

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-10

Subject: Availability of Veterans Affairs Pharmacy Benefit
(Resolution 122, A-09)

Presented by: Barbara L. McAneny, MD, Chair

Referred to: Reference Committee G
(James Chris Fleming, MD, Chair)

1 At the 2009 Annual Meeting, the House of Delegates referred Resolution 122, which was
2 sponsored by the American Psychiatric Association, the American Academy of Child and
3 Adolescent Psychiatry, and the American Academy of Psychiatry and the Law. Resolution 122
4 (A-09) asked that the American Medical Association (AMA) “advocate for the extension of the
5 Veterans Affairs pharmacy benefit to all outpatient veterans who wish to use it.” The Board of
6 Trustees assigned this item to the Council on Medical Service, for a report back to the House of
7 Delegates at the 2010 Annual Meeting.

8
9 This report provides background on the Veterans Health Administration, examines the relationship
10 between health care provided by the Department of Veterans Affairs (VA) and other health
11 insurance coverage, describes the VA pharmacy benefit, outlines VA prescription drug costs,
12 analyzes the impact of expanding the VA pharmacy benefit to all veterans, highlights issues
13 associated with mental health, summarizes relevant AMA policy, and presents policy
14 recommendations.

15 16 BACKGROUND ON THE VETERANS HEALTH ADMINISTRATION

17
18 The Veterans Health Administration (VHA) directly provides a range of services, including
19 inpatient and outpatient care; long-term care; pharmacy and mental health in its facilities, which
20 include more than 1,400 sites of care, including 153 medical centers, 783 community-based
21 outpatient clinics, and 232 Vet Centers. As of 2009, 7.9 million of the 23.4 million veterans in the
22 US were enrolled in VA health care. In fiscal year 2009, approximately 5.7 million unique patients
23 accessed care in VA facilities.

24
25 The Veterans’ Health Care Eligibility Reform Act of 1996 (Public Law 101-262), effective
26 October 1, 1998, mandated that the VA create and use a national enrollment system so that the
27 delivery of health services in the VA system can be more efficiently and effectively managed. As a
28 result, most veterans are required to be enrolled in the VHA to receive care. Veterans who apply
29 for VA health care are assigned to one of eight priority groups of veterans, categorized on the basis
30 of disability rating, income, wars fought, Purple Heart recipient status, Prisoner of War (POW)
31 status and other factors.

32
33 Each year, the Secretary of the VA must determine whether the agency’s medical budget can
34 support providing health care to veterans in all priority groups. If not, VA health care is provided
35 to the highest priority groups first. Currently, all veterans in Priority Groups 1 through 7 are
36 eligible to enroll in the VHA and receive care. In January 2003, the VA made the decision to stop

1 enrolling new Priority Group 8 veterans. Priority Group 8 veterans do not have service-connected
2 disabilities, or have noncompensable service-connected disabilities, and have income and/or net
3 worth above both the VA National Income Thresholds and the VA National Geographic Income
4 Thresholds, which vary based on state and county of residence. In comparison, Priority Group 7
5 veterans have income and/or net worth above the VA national income threshold, but below the VA
6 National Geographic Income Thresholds. Veterans in Priority Groups 7 and 8 are also responsible
7 financially for co-payments.

8
9 However, on June 15, 2009, new regulations went into effect that enable the VA to relax income
10 restrictions on enrollment for health benefits. Therefore, the VA is now enrolling veterans with
11 incomes in excess of the current means-test thresholds by up to 10 percent. In 2011, the VA will
12 start enrolling Priority Group 8 Veterans with incomes in excess of the means-test thresholds by up
13 to 15 percent. The VA estimates that these developments will result in approximately 292,000 new
14 enrollees from 2009 to the end of 2011.

15 16 RELATIONSHIP BETWEEN VA AND OTHER HEALTH INSURANCE COVERAGE

17
18 Since 1999, the VHA has conducted an annual survey of veteran enrollees' health and reliance
19 upon the VA. The results of the 2008 survey, which were released in September 2009, contained a
20 number of key findings regarding the percentage of veteran enrollees who had another form of
21 health insurance coverage. Of those surveyed, more than 79 percent of enrollees also had public or
22 private health insurance coverage. Twenty percent of enrollees reported not having any other
23 health insurance coverage.

24
25 The VA provides for the treatment of service-connected conditions for enrollees, which are
26 conditions that have been determined to be sustained or aggravated in the line of duty. However,
27 for the treatment of non-service-connected conditions, VA medical care is coordinated with private
28 health insurance for those veterans who are dually enrolled. In these instances, the VA bills the
29 enrollee's private health plan for care received at the VA that is related to such condition, including
30 prescription drugs. In general, the VA cannot bill Medicare. It can, however, bill for services and
31 prescriptions covered under Medicare supplemental plans. If a private health plan is billed, the
32 only potential financial obligation of veteran enrollees is a VA co-payment. Veteran enrollees are
33 not responsible for any unpaid balance from the amount billed to the other health plan. In addition,
34 payments from private health plans can offset part or all of an enrollee's co-payment, dollar for
35 dollar.

