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Preface

The Military Health System (MHS) has approximately 8.7 million eligible beneficiaries. These beneficiaries include active duty military personnel and their family members, retired military personnel and their family members, and surviving family members of deceased military personnel. In 2001, the Department of Defense (DoD) spent just over $2 billion on pharmacy benefits. Much like the private health care sector, the MHS has experienced a rapid growth in pharmaceutical expenditures, which have increased an average of 17 percent a year over the past six years. Both the DoD and the U.S. Congress have identified the MHS pharmacy benefit as an area for reform.

To this end, Section 701 of the National Defense Authorization Act for Fiscal Year 2000 requires the Secretary of Defense to establish an effective, efficient, and integrated pharmacy benefits program. According to the legislation, titled the Pharmacy Benefits Redesign Program, “The pharmacy benefits program shall include a uniform formulary of pharmaceutical agents which shall assure the availability of pharmaceutical agents in the complete range of therapeutic classes. . . .” The Act further specifies that “[t]he uniform formulary will be applicable to all prescribers within the facilities of the uniformed services (i.e., military treatment facilities [MTFs]) and the TRICARE program. The pharmaceutical agents on the formulary will be available through the MTFs and retail pharmacies designated or eligible under the TRICARE program, as well as the National Mail Order Pharmacy program.”

Thus, under the new pharmacy benefit program, the Secretary of Defense must submit to Congress the results of surveys of TRICARE prescribers (physicians, physician assistants, and nurse practitioners with prescribing privileges) who practice at MTFs or at TRICARE network facilities. The legislation specifically requires two confidential surveys on the uniform formulary, one conducted pre-implementation and one conducted post-implementation. RAND’s National Defense Research Institute was asked by the TRICARE Management Activity to design and conduct the prescriber survey mandated by the statute.

The survey of clinicians was designed to assess how prescribers who work in MTFs or who are under the supervision of TRICARE contractors perceive formulary restrictions. The baseline survey discussed in this report attempts to gauge prescribers’ perceptions of the formularies’ impact on clinical decisions,
aggregate cost, quality of care, and accessibility of health care provided to MHS beneficiaries. To inform future implementation and monitoring of the uniform formulary system, the study also seeks to gather information on prescribers’ perceptions of the rationale behind formulary systems within the MHS.

This report was prepared at the request of the study’s sponsor to document the baseline survey effort and describe the survey findings. Basic univariate and some bivariate analyses are presented to highlight differences between the survey subsamples. The report’s primary intended audience is the sponsoring office. However, this research should also interest defense health policymakers and those in pharmacy benefits management in both the private and public health care sectors.

This work is sponsored by the Health Program Analysis and Evaluation Unit of the TRICARE Management Activity under the Assistant Secretary of Defense for Health Affairs. The project is being carried out jointly by RAND Health’s Center for Military Health Policy Research and the Forces and Resources Policy Center of the National Defense Research Institute. The latter is a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the unified commands, and the defense agencies.

Comments on this report are welcome and may be addressed to Terri Tanielian at territ@rand.org. For more information on RAND’s Forces and Resources Policy Center, contact the center’s director, Susan Everingham, at 310-393-0411, extension 7654, or at susan_everingham@rand.org.
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Summary

Background

Over the past few decades, pharmaceuticals have become increasingly important in the delivery of medical care. They have also represented one of the fastest growing components of both U.S. civilian and Department of Defense (DoD) health care expenditures. Several factors have contributed to the acceleration of pharmacy costs, including the pace at which new drugs enter the market, the prices of these new drugs, and the increasing availability of prescription drug benefits through private insurance.

In recent years, service delivery organizations that purchase drugs on behalf of beneficiaries have begun to manage the purchase and dispensing of medications more aggressively through what is typically referred to as “pharmacy benefits management” or “formulary management.” This process typically entails managing pharmaceutical care through the development of a formulary (i.e., a list of covered drugs) and the implementation of processes to monitor and control access to those drugs. More than 90 percent of health maintenance organizations (HMOs) use some type of formulary process to manage pharmacy benefits (Hoescht, 1999).

