTF), and the TRICARE Mail Order Pharmacy (TMOP) more than tripled from \$1.6 billion in fiscal year 2000 to \$6.2 billion in fiscal year 2006. Retail pharmacy spending drove most of this increase, rising almost ninefold from \$455 million to \$3.9 billion and growing from 29 percent of overall drug spending to 63 percent. The growth in retail spending reflects the fact that federal pricing arrangements, which generally result in prices lower than retail prices, were not applied to drugs dispensed at retail pharmacies during this time. In addition, beneficiaries' increased use of retail pharmacies over the less costly options of MTFs or the TMOP exacerbated the effect of these higher prices. For example, 2 million beneficiaries used only retail pharmacies in fiscal year 2006—double the number in fiscal year 2002. However, future growth in retail pharmacy spending may slow as the NDAA for Fiscal Year 2008 now requires that federal pricing arrangements be applied to drugs dispensed at retail pharmacies.

DOD's key efforts to limit its prescription drug spending have included its use of the uniform formulary and beneficiary outreach to encourage use of the TMOP. By leveraging its uniform formulary, which was implemented in fiscal year 2005, the agency avoided about \$447 million in drug costs in fiscal year 2006 and \$916 million in fiscal year 2007, according to DOD's data. In exchange for formulary placement, manufacturers can offer DOD prices below those otherwise available through federal pricing arrangements, which at the time of our review were applied only to drugs dispensed at MTFs and the TMOP. To compensate, in August 2006, DOD began obtaining voluntary manufacturer rebates for formulary drugs dispensed at retail network pharmacies. As of October 1, 2007, DOD collected about \$28 million in rebates for fiscal year 2007. Also in 2006, DOD began beneficiary outreach—through quarterly newsletters and other materials—emphasizing the TMOP's convenience and cost savings. To help beneficiaries transfer their prescriptions to the TMOP, DOD launched the Member Choice Center in August 2007 and plans to target related outreach toward beneficiaries who frequently obtain high-cost drugs from retail pharmacies.

DOD's ongoing efforts are important to limit future prescription drug spending. In addition, DOD has the recommendations of a congressionally mandated task force to consider—that copayment policies be changed to encourage beneficiaries to purchase preferred drugs from cost-effective sources. The agency is also undertaking a fundamental reform—the NDAA for Fiscal Year 2008 requirement to apply federal pricing arrangements to drugs dispensed at retail pharmacies—that could have an even greater impact on spending. DOD will need to carefully monitor the impact of this new requirement along with its ongoing efforts in order to assess the progress in controlling spending. DOD will also need to determine what types of additional efforts, if any, will be necessary to ensure the fiscal sustainability of its pharmacy benefits program.

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### Abbreviations

AHLTA	Armed Forces Health Longitudinal Technology Application
BAP	Uniform Formulary Beneficiary Advisory Panel
CHCS	Composite Health Care System
DOD	Department of Defense
MTF	military treatment facility
NDAA	National Defense Authorization Act
PDTS	Pharmacy Data Transaction Service
P&T	Pharmacy and Therapeutics Committee
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
VA	Department of Veterans Affairs
VARR	Voluntary Agreements for TRICARE Retail Network Rebates

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United States Government Accountability Office  
Washington, DC 20548

April 4, 2008

Congressional Committees

As part of our efforts to identify major challenges facing the nation in the 21st century, we reported that prescription drug spending was one of the fastest-growing segments of health care spending in both the public and private sectors.<sup>1</sup> The Department of Defense (DOD) provides pharmacy benefits to about 9 million beneficiaries through TRICARE, its health care program. Estimated to reach \$15 billion by 2015, DOD's prescription drug spending has been a growing concern for the federal government. How the agency can best limit its drug spending has been a focus of recent debate.

Health plans use various strategies to control their drug costs. These strategies include having a formulary, which is a list of preferred drugs that are generally available to beneficiaries; requiring the use of less expensive generic drugs when available; having higher prescription copayments for drugs purchased at pharmacies not in an established network; and offering strong financial incentives to use mail-order pharmacies. DOD instituted some of these strategies in response to a provision in the National Defense Authorization Act (NDAA) for Fiscal Year 2000.<sup>2</sup> The NDAA required the agency to create a pharmacy benefits program that included a uniform formulary, which is a formulary of drugs available to all TRICARE beneficiaries, and authorized the establishment of beneficiary copayments for drug purchases. Furthermore, DOD can use statutory federal pricing arrangements to purchase drugs. These arrangements typically result in prices lower than those otherwise available.<sup>3</sup> During our review, federal pricing arrangements were applied

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<sup>1</sup>GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (February 2005).

<sup>2</sup>See Pub. L. No. 106-65, § 701, 113 Stat. 512, 677-80 (1999) (codified as amended at 10 U.S.C. § 1074g).

<sup>3</sup>Federal pricing arrangements refer to prices made available under 38 U.S.C. § 8126. The Federal Supply Schedule price is generally available to all federal purchasers through contracts administered by the Department of Veterans Affairs. The law also requires drug manufacturers to provide brand-name drugs to the four large federal purchasers of drugs, including DOD, at a price that does not exceed a federal ceiling price. If the Federal Supply Schedule price for a given brand-name drug exceeds the federal ceiling price, manufacturers must offer another price to the four large agencies that is at or below the federal ceiling price. The federal ceiling price does not apply to generic drugs.

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to drugs dispensed only at military treatment facilities (MTF) and the TRICARE Mail Order Pharmacy (TMOP).<sup>4</sup> However, the recently enacted NDAA for Fiscal Year 2008 requires federal pricing arrangements to be applied to drugs dispensed at retail pharmacies as of January 28, 2008.<sup>5</sup>

The John Warner National Defense Authorization Act for Fiscal Year 2007 directed us to examine DOD's pharmacy benefits program.<sup>6</sup> Specifically, as discussed with the committees of jurisdiction, we examined DOD's (1) prescription drug spending trends from fiscal year 2000 through fiscal year 2006; (2) key efforts to limit its prescription drug spending; (3) process for choosing which drugs to include on the uniform formulary; and (4) related quality assurance, beneficiary feedback, and disease management efforts.

To provide information on DOD's prescription drug spending trends from fiscal year 2000 through fiscal year 2006, we obtained and reviewed data provided by DOD's Pharmacoeconomic Center. The data were not adjusted for inflation and included information DOD uses to track drug spending at MTFs, the TMOP, and network and nonnetwork retail pharmacies. The data reviewed also included information on beneficiary use of these points of service and beneficiary prescription drug use by age group.

To describe DOD's efforts to limit its prescription drug spending, we obtained and reviewed DOD data on the costs the agency had avoided at MTFs, the TMOP, and retail network pharmacies for fiscal years 2006 and 2007 that were used to demonstrate the financial impact of its formulary decisions.<sup>7</sup> We also obtained data from DOD that were used to calculate

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<sup>4</sup>In 2004, the Department of Veterans Affairs (VA)—the federal agency responsible for maintaining the Federal Supply Schedule—issued a letter instructing manufacturers to issue refunds to DOD for drugs dispensed at retail pharmacies. These refunds were meant to reflect the difference between the price DOD paid and the price it would have been entitled to under federal pricing arrangements. However, in 2006, the Court of Appeals for the Federal Circuit ruled that VA's letter was insufficient to impose a new substantive rule on the drug manufacturers. The court did not rule on the issue of whether VA could impose federal pricing on manufacturers if it used a rulemaking procedure. See *Coalition for Common Sense in Government Procurement v. Secretary of Veterans Affairs*, 464 F.3d 1306 (Fed. Cir. 2006).

<sup>5</sup>See Pub. L. No. 110-181, § 703, 122 Stat. 3, 188 (to be codified at 10 U.S.C. § 1074g(f)).

<sup>6</sup>See Pub. L. No. 109-364, § 718, 120 Stat. 2083, 2292-93 (2006).

<sup>7</sup>Cost avoidance refers to the drug costs DOD would have otherwise incurred if a formulary decision had not been made.

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the amount of rebates the agency had collected from drug manufacturers through its Voluntary Agreements for TRICARE Retail Network Rebates (VARR) for fiscal year 2007, and we interviewed 10 drug manufacturers to obtain their perspective on why they did or did not use the VARRs.<sup>8</sup> In addition, we interviewed DOD officials about the agency's efforts to limit spending and reviewed reports by DOD's Task Force on the Future of Military Health Care, which was directed by Congress to assess ways to sustain DOD health care services.

