



Pharmacy Benefits for Military Retirees

Controlling Costs Without Compromising Health

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Key findings:

- Military retirees fill more than half of their prescriptions through MTFs, but a growing number are using retail pharmacies.
- Because of higher prices to DoD, retail pharmacies account for the majority of pharmaceutical costs.
- Retail pharmacy use is related to the distance to the nearest MTF and to non-availability of certain drugs at MTFs.
- Implementing a three-tier drug benefit in the private sector slowed the increase in pharmaceutical spending.
- To save costs without adversely affecting beneficiaries' health, DoD should carefully consider the drugs that it places in the more-costly third tier.

retired career service personnel is partly attributable to the double-digit growth in expenditures for prescription drugs.

At a time when the federal government is shaping the prescription drug benefit that will be offered to elderly Medicare recipients, the Department of Defense (DoD) asked researchers at the RAND Center for Military Health Care Policy to assist it in assessing factors contributing to the rising costs of prescription medications for military retirees and their families and proposing measures that might curb those costs without sacrificing patient safety or the quality of care.

Because a prescription filled at a retail pharmacy is substantially more costly to DoD than the same prescription dispensed from a military treatment facility (MTF) or mail-order pharmacy, the researchers first assessed participants' choice of dispensing location. The researchers then examined the potential cost-savings of implementing a three-tier drug benefit. Their findings are as follows:

- Military retirees continue to fill more than half of their prescriptions at MTFs or through the military's TRICARE Mail Order Pharmacy (TMOP), but a growing number—currently 43 percent—are filling their prescriptions at retail pharmacies.

Like the private health care sector, the military health care system has experienced rapid growth in expenditures over the past decade. And just as with the rise in private health care costs over the past decade, the rise in the costs of caring for the nation's active duty forces, their families, and

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This Highlight summarizes RAND research reported in the following publications:

Geoffrey Joyce, Jesse D. Malkin, and Jennifer Pace, *Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector*, Santa Monica, Calif.: RAND Corporation, MG-154-OSD, 2005.

Jesse D. Malkin, Geoffrey Joyce, Jennifer Pace, and Thomas Croghan, *Determinants of Dispensing Location in the TRICARE Senior Pharmacy Program*, Santa Monica, Calif.: RAND Corporation, MG-237-OSD, 2005.

- The majority of pharmaceutical costs is incurred from drugs obtained at retail pharmacies, because the cost of those drugs to DoD is higher than the cost of the same drugs dispensed from an MTF or a mail-order pharmacy. Thus, DoD costs could decrease if retirees shifted from retail pharmacies to military facilities or the TMOP.
- Use of retail pharmacies is related to the distance to the nearest MTF and to the non-availability of certain higher-cost popular drugs at MTFs.
- Analysis of health insurance data from large private employers shows that implementing a three-tier drug benefit in the military health system could slow the rate of increase in spending on pharmaceuticals.
- To achieve the significant cost savings suggested in this study without adversely affecting the health status of beneficiaries, DoD should carefully consider the drugs and drug classes that it places in the more-costly third tier.

Under the TRICARE Senior Pharmacy Program, Where Prescriptions Are Filled Affects Costs

In 2001, Congress mandated expanding pharmacy coverage for the 1.8 million elderly military retirees—those 65 and over—and their elderly dependents. Prior to that expansion of coverage, seniors could use their military prescription benefit only at MTF pharmacies, where prescriptions were dispensed at no cost. Under the TRICARE Senior Pharmacy Program (TSRx), retired seniors could now use their TRICARE pharmacy benefit to obtain prescriptions through any one of four sources: (1) MTF pharmacies, (2) retail pharmacies that are part of the TRICARE network, (3) the TMOP, and (4) non-network retail pharmacies. A modest copayment is applied to all prescriptions dispensed through network retail pharmacies and the TMOP—\$3 for a generic drug and \$9 for a brand-name drug (non-network retail pharmacies charge a higher copay)—whereas prescriptions are obtained at no cost from MTF pharmacies (see Table 1).