Formulary processes can be in the form of either “closed” or “open” systems. A closed formulary is a system that offers a limited set of selected pharmaceutical products, with other non-formulary drugs made available only by waiver or exemption. An open formulary is a system in which the availability of drugs is based on their status as generic, preferred, or non-preferred pharmaceuticals. Pharmacy benefits are also managed through the amount of co-payments, with different, or tiered, price structures for various drugs.

Determination of the actual drugs to be included on a formulary or preferred drug list is typically delegated to a Pharmacy and Therapeutics (P&T) committee—a representative group of clinicians, primarily physicians and pharmacists, for the health plan. Health plans and insurers have frequently delegated the task of pharmacy benefits or formulary development to pharmacy benefit managers (PBMs).
The MHS can move toward a more integrated formulary (i.e., a list of covered drugs) through the use of prior authorization requirements and uniform limitations on certain pharmaceuticals, such as limitations that would be monitored by the DoD’s on-line national pharmacy data transaction system. These requirements and limitations would be overseen by a central pharmacy benefit management group. However, the DoD’s ability to adopt a Uniform Formulary (UF) for all its MTFs has several practical constraints. Moreover, whether and how the DoD will be able to apply a Uniform Formulary to health care providers outside the traditional boundaries of the highly structured MTFs (such as TRICARE contract providers) is unclear.

There are many advantages and disadvantages to formulary systems. On the one hand, they represent an opportunity to incorporate systematic reviews of scientific evidence on clinical effectiveness and cost effectiveness into coverage decisions and management activities, thereby potentially improving health outcomes while reducing costs. On the other hand, overly restrictive formularies may potentially reduce the quality of care by limiting a patient’s access to clinically indicated medicines.

The long-term effects of formularies on patient care and health outcomes are largely unknown. A number of studies\(^1\) suggest that formulary policies can reduce health plans’ pharmacy costs without impinging on patient care. However, other studies\(^2\) have highlighted potential adverse consequences of arbitrarily restricting access to medications.

**DoD Pharmacy Program Redesign**

Section 701 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2000 (Public Law 106-65, codified at Title 10, United States Code, Section 1074g), directs the DoD to establish a single Uniform Formulary to govern Military Health System (MHS) beneficiaries’ access to pharmaceuticals. The military health benefit is organized and delivered through two systems in two distinct settings—the direct-care system (with care delivered by TRICARE in military owned and operated treatment facilities, i.e., MTFs) and the purchased-care system (with care delivered by civilian providers outside MTFs under contract to TRICARE, also known as network providers). Both systems provide

\(^1\)Foulke and Siepler, 1990; Ganz and Saksa, 1997; Dearing et al., 1998; McCombs and Nichol, 1993; Gold et al., 1989; Weiner, Lyles, and Steinwachs, 1991; Futterman, Fillit, and Roglieri, 1997; and Monane et al., 1998.

military beneficiaries with access to pharmaceuticals and currently have very different pharmacy management activities. The Uniform Formulary Program segment of the Pharmacy Benefits Redesign Program, as legislated by Congress, will require an integration of these two systems and the development of additional administrative systems.

Prior to 1999, no single entity within the DoD had responsibility for administering and coordinating pharmacy programs (U.S. General Accounting Office, 1999a). Since then, the DoD has chartered the PharmacoEconomic Center under TRICARE and created and implemented the Pharmacy Data Transaction Service, which is an electronic database designed to track prescriptions dispensed across the MTFs, network retail pharmacies, and the National Mail Order Pharmacy (NMOP).

Work is still under way to implement all requirements of the NDAA legislation and to introduce the UF across the MHS. The details of the UF are still in the rule-making and comment stage as of this writing. The proposed legislation is subject to change during the comment period and will not be considered final until it is published in the Federal Register.