To describe DOD's process for choosing which drugs to include on the uniform formulary, we reviewed relevant federal law and regulations, DOD policy guidance for implementing the process, and minutes from regular meetings at which formulary issues were discussed. We also interviewed officials from the Pharmacoeconomic Center and the TRICARE Management Activity (TMA) to obtain further information.

To identify DOD's quality assurance and beneficiary feedback mechanisms, we interviewed DOD officials and obtained information on specific electronic systems used at the MTFs, the TMOP, and retail network pharmacies. We identified and reviewed surveys DOD uses to obtain beneficiary feedback on its pharmacy program, and we interviewed DOD officials about how DOD uses those surveys and other mechanisms to obtain beneficiary satisfaction data and feedback on the pharmacy benefit. Finally, we reviewed DOD's disease management program policies and information on how beneficiaries are identified for the program.

We obtained the most current data available at the time of our review on DOD's prescription drug spending, cost avoidance, and rebates. We interviewed officials from the Pharmacoeconomic Center and TMA about the methodology used to generate the data and the data's use and limitations. Through these interviews, we determined that the data were sufficiently reliable for our purposes, but we did not independently verify the data. We conducted our review from April 2007 through February 2008 in accordance with generally accepted government auditing standards.

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## Results in Brief

DOD's prescription drug spending more than tripled from \$1.6 billion in fiscal year 2000 to \$6.2 billion in fiscal year 2006. Retail pharmacy

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<sup>8</sup>VARRs are used by DOD to obtain rebates specifically for drugs dispensed at TRICARE retail network pharmacies.

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spending drove most of this increase, rising from \$455 million to \$3.9 billion and growing from 29 percent of DOD's overall drug spending to 63 percent. TMOP spending likewise rose, from \$106 million to \$721 million, but increased from only 7 percent of total drug spending to 12 percent. MTF spending increased from \$1 billion to \$1.5 billion, but its share of total drug spending decreased from 65 percent to 25 percent. Three overarching factors influenced these trends. First, federal pricing arrangements, which generally result in lower drug prices, were not applied to drugs dispensed at retail pharmacies during this time, so these drugs were generally more expensive for both DOD and its beneficiaries. Second, increased use of retail pharmacies has exacerbated the effect of higher retail prices. For example, 2 million beneficiaries used only retail pharmacies in fiscal year 2006—double the number in fiscal year 2002. DOD officials cited base closures reducing access to MTFs, MTF personnel deployments, and the convenience of retail pharmacies as reasons for this trend. Third, according to DOD officials, TRICARE expansions beginning in 2001 led, by fiscal year 2006, to 1.7 million eligible beneficiaries age 65 or older, who use more drugs.

DOD's key efforts to limit its prescription drug spending include its use of the uniform formulary, beneficiary outreach to encourage use of the TMOP, and proposed changes to beneficiary copayments. As a result of its uniform formulary decisions, DOD's data show that it avoided about \$447 million in drug costs in fiscal year 2006 and \$916 million in fiscal year 2007. In exchange for formulary placement, manufacturers can offer DOD lower prices than those otherwise available through statutory federal pricing arrangements, which, at the time of our review, were applied only to drugs dispensed at MTFs and the TMOP. MTFs, which are generally limited to dispensing formulary drugs, accounted for most of DOD's cost avoidance. To compensate, in August 2006, DOD began obtaining voluntary manufacturer rebates for formulary drugs dispensed at retail network pharmacies. As of October 1, 2007, DOD collected about \$28 million through its voluntary manufacturer rebates for fiscal year 2007. Also in 2006, DOD began beneficiary outreach—through quarterly newsletters, news releases, and other materials—emphasizing the TMOP's convenience and cost savings. To help beneficiaries transfer their prescriptions to the TMOP, DOD launched the Member Choice Center in August 2007 and plans to target outreach about the center toward beneficiaries who frequently obtain high-cost drugs from retail pharmacies. DOD also proposed for fiscal years 2007 and 2008 to eliminate copayments at the TMOP and increase copayments at retail pharmacies to encourage beneficiaries to use the TMOP. However, DOD has been prohibited from increasing copayments at retail pharmacies through fiscal

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year 2008. Nonetheless, the Task Force on the Future of Military Health Care recommended in December 2007 that DOD's copayment policies be changed to create more incentive for beneficiaries to use preferred drugs and cost-effective points of service.

DOD's process for choosing which drugs to include on the uniform formulary is based on reviews in which the clinical and cost-effectiveness of a drug is compared with other drugs in its therapeutic class. This process, established by law, involves three entities. The Pharmacy and Therapeutics (P&T) Committee recommends drugs to be added to the formulary based on clinical and cost-effectiveness reviews. The Uniform Formulary Beneficiary Advisory Panel (BAP) comments on the P&T Committee's recommendations from a beneficiary perspective. The Director of TMA makes final decisions after considering both the P&T Committee's recommendations and the BAP's comments. As of October 2007, 28 drug classes representing 322 drugs had been reviewed for the uniform formulary. Of the 322 drugs reviewed, 249 were designated as formulary.

DOD has several methods for quality assurance and beneficiary feedback and uses pharmacy data to inform its disease management programs. DOD provides quality assurance in its pharmacy program at MTFs, the TMOP, and retail network pharmacies through the use of several electronic systems that detect potential problems related to prescribed drugs. For example, the Armed Forces Health Longitudinal Technology Application (AHLTA) alerts MTF providers of duplicate treatments, therapeutic overlap, drug interactions, and drug allergies when a prescription is entered into the system. The agency obtains beneficiary feedback through surveys with questions about pharmacy access and utilization and satisfaction with the TMOP. DOD also reviews beneficiary comments obtained at meetings with military beneficiary associations. It uses beneficiary feedback to make improvements to the pharmacy program—for example, to simplify and encourage the use of the TMOP, including transferring prescriptions from retail pharmacies—an outreach effort that would help limit retail pharmacy spending. DOD also uses its pharmacy data to identify beneficiaries for its asthma, diabetes, and congestive heart failure disease management programs.

To help ensure the fiscal sustainability of DOD's pharmacy benefits program and complement more fundamental reforms recently enacted or being considered, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to

- 
- monitor the effect of federal pricing arrangements for drugs dispensed at retail pharmacies along with ongoing efforts to limit pharmacy spending to determine the extent to which they reduce the growth in retail pharmacy spending; and
  - identify, implement, and monitor other efforts, as needed, to reduce the growth in retail pharmacy spending.

In its written comments on a draft of this report, DOD concurred with our findings and recommendations.

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## Background

TRICARE, DOD's health care program, has 9.1 million eligible beneficiaries that include active duty, certain reservists, and retired members of the uniformed services, as well as their families and survivors. Beneficiaries may generally obtain care from either MTFs or civilian providers.<sup>9</sup> TRICARE beneficiaries can obtain prescription drugs directly from MTFs, the TMOP, and network and nonnetwork retail pharmacies.<sup>10</sup>

The pharmacy benefits law, as passed in October 1999, directed the Secretary of Defense to establish a pharmacy benefits program.<sup>11</sup> The program is, among other things

- required to include a uniform formulary that should ensure drugs are available in the complete range of therapeutic classes;<sup>12</sup>
- required to make drugs on the uniform formulary available to beneficiaries at MTFs, the TMOP, and retail pharmacies; and

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<sup>9</sup>TRICARE is a regionally structured program that uses contractors to maintain provider networks to complement health care provided at MTFs.

<sup>10</sup>DOD contracts with Express Scripts, Inc., a private pharmacy benefits management company, to operate DOD's retail pharmacy program and the TMOP. Express Scripts has a network of about 59,000 retail pharmacies where DOD beneficiaries can pick up prescriptions; beneficiaries can also use nonnetwork retail pharmacies—that is, any retail pharmacy not in Express Scripts' network.

<sup>11</sup>See Pub. L. No. 106-65, § 701, 113 Stat. 512, 677-80 (1999) (codified as amended at 10 U.S.C. § 1074g).

<sup>12</sup>A therapeutic class is a group of drugs that are similar in chemical structure, pharmacological effect, or clinical use.