While DoD's pharmaceutical costs were rising fairly steadily before the expansion of coverage, those costs suddenly accelerated in 2001 due in part to the change in the structure of the pharmacy benefit (the expansion of coverage) and in part to a general trend seen in the civilian population as well. Costs to DoD for medications obtained from retail pharmacies are typically higher than the costs DoD is able to negotiate with pharmaceutical companies for medications dispensed through MTFs and the TMOP. Thus, the cost to DoD of allowing TRICARE participants to fill prescriptions at retail pharmacies is significantly higher than if prescriptions were filled only through MTFs and the TMOP, particularly for high-price, widely prescribed drugs. If, for

example, in 2001, seniors began filling a considerable proportion of their prescriptions at retail pharmacies, the switch in dispensing location could have been a factor in the increasing costs of drugs. Thus, as a first step in identifying the causes of the rapidly rising costs and devising methods to cut those costs, RAND researchers were asked to assess where senior TRICARE beneficiaries purchase their prescription drugs.

By examining TRICARE pharmacy claims data, the researchers found that the majority of TSRx prescriptions has been dispensed from MTFs (see the figure). However, they also noted a major decline in the use of MTFs for prescriptions—from 100 percent to 60 percent of prescriptions in the two years following the launch of the new program—and a corresponding increase in the use of retail pharmacies.

The upside of the policy change for beneficiaries included expanded access to—and availability of—pharmaceuticals. And TRICARE experienced an influx of new pharmacy benefit users. Yet, for DoD, the new policy had a considerable downside: Although most TSRx prescriptions were still dispensed from MTFs or through mail order, the researchers found that drugs dispensed from retail pharmacies accounted for the highest proportion of total pharmaceutical costs for the TSRx program (see the figure). Thus, TSRx costs would decrease if drug dispensing could be shifted from retail pharmacies to those sources where federal pricing limits DoD's drug costs. For example, if all prescriptions written for TSRx participants for Zocor (a cholesterol-lowering drug) alone were filled at MTFs or through the TMOP, DoD would save 76 percent of the retail cost of that drug—almost \$14 million yearly (see Table 2).

What Kinds of Factors Influence Where TSRx Participants Fill Their Prescriptions?

Clearly, if saving money were participants' only concern, most prescriptions would be filled at MTFs, which charge no copayment. Thus, researchers considered other factors—proximity of the nearest MTF to participants' residences and the availability of widely used medications at MTFs.

It is well recognized that proximity of a business that offers a needed product or service increases the likelihood that consumers will use that business. The researchers used the residential zip codes of senior TRICARE participants to measure the distance participants must travel to the nearest MTF. When researchers compared the distance between military retirees and the nearest MTF with their pharmacy use, they found that retirees who reside within 20 miles of an MTF are more likely to participate in TSRx and to use an MTF to fill their prescriptions than retirees who live more than 20 miles from an MTF. As such, the farther a

Table 1
Current and Proposed TSRx Copayment Schedule

Current Copayment Schedule			Proposed Copayment Schedule		
Place of Service	Beneficiary's Cost		Beneficiary's Cost		
	Generic Drugs	Brand-Name Drugs	Generic Drugs	Preferred Brands	Non-preferred Brands
MTF	\$0	\$0	\$0	\$0	Not covered
TMOP (up to a 90-day supply)	\$3	\$9	\$3	\$9	\$22
In-network retail pharmacy ^a	\$3	\$9	\$3	\$9	\$22
Out-of-network retail pharmacy ^a	The greater of \$9 or 20% of drug cost; deductibles apply		The greater of \$22 or 20% of drug cost; deductibles apply		

SOURCE: *Federal Register*, Vol. 67, No. 71, April 12, 2002.

^aIn-network retail pharmacies are those pharmacies with which DoD contracts to fill TRICARE prescriptions at a cost to DoD that is negotiated. Out-of-network pharmacies have not contracted with DoD.