The proposed rule introduces a three-tier co-payment structure based upon a pharmaceutical agent’s classification in the UF (i.e., generic, formulary, or non-formulary) and the point of service from which the agent is acquired (i.e., an MTF, retail network pharmacy, retail non-network pharmacy, or the NMOP). For the direct-care system (i.e., drugs dispensed at the MTF), the proposed UF will resemble an expanded basic core formulary (BCF) and will continue to allow local MTF P&T committees to make additions to the formulary based on the scope of care. For the NMOP (for prescriptions written by either a direct-care provider or purchased-care provider), the proposed UF will make non-formulary medications available at the third-tier co-payment amount. In the retail network pharmacies (again, for prescriptions written by either direct-care or purchased-care providers), the UF will make 30-day supplies of non-formulary medications available at the third-tier co-payment amount.

The proposed UF program will represent a major management shift in the purchased-care system, in which formularies, currently, are open and offer few opportunities for the DoD to manage the cost of pharmacy benefits. Thus, through the proposed UF, the DoD will gain the ability to determine how prescriptions are dispensed, from a cost standpoint, in the purchased-care sector. The DoD will gain this ability through higher co-payments, which will create incentives for beneficiaries to opt for preferred formulary medications and to
consider filling their prescriptions for such medications through the MTF pharmacies or through the NMOP.

Survey of Military Health System Prescribers

To assess the impact of the uniform formulary on the care delivered in the Military Health System, particularly in regard to perceived access to pharmaceuticals, Congress required two surveys of MHS prescribers, one prior to UF implementation (the baseline survey) and another following the UF implementation (the follow-up survey). At the request of the TRICARE Management Activity (TMA) and in compliance with Section 701 of the NDAA for FY 2000, RAND conducted the first of these surveys in mid-2001. The purpose of the first survey effort was to measure and evaluate the perceptions of prescribers who practice at MTFs and prescribers who practice under TRICARE contract in the civilian sector. The survey sought feedback regarding obstacles prescribers face in providing beneficiaries with formulary medications, non-formulary medications (or “non-preferred” medications as they may currently be called), and quality pharmacotherapeutic care. The baseline survey described in this report assesses how prescribers’ perceptions of and attitudes toward formularies may be currently influencing their decisions on prescribing pharmaceutical products.

Because military benefits (including pharmacy benefits) are delivered in two distinct systems—direct-care and purchased-care—and because these two systems currently have two different formulary management systems, two separate survey instruments were designed for MHS prescribers. One survey instrument was aimed at TRICARE prescribers working within the direct-care system in MTFs, and a second survey instrument was aimed at prescribers who provide services to military beneficiaries at network facilities under contract to TRICARE.

Seven hundred MTF (i.e., direct-care) prescribers and 600 network (i.e., purchased-care) prescribers were sampled using data obtained from claims records for fall 2000. We drew a stratified sample within each of the two target populations to ensure representation of specific analytic groups of interest (e.g., non-M.D. providers, specialists, and others). Prescribers were asked a series of questions about their knowledge of and degree of familiarity with formularies, formulary development, and management practices. They were also asked

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3“Prescribers” as defined by the FY 2000 NDAA are physicians, physician assistants, and nurse practitioners with prescribing privileges.
specific questions about their perceptions of the impact of formulary management on their own prescribing behavior and the quality of care provided to their patients. Participants were also questioned about their background and medical practice. Sixty-nine percent of eligible MTF (direct-care) prescribers and 39 percent of eligible network (purchased care) prescribers responded.

Conclusions

MTF prescribers who responded to the survey reported a high degree of familiarity with the formulary and formulary management practices in place at their own MTFs. In general, MTF respondents perceived formulary management as contributing toward quality of care and agreed that controlling costs through such formulary management is important.

Network prescribers who responded to the survey reported interacting with multiple formularies and formulary management practices. Network respondents reported less familiarity and comfort with formulary lists and the rules governing their use. They did not believe that formulary management was contributing to the quality of care they provided.