- authorized to establish copayment requirements for generic, formulary, and nonformulary drugs.

The pharmacy benefits law also directed the Secretary of Defense to establish the P&T Committee to develop the uniform formulary, and the BAP to review and comment on the development of the uniform formulary. Finally, the Secretary of Defense was to implement the use of the Pharmacy Data Transaction Service (PDTS) at designated MTFs, the TMOP, and retail network pharmacies. The PDTS is an electronic service that DOD uses to maintain prescription drug information for all TRICARE beneficiaries worldwide.

In 2001, DOD established the current pharmacy copayment structure, which is based on whether a drug is classified as formulary generic (tier 1), formulary brand-name (tier 2), or nonformulary (tier 3). The copayment also depends on where the beneficiary chooses to fill his or her prescription. (See table 1.)

**Table 1: Current Pharmacy Copayments for DOD Civilian Beneficiaries**

Delivery option	Supply	Copayments		
		Formulary generic (tier 1)	Formulary brand (tier 2)	Nonformulary (tier 3)
Military treatment facility (MTF)	up to 90 days	\$0	\$0	\$0 <sup>a</sup>
TRICARE Mail Order Pharmacy (TMOP)	up to 90 days	\$3	\$9	\$22
Retail network pharmacy	up to 30 days	\$3	\$9	\$22
Retail nonnetwork pharmacy, TRICARE Extra and Standard <sup>b</sup>	up to 30 days	Greater of \$9 or 20 percent of total cost	Greater of \$9 or 20 percent of total cost	Greater of \$22 or 20 percent of total cost
Retail nonnetwork pharmacy, TRICARE Prime <sup>b</sup>	up to 30 days	50 percent	50 percent	50 percent

Source: DOD.

Notes: Active duty service members are not required to pay copayments at MTFs, the TMOP, or retail network pharmacies. Active duty service members who fill prescriptions for covered medications under the pharmacy benefit at nonnetwork retail pharmacies are required to pay the total cost of the prescription and then file a claim for reimbursement with Express Scripts, Inc., a private pharmacy benefits management company that operates DOD's retail pharmacy program and the TMOP.

<sup>a</sup>MTFs can only dispense nonformulary drugs if medically necessary. Proof of medical necessity is not required for nonformulary drugs to be dispensed at the TMOP or retail pharmacies.

<sup>b</sup>Under TRICARE, beneficiaries can choose among three benefit options: a health maintenance organization option called TRICARE Prime, a preferred-provider organization option called TRICARE Extra, and a fee-for-service option called TRICARE Standard.

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The NDAA for Fiscal Year 2007 directed DOD to establish the Task Force on the Future of Military Health Care to assess health care services provided to members of the military, retirees, and their families and to make recommendations for sustaining those services.<sup>13</sup> In addition to other aspects of DOD's health care system, the task force reviewed DOD's pharmacy benefits program.<sup>14</sup> It issued an interim report in May 2007 and a final report in December 2007 to the Secretary of Defense on its findings and recommendations. The Secretary of Defense may comment on the recommendations provided in the task force's final report and, within 90 days of its issuance, must forward the report to the Committees on Armed Services of the Senate and the House of Representatives.

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## DOD's Prescription Drug Spending More Than Tripled from Fiscal Years 2000 through 2006, with Retail Pharmacies Accounting for the Largest Increase

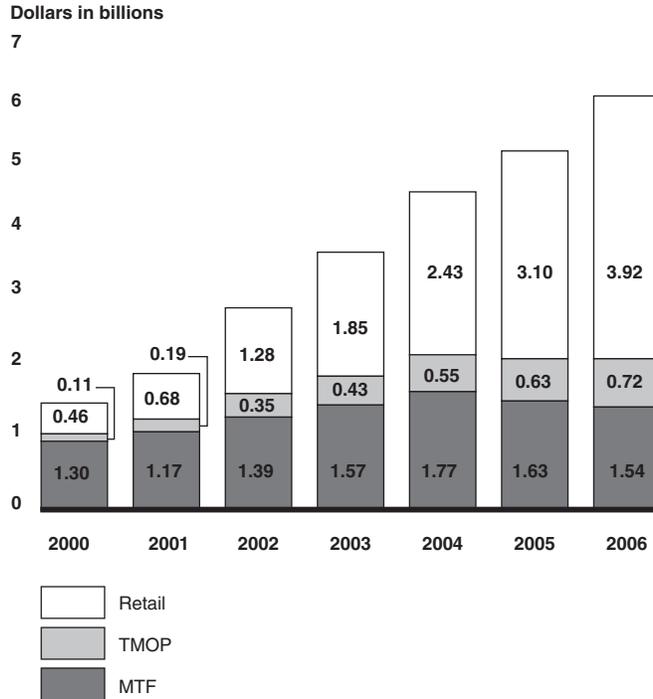
DOD's spending on prescription drugs more than tripled from \$1.6 billion in fiscal year 2000 to \$6.2 billion in fiscal year 2006. Retail pharmacy spending accounted for the greatest increase, rising almost ninefold from \$455 million to \$3.9 billion. It also grew from 29 percent of DOD's overall drug spending to 63 percent—the largest increase of the points of service. TMOP spending rose from \$106 million to \$721 million and increased from 7 percent of total spending to 12 percent. MTF pharmacy spending rose from \$1 billion in fiscal year 2000 to \$1.7 billion in fiscal 2004, but declined slightly to \$1.5 billion in fiscal year 2006. In fiscal year 2000, MTF spending accounted for 65 percent of DOD's overall drug spending but declined to 25 percent in fiscal year 2006. (See fig. 1.)

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<sup>13</sup>See Pub. L. No. 109-364, § 711, 120 Stat. 2083, 2284-87 (2006).

<sup>14</sup>During a meeting on April 18, 2007, the Comptroller General testified before the task force and provided information on DOD's overall health care spending and its pharmacy copayments. He suggested that the task force consider whether TRICARE's copayment structure should be brought into parity with those of other public and private payers. See GAO, *DOD's 21st Century Health Care Spending Challenges, Presentation for the Task Force on the Future of Military Health Care*, [GAO-07-766CG](#) (Washington, D.C.: Apr. 18, 2007).

**Figure 1: DOD Prescription Drug Spending for Fiscal Year 2000 through Fiscal Year 2006, by Point of Service**



Source: DOD.

Note: Data were not adjusted for inflation.

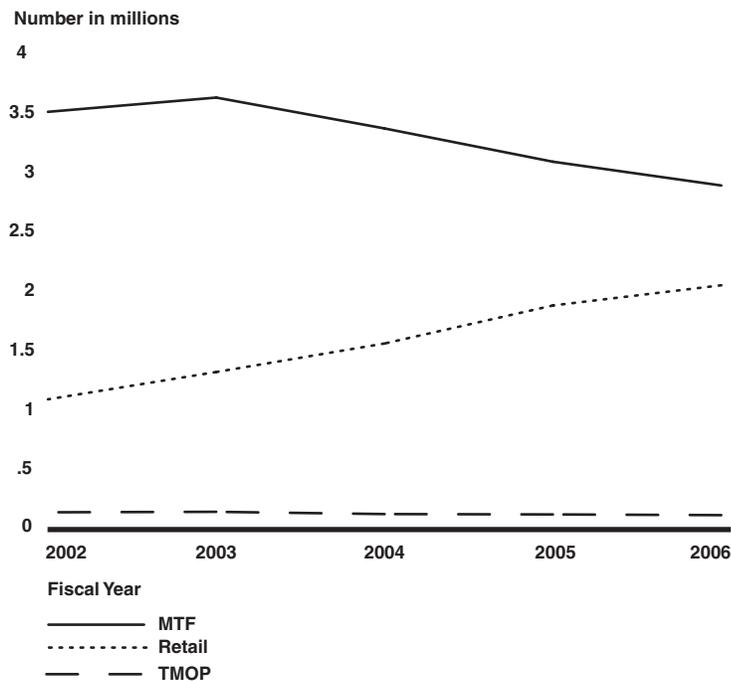
Three overarching factors influenced these trends. First, because federal pricing arrangements that generally result in lower prices were not applied to drugs dispensed at retail pharmacies during this time period, these drugs were generally more expensive for both DOD and its beneficiaries than the drugs dispensed at MTFs or the TMOP. However, the NDAA for Fiscal Year 2008 requires that federal pricing arrangements now be applied to TRICARE prescriptions filled at retail pharmacies.