Proportion of Prescriptions Filled and Costs to DoD for Each Type of Dispensing Location

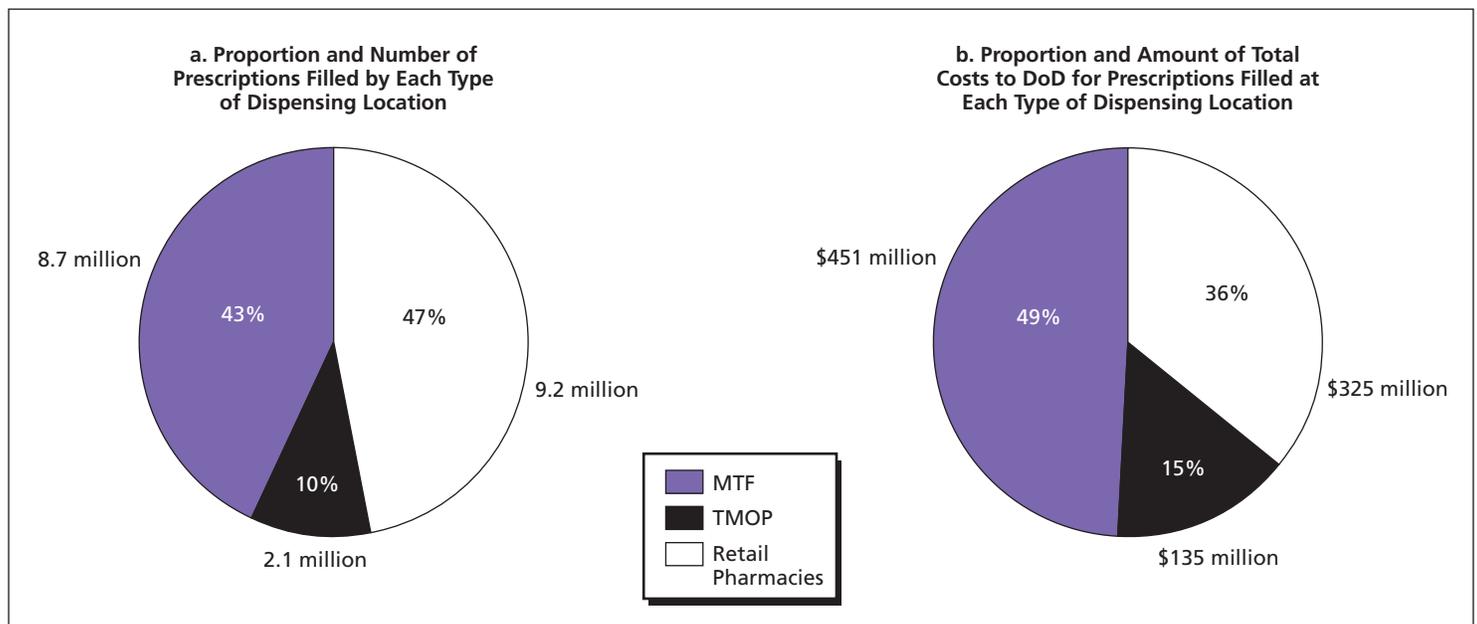


Table 2
Potential Cost Savings to DoD If Prescriptions for Seven of the Most Popular Drugs Were Filled at MTFs Instead of at Retail Pharmacies

Medicine	Cost of Drugs Dispensed Through Retailers in 2002 (\$)	Potential Savings	
		Percentage ^a	Dollars
Zocor	18,300,000	76	13,882,000
Prilosec	16,500,000	44	7,262,000
Celebrex	12,600,000	33	4,200,000
Vioxx	8,135,200	36	2,758,000
Norvasc	6,505,000	43	2,613,000
Plavix	10,000,000	73	4,098,000
Fosamax	5,445,800	43	2,130,000

^aThe percentage of total dollars spent per drug in 2002 that would have been saved if prescriptions for that drug had been filled only at MTFs.

participant lives from an MTF, the more likely he or she is to use retail pharmacies or the TMOP instead of the MTF (see Table 3). And proximity to an MTF affects not only whether a retiree uses the MTF but the proportion of prescriptions he or she fills at the MTF. Most Americans live within five miles of a retail pharmacy, while more than half of TSRx participants live more than 20 miles from an MTF. Thus, it is not surprising that a population of older individuals, who may limit the distances they drive for health or economic reasons, would seek the more accessible pharmacy.