Some differences were observed within each sample. For example, within the direct-care system, primary-care providers reported having a higher level of familiarity and greater comfort with formulary management techniques than did secondary-care providers. Direct-care providers within smaller MTFs also reported greater familiarity with the activities of P&T committees and with the rules governing non-formulary prescriptions at their MTF than did direct-care providers at larger MTFs. Within the purchased-care system, primary-care providers interacted with a greater number of preferred or formulary drug lists than did their secondary-care provider counterparts.

A follow-up RAND survey, which will be administered approximately six months subsequent to implementation of the UF, will assess changes in prescribing behaviors and in prescribers’ perceptions and attitudes about formulary management in general, as well as assess prescribers’ actual experiences with the DoD Uniform Formulary specifically.
Acknowledgments

The authors wish to thank several individuals for their guidance and support in carrying out this work. We are especially grateful to Colonel William Davies, director of the DoD Pharmacy Benefit Program, for providing valuable information with regard to the DoD pharmacy programs, feedback on survey instruments, and insight into the results. We also acknowledge the guidance of Lee Hilborne, M.D., who served as a mentor and co-principal investigator for the survey. We thank Ross Anthony for his leadership and advice in making this effort successful. We also acknowledge the support of the project officer, Lieutenant Colonel Thomas Williams, and the staff within TMA’s Health Program Analysis and Evaluation office. We would also like to thank John Downs, M.D., and Jesse Malkin, M.Phil., Ph.D., for their review and valuable comments, and Nancy DelFavero for her editing work on this report.

Finally, we also thank the prescribers within the MHS who took the time to complete the survey instrument; without their responses, this report would not have been possible.
# Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>BCF</td>
<td>Basic Core Formulary</td>
</tr>
<tr>
<td>BRAC</td>
<td>Base realignment and closure</td>
</tr>
<tr>
<td>CHCS</td>
<td>Composite Health Care System</td>
</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>DSC–P</td>
<td>Defense Supply Center–Philadelphia</td>
</tr>
<tr>
<td>DTC</td>
<td>Direct-to-consumer (marketing)</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GAO</td>
<td>U.S. Government Accounting Office</td>
</tr>
<tr>
<td>HCPR</td>
<td>Health Care Provider Record</td>
</tr>
<tr>
<td>HCSR</td>
<td>Health Care Service Record</td>
</tr>
<tr>
<td>HMO</td>
<td>Health maintenance organization</td>
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<tr>
<td>HPAE</td>
<td>Health program analysis and evaluation</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>MHS</td>
<td>Military Health System</td>
</tr>
<tr>
<td>MTF</td>
<td>Military treatment facility</td>
</tr>
<tr>
<td>N</td>
<td>Number (in sample)</td>
</tr>
<tr>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>NDAA</td>
<td>National Defense Authorization Act</td>
</tr>
<tr>
<td>NMOP</td>
<td>National Mail Order Pharmacy</td>
</tr>
<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
</tr>
<tr>
<td>OTC</td>
<td>Over-the-counter (medications)</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
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<tr>
<td>p</td>
<td>Probability (of difference being due to chance)</td>
</tr>
<tr>
<td>PA/APN</td>
<td>Physician assistant/Advanced practice nurse</td>
</tr>
<tr>
<td>PBM</td>
<td>Pharmacy benefits manager</td>
</tr>
<tr>
<td>PDTS</td>
<td>Pharmacy Data Transaction Service</td>
</tr>
<tr>
<td>PEC</td>
<td>PharmacoEconomic Center</td>
</tr>
<tr>
<td>P&amp;T</td>
<td>Pharmacy and Therapeutics (committee)</td>
</tr>
<tr>
<td>SADR</td>
<td>Standard Ambulatory Data Record</td>
</tr>
<tr>
<td>SD</td>
<td>Standard deviation</td>
</tr>
<tr>
<td>TMA</td>
<td>TRICARE Management Activity</td>
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<tr>
<td>TRICARE</td>
<td>The Department of Defense managed care program</td>
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<td>UF</td>
<td>Uniform Formulary</td>
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<td>VA</td>
<td>Department of Veterans Affairs</td>
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