Second, the increased use of retail pharmacies has exacerbated the effect of higher retail prices. More beneficiaries are using only retail pharmacies to obtain their prescriptions—about 2 million in fiscal year 2006, up from about 1 million in fiscal year 2002 (see fig. 2).<sup>15</sup> Further, beneficiaries are

<sup>15</sup> Full-year data for beneficiaries were available beginning in fiscal year 2002.

obtaining more maintenance drugs—drugs for long-term conditions, such as high blood pressure or cholesterol—at retail pharmacies (see fig. 3). From fiscal year 2004 through fiscal year 2006, the number of maintenance drug prescriptions dispensed at retail pharmacies increased by more than 11.6 million. Those dispensed at the TMOP increased much less, by about 1.5 million, while those at MTFs decreased by about 2.5 million. DOD officials cited additional reasons that they believed contributed to the increased use of retail pharmacies, though they could not quantify the effect of these reasons. These reasons included: base closures, which have decreased the number of MTF pharmacies; deployment of MTF personnel, which limits MTF appointment availability, resulting in more beneficiaries going to civilian providers and filling their prescriptions at retail pharmacies; the vast TRICARE retail network of about 59,000 pharmacies, which has become more convenient for beneficiaries; and the prescription copayment structure, which does not discourage beneficiaries from using the more costly retail pharmacies.

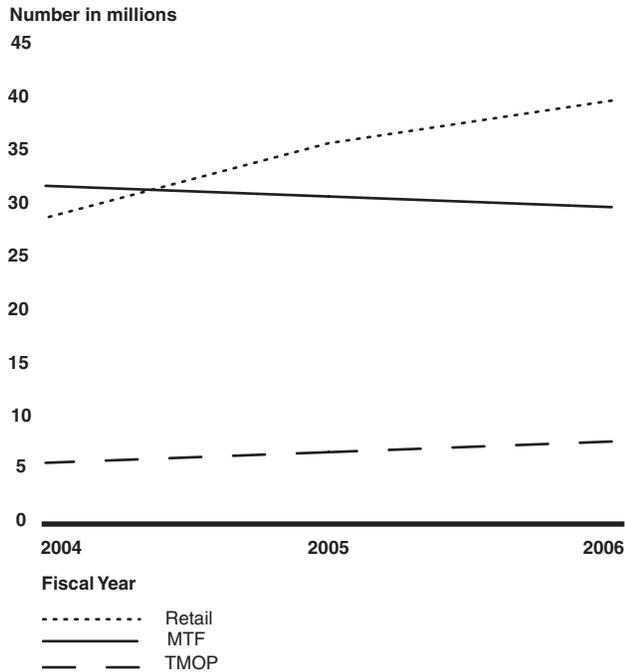
**Figure 2: Trends in the Number of Beneficiaries Obtaining Drugs from a Single Point of Service**



Source: GAO analysis of DOD data.

Notes: Full-year data were available beginning in fiscal year 2002. Data exclude beneficiaries who obtain drugs from more than one point of service. Most beneficiaries who use multiple points of service use retail pharmacies in addition to another point of service.

**Figure 3: Trends in the Number of Maintenance Drug Prescriptions Filled for DOD Beneficiaries, by Point of Service**



Source: GAO analysis of DOD data.

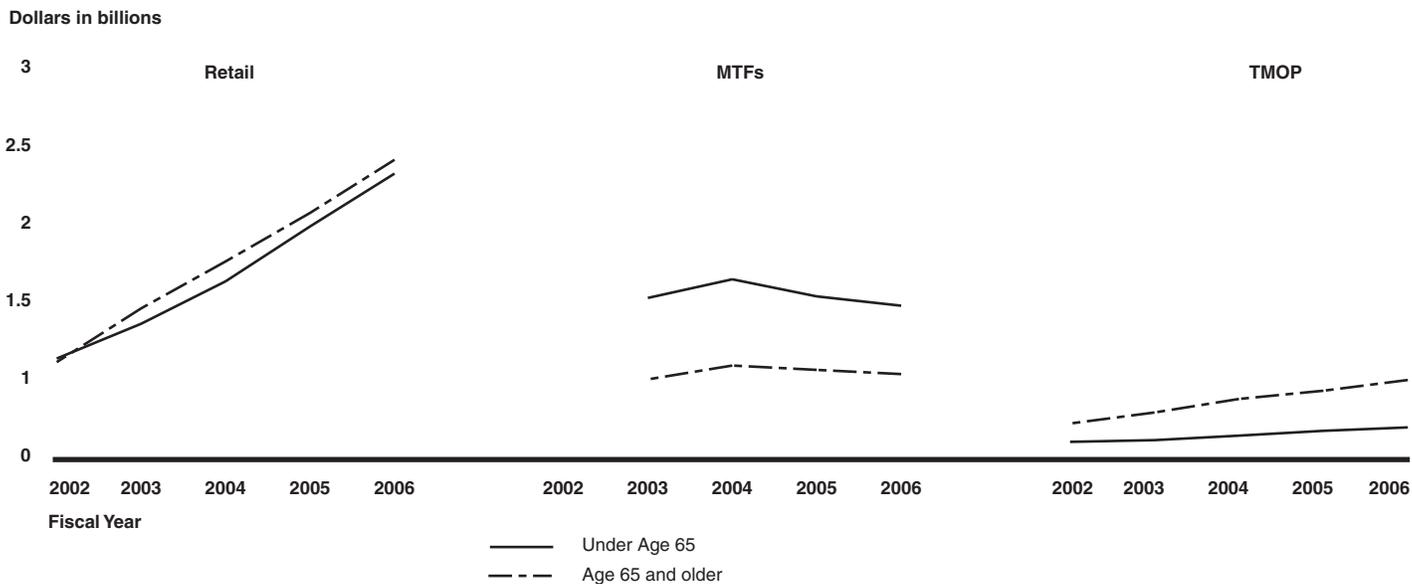
Note: Data were available beginning in fiscal year 2004.

Third, according to DOD officials, TRICARE expansions have led to a growing population of aging beneficiaries, who use more drugs. By fiscal year 2006, about 1.7 million beneficiaries, age 65 or older, were eligible for the pharmacy benefit through TRICARE benefit expansions that began in 2001.<sup>16</sup> According to DOD data, retail pharmacy spending for beneficiaries

<sup>16</sup>Implemented in April 2001, the TRICARE Senior Pharmacy Program allowed beneficiaries and their dependents, all of whom must be age 65 or older, to obtain prescriptions from the TMOP and retail pharmacies. See Pub. L. No. 106-398, § 711, 114 Stat. 1645A-175 through 1645A-176 (2000). Before this program, these beneficiaries could fill their prescriptions only at MTFs. The TRICARE Senior Pharmacy Program has been absorbed into TRICARE for Life, the program that began in October 2001 and provides medical benefits to beneficiaries who are eligible for Medicare Part A and are enrolled in Medicare Part B on the basis of age, disability, or end-stage renal disease. In fiscal year 2005, Congress authorized the TRICARE Reserve Select program. Eligible reservists that enroll in the program may obtain prescriptions similarly to other TRICARE beneficiaries. See 10 U.S.C. § 1076d. According to DOD officials, more than 485,000 reservists became eligible for the pharmacy benefit, but over 11,000 had enrolled as of December 2006.

age 65 or older increased by about 207 percent from fiscal year 2002 through fiscal year 2006—slightly higher than the 184 percent increase for beneficiaries under age 65. (See fig. 4.) DOD officials told us that the average cost per beneficiary at retail pharmacies in fiscal year 2006 was about \$1,277 for beneficiaries age 65 or older, compared with about \$368 for those under age 65. MTF spending declined slightly for both age groups as TMOP spending increased.<sup>17</sup> Those under age 65 were more likely to use MTFs, while those age 65 or older were more likely to use the TMOP.

**Figure 4: Pharmacy Spending by Age Group and Point of Service for Fiscal Years 2002 through 2006**



Source: GAO analysis of DOD data.

Note: Full-year data were available beginning in fiscal year 2002 for retail pharmacies and the TMOP and in fiscal year 2003 for MTFs. Data were not adjusted for inflation.

<sup>17</sup> Full-year MTF data were available beginning in fiscal year 2003.