The researchers also considered the availability of medications widely used by seniors. The products carried by each MTF pharmacy are determined by a formulary established by the DoD. Within each therapeutic class, the DoD Pharmacy & Therapeutics Committee designates a particular

Table 3
Effect of Residential Distance from an MTF on the Likelihood of a Beneficiary Using an MTF, TMOP, or Retail Pharmacy

Distance of Beneficiary from MTF	MTF Pharmacy Use		TMOP Use		Retail Pharmacy Use	
	N	%	N	%	N	%
Within 20 miles of two MTFs (N = 379,080)	320,422	84.53	50,312	13.27	187,157	49.37
21–40 miles from closest MTF (N = 80,815)	43,434	53.74	21,846	27.03	58,857	72.83
More than 40 miles from closest MTF (N = 360,654)	107,174	29.72	123,922	34.36	301,198	83.51

brand or brands of drugs as being “preferred,” based on several factors, including the negotiated cost of that brand to the DoD. When a generic drug is available, it is generally the preferred drug. MTFs do not dispense “non-preferred” drugs (i.e., name brands, which are usually more costly) unless a military physician documents medical necessity. Prescriptions for non-preferred drugs generally must be filled at a retail pharmacy. After examining the choice of dispensing locations by participants who had prescriptions for two of the most commonly prescribed types of drugs (cholesterol-lowering drugs and antacids), the researchers found that availability of a drug at an MTF was associated with greater use of the MTF, not only to obtain that drug but to also obtain other prescriptions. But if an MTF did not offer a certain drug, users who turned to a retail pharmacy to fill their prescriptions for the drug were more likely to also fill their other prescriptions at the retail pharmacy.

The effects of proximity and the availability of non-preferred drugs suggest that convenience strongly influences the decision to use retail pharmacies. However, to manage costs, DoD must identify ways to encourage more seniors to fill their prescriptions at MTFs or through the TMOP, or to at least discourage use of retail pharmacies. Options under consideration include (1) making MTF pharmacies more accessible by creating more of them or by providing delivery service from MTFs to participants’ homes, (2) allowing beneficiaries to obtain non-preferred drugs from the TMOP without proof of medical necessity (while at the same time no longer reimbursing beneficiaries for non-formulary drugs obtained at retail pharmacies), and (3) increasing copays for non-preferred drugs. In a follow-up to this study, the

researchers were asked to explore the likely consequences of the third alternative, which would add a third tier to the copay structure currently used by TRICARE.

Changing How Much TRICARE Beneficiaries Pay for Prescription Drugs

In its effort to increase the efficiency and integration of its pharmacy benefits program as well as to control the costs of prescription drugs, DoD is in the process of standardizing the drugs available at each MTF by establishing a Uniform Formulary. As part of this effort, DoD is considering moving from a two-tier to a three-tier copayment system. Under a two-tier system, lower-cost (i.e., preferred) drugs are offered to participants at no cost or for a lower copayment than is charged for non-preferred brands in the same therapeutic class of drug. The proposed three-tier system would impose a \$22 copay for non-preferred prescription medications for all TRICARE participants (see Table 1). The RAND researchers were asked to assist DoD in assessing the potential implications of this change—that is, how such a change might affect (1) DoD’s costs and (2) beneficiaries’ out-of-pocket costs and use of drugs. To address this issue, the researchers examined how beneficiaries with private drug coverage responded to similar changes in benefits, using data gathered by a private health benefits company.