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## DOD Has Efforts Under Way to Limit Prescription Drug Spending through the Uniform Formulary, Beneficiary Outreach, and Other Proposed Changes

DOD has efforts under way to limit its prescription drug spending through the use of its uniform formulary and through beneficiary outreach for the TMOP. In an attempt to further limit its drug spending, both DOD and its Task Force on the Future of Military Health Care have recommended changes to the beneficiary copayment structure intended to encourage beneficiaries to use more cost-effective points of service. However, the NDAA through Fiscal Year 2008 prohibits any increase to retail copayments through fiscal year 2008.

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## DOD's Uniform Formulary Has Limited Prescription Drug Spending

According to DOD officials, the agency has limited its prescription drug spending primarily through costs avoided through the use of its uniform formulary, which was implemented during 2005. DOD data show that the agency avoided about \$447 million in drug costs in fiscal year 2006 and \$916 million in drug costs in fiscal year 2007.

MTFs accounted for most of DOD's cost avoidance, while retail network pharmacies accounted for the least. Cost avoidance is affected by the following factors that result from DOD's formulary decisions:

- The prices DOD obtains for drugs. In exchange for including a manufacturer's drug on the uniform formulary, manufacturers can offer DOD prices below those otherwise available through statutory federal pricing arrangements, which applied only to drugs dispensed at MTFs and the TMOP during the time of our review. According to DOD officials, the agency had obtained prices for drugs dispensed at MTFs and the TMOP that are about 30 percent to 50 percent lower than the prices it obtained for drugs dispensed at network and nonnetwork retail pharmacies. This difference in price can be attributed to savings achieved through the discounts obtained for uniform formulary placement as well as the lower prices obtained through federal pricing arrangements for drugs dispensed at MTFs and the TMOP.
- Changes in beneficiaries' use of formulary and nonformulary drugs within a therapeutic class. Once a drug is designated nonformulary, its use may be substituted with a formulary drug, which results in lower copayments for the beneficiary and lower costs to DOD. Because MTFs are generally limited to dispensing formulary drugs, cost avoidance attributed to the use of formulary drugs over nonformulary drugs is higher at this point of

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service than at the TMOP and retail network pharmacies, where beneficiaries can obtain more costly nonformulary drugs.<sup>18</sup>

- Changes in beneficiaries' use of generic and brand-name drugs within a therapeutic class. For both formulary and nonformulary drugs, DOD requires the substitution of generic drugs for brand-name drugs at MTFs, the TMOP, and retail pharmacies when a generic equivalent is available.<sup>19</sup> A brand-name drug having a generic equivalent may be dispensed only if the prescribing physician establishes medical necessity for its use. A beneficiary's use of a generic drug in place of a brand-name drug results in lower costs to the beneficiary and to DOD.
- Changes in beneficiaries' use of MTFs, the TMOP, and retail pharmacies as a result of formulary designations. For example, a beneficiary may shift from obtaining a 30-day supply of a formulary drug at a retail pharmacy, where the beneficiary's copayment would be higher, to an MTF where the beneficiary can obtain a 90-day supply of the drug without a copayment.

To calculate cost avoidance, DOD first determines the costs it incurred at MTFs, the TMOP, and retail network pharmacies for each drug as a result of its designation as either formulary or nonformulary. DOD then subtracts these incurred costs from the estimated costs it would have incurred at MTFs, the TMOP, and retail network pharmacies if the designation had not been made.<sup>20</sup> Cost avoidance is the difference between the incurred and estimated costs.

In addition to costs avoided, DOD has obtained voluntary manufacturer rebates for some of the formulary drugs dispensed at retail network pharmacies—though these rebates are a much smaller proportion of overall savings. Because federal pricing arrangements were not previously applied to drugs dispensed at retail pharmacies, DOD implemented the

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<sup>18</sup>MTFs can dispense nonformulary drugs if medically necessary. Proof of medical necessity is not required for nonformulary drugs to be dispensed at the TMOP or retail pharmacies.

<sup>19</sup>If no generic equivalent exists or if using a brand-name drug is medically necessary when a generic equivalent is available, the brand-name drug will be dispensed at no copayment at MTFs and at the brand-name copayment at the TMOP and retail pharmacies. If a beneficiary insists on obtaining a brand-name drug that is not considered medically necessary when a generic equivalent is available, the beneficiary is responsible for the full cost of the prescription.

<sup>20</sup>DOD determines these estimated costs using utilization and price data for each drug before formulary placement was determined.

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VARR in August 2006 to allow manufacturers to offer rebates for these drugs. There are two types of VARRs: the Uniform Formulary VARR and the Utilization VARR. The Uniform Formulary VARR is an agreement between DOD and a manufacturer that is contingent on the manufacturer's drug being selected for the uniform formulary. DOD officials told us that as of October 1, 2007, the agency had collected about \$28 million through Uniform Formulary VARRs for fiscal year 2007.<sup>21</sup> As manufacturers continue to enter into these agreements, DOD expects the amount it collects to increase over time. The Utilization VARR allows manufacturers to offer a rebate to DOD for drugs that are not on the uniform formulary. According to DOD, this includes drugs that have not yet been reviewed for the uniform formulary and drugs that have been reviewed and designated nonformulary. Unlike the Uniform Formulary VARR, the Utilization VARR does not secure formulary placement. As of October 2007, no manufacturers had entered into a Utilization VARR with DOD.

In our discussions with 10 drug manufacturers about the VARR program, 7 of them told us that they had submitted Uniform Formulary VARRs for DOD's consideration. Of these 7 manufacturers, 5 indicated that their participation was driven by the possibility that their drug would be selected for the uniform formulary. With regard to the Utilization VARR, 8 of the 10 manufacturers we spoke with indicated that there was little or no incentive provided to manufacturers to enter into these rebate agreements with DOD.

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## DOD Has Beneficiary Outreach Efforts Under Way

DOD has outreach efforts under way intended to help encourage beneficiaries to use the TMOP instead of retail pharmacies. In 2006, according to DOD officials, the agency began to expand its outreach for the TMOP through quarterly newsletters, news releases, and other materials emphasizing its convenience and cost savings for beneficiaries. DOD partnered with, for example, beneficiary organizations and family

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<sup>21</sup>DOD projected that it would collect at least \$120 million through Uniform Formulary VARRs for fiscal year 2008. This projection was based on rebates that it collected in fiscal year 2007 and did not account for new rebate agreements that would be implemented for drugs reviewed in fiscal year 2008. DOD officials noted that these rebate projections are contingent on assumptions, for example, about changing market conditions, and the potential for rebate agreements to be terminated. This projection was determined prior to the enactment of the NDAA for Fiscal Year 2008. DOD officials stated that the amount in rebates that the agency expected to collect for fiscal year 2008 may vary given the requirement that federal pricing arrangements be extended to drugs dispensed at retail pharmacies.

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support groups to help distribute these outreach materials. DOD also encouraged health care providers to promote the use of the TMOP among the TRICARE beneficiaries they serve. MTF pharmacists also participated in these efforts by posting signs advertising the TMOP in their facilities.

In addition, DOD launched its Member Choice Center in August 2007, the goal of which is to help beneficiaries transfer their prescriptions from retail pharmacies to the TMOP. To educate beneficiaries about the center's availability, DOD included information about it in newsletters and other outreach materials. According to DOD officials, the center transferred about 60,000 prescriptions from retail pharmacies to the TMOP as of late December 2007. In addition to these efforts, DOD intended to specifically target those beneficiaries who frequently obtained high-cost drugs from retail pharmacies. DOD officials told us that, as of January 2008, this aspect of the program had not yet begun and that DOD was working with the contractor for the TMOP to develop a letter to be sent to these beneficiaries.

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### DOD and Its Task Force on the Future of Military Health Care Have Proposed Other Changes to Limit Spending

DOD has proposed changes to beneficiary copayments for fiscal years 2007 and 2008 in an effort to encourage beneficiaries to obtain prescriptions from more cost-effective points of service. Specifically, DOD proposed to eliminate copayments for generic drugs dispensed at the TMOP and to increase retail pharmacy copayments from \$3 for formulary generic drugs to \$5, and from \$9 for formulary brand-name drugs to \$15. DOD first proposed these changes for fiscal year 2007, but Congress prohibited any increase to retail pharmacy copayments for that fiscal year.<sup>22</sup> DOD repeated the proposal for the next fiscal year, but the NDAA for Fiscal Year 2008 prohibits any increase to retail copayments through the fiscal year.<sup>23</sup>

In addition, the Task Force on the Future of Military Health Care concluded in its final report that DOD's copayment policies and formulary tier structure do not create effective incentives to stimulate compliance with clinical best practices or the most cost-effective points of service for obtaining drugs. It recommended that DOD's pharmacy tier and copayment structures be revised based on clinical and cost-effectiveness standards to promote greater incentive to use preferred medications and

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<sup>22</sup>See NDAA for Fiscal Year 2007, Pub. L. No. 109-364, § 704(a), 120 Stat. 2280 (2006).

<sup>23</sup>See Pub. L. No. 110-181, § 702, 122 Stat. 3, 188.

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cost-effective points of service. Specifically, the task force stated that a four-tier formulary could encourage beneficiaries to use less costly drugs and use them more appropriately. It also stated that when a formulary includes more tiers, it is easier to lower out-of-pocket costs for drugs that treat certain chronic diseases and remove compliance barriers.<sup>24</sup>

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## DOD's Process for Choosing Drugs for Its Uniform Formulary Is Based on Clinical and Cost-Effectiveness Reviews

DOD decides which drugs to include on the uniform formulary based on reviews in which the clinical and cost-effectiveness of a drug is compared with other drugs in its class.<sup>25</sup> This process, established by DOD under the requirements of the pharmacy benefits law, involves three entities:

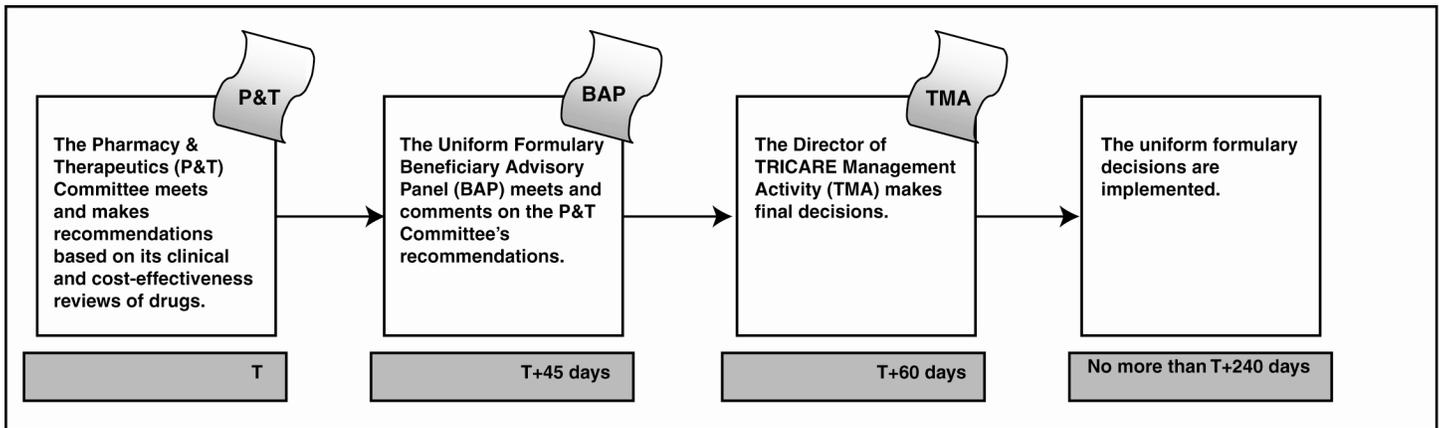
- The Pharmacy and Therapeutics (P&T) Committee recommends drugs to be added to the uniform formulary based on clinical and cost-effectiveness reviews. (For P&T Committee membership, see app. I.)
- The BAP comments on the P&T Committee's recommendations from a beneficiary perspective. (For BAP membership, see app. I.)
- The Director of TMA makes final decisions after considering both the P&T Committee's recommendations and the BAP's comments. (See fig. 5.)

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<sup>24</sup>The following formulary categories were suggested: (1) Preferred drugs, including generic, cost-effective brand-name, and selected over-the-counter drugs; (2) other formulary drugs; (3) nonformulary drugs; and (4) "Special Category" drugs, such as specialty, very expensive, and biotechnology drugs. The task force recommended specific copayments for the first three tiers of its proposed formulary structure and suggested that Congress grant DOD the authority to mandate the most cost-effective point of service where "Special Category" drugs can be obtained.

<sup>25</sup>Until a drug has been reviewed for the uniform formulary, it is made available to TRICARE beneficiaries at either the formulary generic or brand-name copayment depending on the type of drug and where the beneficiary chooses to obtain it.

**Figure 5: Key Steps of DOD's Uniform Formulary Decision Process**



Source: GAO analysis of DOD data.

Note: "T" refers to the day of the P&T Committee meeting. Steps are listed as the number of days from "T."

The P&T Committee meets quarterly and generally reviews two to four drug classes at each meeting. The priority for therapeutic class reviews is determined by various factors, such as the conversion of a drug from brand-name to generic and the rate of utilization among beneficiaries. The P&T Committee first reviews the clinical effectiveness of the drugs in a class. It considers such information as indications for which the drug has been approved by the Food and Drug Administration, the incidence and severity of adverse effects, and the results of studies on effectiveness and clinical outcomes. Using this information, the committee determines whether the drugs are therapeutically equivalent. It then reviews the cost-effectiveness of the drugs, considering such information as the price and rebate quotes submitted by manufacturers and the estimated financial effect of possible formulary decisions. The committee then determines the relative cost-effectiveness of each drug in the class.

On the basis of the outcomes of both the clinical and cost-effectiveness reviews, the committee recommends that each drug in the class be designated as either formulary or nonformulary. If the committee finds that the drugs in a class are therapeutically equivalent, it generally recommends that the lower-cost drugs be designated as formulary. However, the committee has recommended that certain higher-cost drugs it believed offered additional clinical benefits be designated as formulary.

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For example, the committee recommended that two drugs used to treat breakthrough pain in cancer patients,<sup>26</sup> Fentora and Actiq, be designated as formulary despite a more than a fortyfold increase in cost over the two most cost-effective drugs in the class. While therapeutically equivalent to the other drugs in the class, both Fentora and Actiq can be dissolved orally, which the committee valued for patients who have difficulty swallowing drugs in tablet form. In addition to recommending that a drug be designated as formulary or nonformulary, the P&T Committee recommends an implementation period to inform pharmacies and beneficiaries of formulary decisions. Its recommendations are then provided to the BAP.

Once the BAP receives the P&T Committee's recommendations, it provides comments on behalf of beneficiaries. It reviews each recommendation and determines whether it agrees or disagrees with the P&T Committee. As of October 2007, the BAP and the P&T Committee disagreed about 17 percent of the time, mostly about the length of implementation periods. For example, the P&T Committee recommended that formulary and nonformulary designations for drugs used to treat overactive bladder conditions become effective about 60 days after the final formulary decision was made. The BAP stated that additional time was needed to notify beneficiaries currently using drugs within the class, suggesting that the formulary designations become effective about 120 days after the final formulary decision was made. Finally, the BAP's comments are documented and submitted to the Director of TMA for consideration when making final formulary decisions.

After reviewing both the P&T Committee's recommendations and the BAP's comments, the Director of TMA makes final formulary decisions. In a decision paper, the director approves or disapproves of the P&T Committee's recommendations and may provide written comments explaining his decision. Although the Director of TMA makes the final decision, no drug may be designated as nonformulary unless the P&T Committee has recommended the nonformulary designation.<sup>27</sup> As of October 2007, the Director of TMA had approved 188 out of the 190 P&T Committee recommendations. Uniform formulary decisions become effective on the date decision papers are signed by the Director, and the

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<sup>26</sup>Breakthrough pain refers to the intermittent flares of severe pain that can occur in patients taking medications for chronic pain control on a fixed schedule.

<sup>27</sup>See 10 U.S.C. § 1074g(a)(2)(D).

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papers are made publicly available on the TRICARE Web site.<sup>28</sup> As of October 2007, 28 drug classes representing 322 drugs had been reviewed for the formulary.<sup>29</sup> Of the 322 drugs reviewed, 249 were designated as formulary.