Specifically, the researchers assessed how changes in plan expenditures, drug use, and participants’ costs over one year’s time compared between plans that switched from two to three tiers and those that remained the same. (Table 4 shows average copayments for each plan type.) They also

Table 4
Average Copayments by Plan Type for Private Health Plans Studied

Type of Plan	Description	Type of Drug		
		Generic	Preferred Brand-Name	Non-preferred Brand-Name
Fixed 2-tier	Separate copayments for generic and brand-name drugs	\$5	\$15	\$15
Fixed 3-tier	Separate copayments for generic, preferred brand, and non-preferred brand-name drugs	\$6	\$11	\$21
New 3-tier	Adds highest copayment for non-preferred brand-name drugs	\$5	\$13	\$26

assessed whether the use and cost of some therapeutic classes of drugs were more affected by the changes than the use and cost of other classes of drugs and whether the demand for particular drugs was affected.

The researchers found that from 1999 to 2000, the rate of increase in pharmacy spending was significantly smaller in plans that switched from two to three tiers than in fixed two-tier health plans (see Table 5). However, beneficiaries' out-of-pocket spending grew considerably more rapidly for those enrolled in three-tier plans—both new and fixed—than for those enrolled in fixed two-tiered plans. This pattern was observed for most high-cost therapeutic classes of drugs, such as medications for asthma, high cholesterol, gastric acid disorders, and depression.

This study showed that civilian plans that implemented changes in their benefit structure that were similar to the changes proposed for the military's Uniform Formulary achieved significant savings in the year following the changes. However, some differences between the proposed Uniform Formulary and the changes in benefit structures that were the subject of this study may limit the applicability of the findings to DoD. For example, TRICARE's formulary restrictions and prior authorization requirements may differ from those of the plans for which data were evaluated, and a number of factors such as discounts and rebates could not be taken into account. Further, the proposed Uniform Formulary would allow third-tier drugs to be obtained from the TMOP with no prior authorization and a lower copay than if the drugs were purchased from retail pharmacies. While this policy would work against trying to switch users to less costly drugs, it might, in the long run, encourage less use of the more costly retail pharmacies and greater use of the less costly TMOP.

Implications for DoD, TSRx, and Medicare

If the DoD elects to implement the three-tier Uniform Formulary, it will need to make a number of decisions. For example, to achieve savings without adverse health consequences, DoD should carefully consider the drugs and drug classes that it places in the non-preferred third tier. Criteria for selection include the availability of suitable substitutes, the level of spending on the class overall and on specific

Table 5
Effects of Altering Tier Structure on Changes in Plan and Beneficiary Spending

Plan Type	Benefit Change	Increase in Total Pharmacy Spending (%)	Increase in Beneficiary Spending per Member per Year
Fixed 2-tier	None	17	\$7
Fixed 3-tier	None	12	\$27
New 3-tier	Added third tier	8	\$38

drugs in particular, and potential unintended consequences from switching medications. The most heavily scrutinized drugs should be those in the costliest therapeutic classes, which account for a disproportionate share of expenditures.

In addition, to achieve greater cost savings, DoD must assess the possible advantage of lowering the copay for third-tier medications obtained from the TMOP, easing some of the prior authorization requirements at MTFs, and instituting other changes that would limit the incentive to use retail pharmacies.

Policymakers must also consider whether reduced pharmaceutical use or a switch to generic alternatives, which might result from higher patient copays and the change in benefit structure, would have an adverse effect on health. The likelihood of seeing such effects on health is minimized if the third, and most costly, tier is reserved for drugs with close generic substitutes.

The Medicare Modernization Act (MMA) of 2003 has added a prescription drug benefit to the Medicare Program. Under the new plan, individual participants may be responsible for \$2,850 in expenses. Under MMA, the federal government has encouraged the private plans that administer Medicare benefits to devise ways to eliminate this potential gap in coverage. One proposal is to implement a three-tier copay structure. Thus, a finding of the RAND study—that copays matter—is of interest not only to DoD as it restructures the pharmacy benefit for active duty military personnel and retirees but to the civilian sector as it seeks ways to control and redirect the costs of medications for the Medicare population. ■

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