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## DOD Has Several Methods for Quality Assurance and Beneficiary Feedback and Uses Pharmacy Data to Inform Its Disease Management Programs

DOD uses electronic systems, which detect potential problems related to prescribed drugs, for quality assurance at MTFs, the TMOP, and retail network pharmacies. It also takes steps to obtain beneficiary feedback through surveys and by obtaining beneficiaries' comments. In addition, DOD uses pharmacy data to identify beneficiaries who might benefit from participating in a disease management program.

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## Electronic Systems Provide Quality Assurance for Prescriptions

AHLTA, a global electronic health information system, alerts MTF providers to duplicate drug treatments, therapeutic overlap, drug interactions, and drug allergies when a prescription is entered into the system. MTF providers<sup>30</sup> are required to use AHLTA when prescribing drugs. If, for example, AHLTA identifies a drug allergy, the provider receives an alert and can prescribe an alternative drug.

The Composite Health Care System (CHCS) provides similar alerts to staff at MTF pharmacies. When a patient's prescription is processed, the CHCS informs the staff of duplicate treatments, therapeutic overlap, drug interactions, and drug allergies. DOD officials stated that CHCS acts as a redundant quality assurance mechanism, allowing the pharmacists to double-check prescriptions written by MTF providers. If a beneficiary brings a prescription to the MTF pharmacy from a contract provider (outside of the MTF), CHCS will still inform the pharmacy staff of

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<sup>28</sup>See "DOD Pharmacy and Therapeutics Committee," [http://www.tricare.mil/pharmacy/PT\\_Cmte/default.htm](http://www.tricare.mil/pharmacy/PT_Cmte/default.htm), downloaded December 3, 2007.

<sup>29</sup>The 322 drugs reviewed for the uniform formulary include multiple forms of a single drug classified by such factors as its various dosage forms, strengths, and manufacturers.

<sup>30</sup>MTF providers include physicians, nurse practitioners, podiatrists, and others.

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potential problems when they enter the prescription information into the system.

The PDTS detects duplicate drug treatments, therapeutic overlap, and drug interactions at the TMOP and retail network pharmacies. From these points of service, the prescription information is electronically submitted to the PDTS, which verifies the individual's TRICARE enrollment and provides information on duplicate treatments, therapeutic overlap, and drug interactions. The TMOP and retail network pharmacies are responsible for obtaining drug allergy information from the beneficiary, because the PDTS does not contain that information. Beneficiaries are asked to provide drug allergy information when they sign up to receive prescriptions through the TMOP. At retail pharmacies, the pharmacist is supposed to ask the beneficiary about their drug allergies and check their local pharmacy system for this information. Prescriptions filled at nonnetwork retail pharmacies are input into the PDTS when DOD receives a claim submitted by the beneficiary.

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### DOD Obtains Feedback on Its Pharmacy Benefit through Beneficiary Surveys and Comments

DOD administers two surveys that ask specific questions about the TRICARE pharmacy benefit. The Health Care Survey of DOD Beneficiaries is administered quarterly, but questions specific to the pharmacy benefit are asked once a year. The survey asks beneficiaries who had prescriptions filled during the last 90 days about pharmacy access and utilization. The second survey, the TMOP Satisfaction Survey, is a telephone survey administered quarterly. Survey participants are selected randomly among beneficiaries who used the TMOP in the last 90 days. The purpose of this survey is to determine whether Express Scripts, the contractor that administers the TMOP, will receive an incentive payment. Express Scripts is provided this payment when the level of beneficiary satisfaction with the TMOP is 90 percent or greater.<sup>31</sup> Express Scripts has scored 90 percent or greater for 17 of the 18 quarters since March 2003.

DOD officials stated that they also obtained beneficiary comments on the pharmacy benefits program during meetings with representatives of military associations that represent many TRICARE beneficiaries. At the local level, MTFs also collect information about beneficiary experience

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<sup>31</sup>Express Scripts can receive payment in each quarter based on beneficiaries' satisfaction rates: \$250,000 at 90 percent; \$500,000 at 92 percent; \$750,000 at 94 percent; \$1 million at 96 percent; \$1.25 million at 98 percent; and \$1.5 million at 100 percent.

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with the MTF pharmacy on such issues as hours of operation, waiting times, and service provided by the pharmacy technicians. These issues are usually addressed at the individual MTFs.

DOD generally uses the results of the Health Care Survey of DOD Beneficiaries to tailor articles in newsletters about the pharmacy program and to make improvements to it—for example, to simplify and encourage the use of the TMOP. DOD officials stated that on the basis of the results of the 2006 survey and feedback from military associations, they learned DOD beneficiaries wanted an easy method to transfer their prescriptions from retail pharmacies to the TMOP. In August 2007, DOD launched the Member Choice Center, where beneficiaries can call for assistance, register online for the TMOP, and transfer their prescriptions from retail pharmacies. The center contacts the beneficiary’s physician, at the beneficiaries’ request, to obtain new prescriptions and forward them to the TMOP for processing.

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### DOD Uses Pharmacy Data to Identify Beneficiaries for Disease Management Programs

According to DOD officials, DOD uses PDTS data to identify beneficiaries who might benefit from participating in DOD’s disease management program, an organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases, for which care practices may be subject to considerable variation.<sup>32</sup> The PDTS contains data on specific drugs, dosages, and dispensing dates. So, for example, DOD uses PDTS data on drugs dispensed for asthma to identify beneficiaries who have asthma. DOD uses this information and other criteria to determine whether a beneficiary is a candidate for the asthma disease management program. Once identified, DOD provides patient lists to the managed care support contractors, who also provide the information to MTFs. Providers are encouraged to support their patient’s active participation in the disease management program and to facilitate care, such as needed laboratory tests or screening examinations.

DOD implemented disease management programs for congestive heart failure and asthma in September 2006 and diabetes in June 2007, which are administered by the managed care support contractors. MTFs are required to provide disease management programs for asthma, diabetes, and

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<sup>32</sup>Disease management programs are interventions that are evidence-based to direct the patient’s plan of care. Programs also equip the patient with information and a self-care plan to self-manage wellness and prevent complications that may result from poor control of the disease process.

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screening mammograms. DOD conducts annual comprehensive analyses to quantify the effect of the disease management programs. The NDAA for Fiscal Year 2007 required that DOD's disease management program address, at a minimum: diabetes, cancer, heart disease, asthma, chronic obstructive pulmonary disorder, and depression and anxiety disorders.<sup>33</sup> DOD is working to expand its disease management program to include all of the specific diseases and conditions mandated and plans to report to Congress in March 2008 on the program's design, development, and implementation plan.

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## Conclusions

DOD's pharmacy spending increased at an unsustainable rate from fiscal year 2000 through fiscal year 2006. Retail pharmacy spending drove most of the increase, primarily due to the lack of federal pricing arrangements and increased beneficiary utilization at these pharmacies. In contrast, increases in pharmacy spending at MTFs and the TMOP, typically the more cost-effective points of service, were less pronounced. DOD has taken steps to curtail its rising pharmacy spending, including using its uniform formulary to obtain lower drug prices and creating a rebate program for retail pharmacies—efforts that have saved the agency hundreds of millions of dollars. More recently, DOD established an outreach program to encourage beneficiaries to transfer their prescriptions from retail pharmacies to the TMOP, which has been a less costly option for both DOD and its beneficiaries.

DOD's ongoing efforts are important to limit future prescription drug spending. In addition, the agency has its task force's proposals to consider, which include changes to the copayment and tier structures aimed at shifting beneficiary utilization away from retail pharmacies. The agency is also undertaking a fundamental reform—the NDAA for Fiscal Year 2008 requirement to apply federal pricing arrangements to drugs dispensed at retail pharmacies—that could have an even greater effect on spending. DOD will need to carefully monitor the effect of this new requirement along with its ongoing efforts in order to assess the progress in controlling spending. DOD will also need to determine what types of additional efforts, if any, will be necessary to ensure the fiscal sustainability of its pharmacy benefits program.

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<sup>33</sup>See Pub. L. No. 109-364, § 734, 120 Stat. 2083, 2299-301 (2006).

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## Recommendation for Executive Action

To help ensure the fiscal sustainability of DOD's pharmacy benefits program and complement more fundamental reforms recently enacted or recently proposed, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to

- monitor the effect of federal pricing arrangements for drugs dispensed at retail pharmacies along with ongoing efforts to limit pharmacy spending to determine the extent to which they reduce the growth in retail pharmacy costs, and
- identify, implement, and monitor other efforts, as needed, to reduce the growth in retail pharmacy spending.

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## Agency Comments and Our Evaluation

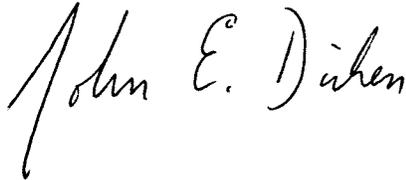
In commenting on a draft of this report, DOD stated that it concurred with our findings and recommendations and that it remains diligent in its efforts to curtail retail pharmacy costs. DOD noted that its recently implemented outreach program to encourage beneficiaries to transfer prescriptions from retail pharmacies to the less expensive TMOP has had an unanticipated level of participation.

Specifically, in response to our recommendation to monitor the impact of federal pricing arrangements for drugs dispensed at retail pharmacies, DOD stated that it has requested additional resources to implement this NDAA for Fiscal Year 2008 requirement. DOD acknowledged that, when fully implemented, this authority will have a significant impact on controlling the growth in retail pharmacy costs. While this may likely be the case, we reiterate the need for DOD to monitor the extent to which the federal pricing reduces growth in pharmacy spending in order to determine whether additional efforts to reduce spending are warranted. With regard to our recommendation to implement other efforts, as needed, to reduce growth in retail pharmacy spending, DOD responded that the recommendations of its task force would have an impact on overall DOD pharmacy costs in general and retail pharmacy costs in particular. However, DOD stated that congressional action is necessary for these measures to be implemented and that it stands ready to implement them if granted the authority to do so. Nonetheless, our recommendation was not limited solely to the task force recommendations. DOD could explore other cost saving initiatives, similar to its outreach efforts to encourage beneficiaries' use of the TMOP, which do not require congressional action. DOD's comments are reprinted in appendix II.

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We are sending copies of this report to the Secretary of Defense and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Bonnie Anderson, Assistant Director; Keyla Lee; Lesia Mandzia; and Tim Walker.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial 'J' and 'D'.

John E. Dicken  
Director, Health Care

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*List of Committees*

The Honorable Carl Levin  
Chairman  
The Honorable John McCain  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Daniel K. Inouye  
Chairman  
The Honorable Ted Stevens  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
United States Senate

The Honorable Ike Skelton  
Chairman  
The Honorable Duncan L. Hunter  
Ranking Member  
Committee on Armed Services  
House of Representatives

The Honorable John P. Murtha  
Chairman  
The Honorable C.W. Bill Young  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
House of Representatives

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# Appendix I: The DOD P&T Committee and the Uniform Formulary BAP

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## Composition of the Department of Defense Pharmacy and Therapeutics Committee

The Department of Defense Pharmacy and Therapeutics Committee consists of both voting and nonvoting members.

### Voting Members:

- Physician Chairman, Health Affairs/TRICARE Management Activity
- Director, Department of Defense Pharmacy Programs, TRICARE Management Activity
- Director, Department of Defense Pharmacoeconomic Center
- The Army, Navy, and Air Force Surgeons General Internal Medicine specialty consultants or designees
- One Army, Navy, or Air Force Surgeon General Pediatric specialty consultant or designee
- One Army, Navy, or Air Force Surgeon General Family Practice specialty consultant or designee
- One Army, Navy, or Air Force Surgeon General Obstetric/Gynecology specialty consultant or designee
- One physician or pharmacist from the United States Coast Guard
- The Army, Navy, and Air Force Pharmacy specialty consultants or designees
- One provider at large from the Army, Navy, and Air Force
- One physician or pharmacist from the Department of Veterans Affairs
- The Contracting Officer's Representative for the TRICARE Retail Pharmacy Program
- The Contracting Officer's Representative for the TRICARE Mail Order Pharmacy

The Pediatric, Family Practice, and Obstetric/Gynecology positions on the P&T Committee are rotated among the services every 3 years.

Nonvoting Members:

- Representative(s) of the Joint Readiness Clinical Advisory Board
- Representative(s) of the TRICARE Management Activity Office of General Counsel
- Representative(s) of the TRICARE Management Activity Resource Management Directorate
- Representative(s) of the Defense Supply Center Philadelphia

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**Composition of the  
Uniform Formulary  
Beneficiary Advisory  
Panel**

The Uniform Formulary Beneficiary Advisory Panel consists of the following members:

- members of nongovernment organizations and associations that represent the views and interests of TRICARE beneficiaries
- contractors for the TRICARE Retail Pharmacy Program
- contractors for the TRICARE Mail Order Pharmacy
- TRICARE network providers

# Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

Mr. John E. Dicken  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, N.W.  
Washington, DC 20548

MAR 19 2008

Dear Mr. Dicken:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report, GAO-08-327, "DoD PHARMACY PROGRAM: Continued Efforts Needed to Reduce Growth in Spending at Retail Pharmacies," dated February 25, 2008 (GAO Code 290604).

Thank you for the opportunity to review and comment on the Draft Report. Overall, I concur with the report (enclosed). In addition, I have received concurrence from the three Uniformed Services. As stated in the report, DoD has taken numerous steps to curtail rising pharmacy spending including using the DoD Uniform Formulary to leverage negotiations for lower drug prices and creating a voluntary rebate program that has saved the agency hundreds of millions of dollars. In addition, the recently implemented outreach program to encourage beneficiaries to transfer their prescriptions from the retail program to the less expensive mail order program has had an unanticipated level of participation.

The Department remains diligent in its efforts to curtail retail pharmacy costs. We will continue to employ outcomes research, best business practices and pharmacy benefit management principles, including formulary management, step-therapy, coordination of benefits, and incentives through co-pay adjustments. Furthermore, the National Defense Authorization Act for Fiscal Year 2008, Section 703, extends federal discounts to the purchase of pharmaceuticals used in the TRICARE retail pharmacy network. When fully implemented, this authority will have a significant impact on controlling the growth in retail pharmacy costs.

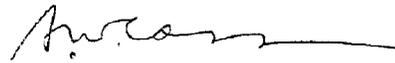
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**Appendix II: Comments from the Department  
of Defense**

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My points of contact on this issue are RADM Thomas McGinnis (Functional) and Mr. Gunther Zimmerman (Audit Liaison) who may be reached (703) 681-2890 and (703) 681-4360 respectively.

Sincerely,



S. Ward Casscells, MD

Enclosure:  
As stated

GOVERNMENT ACCOUNTABILITY OFFICE DRAFT  
REPORT DATED FEBRUARY 26, 2008  
(GOVERNMENT ACCOUNTABILITY OFFICE CODE  
290604)

**“DoD PHARMACY PROGRAM: Continued Efforts Needed to Reduce Growth in  
Spending at Retail Pharmacies”**

**DEPARTMENT OF DEFENSE COMMENTS  
TO THE RECOMMENDATION**

To help ensure the fiscal sustainability of the Department of Defense’s (DoDs) pharmacy benefits program and complement more fundamental reforms recently enacted or recently proposed, we recommend that the Secretary of Defense direct the Assistance Secretary of Defense (Health Affairs) to:

**RECOMMENDATION #1:** Monitor the impact of federal pricing arrangements for drugs dispensed at retail pharmacies along with ongoing efforts to limit pharmacy spending to determine the extent to which they reduce the growth in retail pharmacy costs.

**DOD RESPONSE:** Concur. We have requested additional resources to make the federal mandate operational.

**RECOMMENDATION #2:** Identify, implement, and monitor other efforts, as needed, to reduce the growth in retail pharmacy spending.

**DOD RESPONSE:** Concur. Implementing the recommendations of the recent DoD Task Force on the Future of Military Health Care include adjusting pharmacy co-pays, excluding non-formulary medication out-of-pocket costs from the catastrophic cap, include selected over-the-counter drugs to the Uniform Formulary, and mandating a point of service for selected medications will all require Congressional action through legislative relief. Each of these actions would have impact on overall DoD pharmacy costs in general and retail pharmacy costs in particular. The Department stands ready to implement any or all of these efforts if granted the authority to do so.

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## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

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