36 37 VA PHARMACY BENEFIT

38
39 As noted in the third whereas clause of Resolution 122 (A-09), prescription medications comprise
40 part of the VA's medical benefits package available to all enrolled veterans. Under this benefit,
41 prescription drugs generally must be prescribed by a VA provider, filled at a VA pharmacy, and
42 listed on the VA national drug formulary. In 2008, the VA provided 126 million outpatient
43 prescriptions to more than 4.4 million patients. The VA has reported an error rate of less than one
44 in every 294,000 for these prescriptions. In 2006, the VA spent an estimated \$3.4 billion on
45 prescription drugs, a small fraction of the \$216.7 billion that was spent in the US on prescription
46 drugs that year.

47
48 For the treatment of conditions that are not service-connected, the majority of veterans are charged
49 \$8 for each prescription drug provided by the VA for a 30-day or less supply. The out-of-pocket
50 maximum for prescription drug co-payments for veterans enrolled in Priority Groups 2 through 6 is
51 \$960. Several groups of veterans are not charged prescription drug co-pays, including veterans

1 with a service-connected disability of 50 percent or more and veterans receiving medication for
2 service-connected conditions. The VA consolidated all of its formularies into a single national
3 formulary in 2009. As of June 2009, the VA national drug formulary included 570 categories of
4 drugs. In cases of medical necessity, the VA may provide drugs that are not on the formulary to
5 enrolled veterans.

6
7 Some of the most striking findings of the 2008 VHA enrollee survey had to do with veteran
8 enrollee awareness of VA prescription drug coverage. Of those veteran enrollees surveyed—all of
9 whom have prescription drug coverage from the VA—65 percent said that they had coverage, 30
10 percent said that they did not have coverage, and 4.4 percent did not know or refused to answer.
11 This finding demonstrates that the VA pharmacy benefit may go underutilized among those already
12 enrolled in VA medical care. For those veteran enrollees surveyed who responded that they also
13 had private health insurance coverage, 81 percent said that they had prescription drug coverage
14 under their private health plan, whereas 17 percent said they did not.

15
16 There is also overlap between the pharmacy benefit of the VA and prescription drug coverage
17 provided under Medicare Part D, even though enrollment in the VA health care system is
18 considered to be “creditable coverage” for the purpose of Medicare Part D enrollment. Of those
19 veteran enrollees with Medicare coverage surveyed, 34 percent reported having coverage under
20 Medicare Part D. VHA enrollees may choose to have Medicare Part D coverage for several
21 reasons. Many enrolled veterans who also have Medicare Part D coverage may find the VA
22 formulary restrictive and are in need of prescription drugs that are not on the VA formulary, which
23 are prescribed by non-VA physicians. Also, enrolled veterans may want the option to get their
24 prescriptions written by non-VA physicians filled at local pharmacies, which may be more
25 convenient to get to than VA pharmacies. Finally, there may be some lack of awareness of the VA
26 pharmacy benefit.

27 28 VA PRESCRIPTION DRUG COSTS

29
30 The VA has the ability to pay the lowest price available for prescription drugs out of several
31 options available to it. First, the VA can also choose to pay federal ceiling prices for prescription
32 drugs, which are statutorily required to be 24 percent lower than nonfederal average manufacturer
33 prices. The VA also has the option to pay Federal Supply Schedule (FSS) prices, which are
34 negotiated by the VA’s National Acquisition Center with drug manufacturers. Ultimately, the goal
35 of FSS pricing is for the VA to be charged no more than the prices manufacturers charge
36 comparable most-favored nonfederal customers. Drug manufacturers must list their brand-name
37 drugs on the FSS in order to be reimbursed for prescription drugs under Medicaid. Because the
38 negotiation process for FSS pricing is not connected to federal ceiling prices, the VA ultimately
39 can secure prices for prescription drugs far below ceiling prices. Even if the negotiated FSS price
40 comes out higher than the federal ceiling price, the VA is obligated to pay no more than the federal
41 ceiling price.

42
43 The VA, either separately or in collaboration with the Department of Defense, can also enter into
44 blanket purchase agreements and other national contracts with drug manufacturers. These
45 agreements and contracts can result in the VA being able to negotiate prices below FSS prices.
46 The VA has also achieved lower prescription drug prices through its use of a national formulary
47 and prime vendors. In general, the VA is able to obtain more competitive pricing for drugs placed
48 on the VA national formulary. In addition, the VA uses prime vendors, also known as preferred
49 drug distributors, to purchase prescription drugs from manufacturers and have them delivered to
50 VA facilities. Prime vendors give the VA discounts for these prescription drugs. As of June 2004,
51 the prime vendor discount received by the VA amounted to five percent.

1 IMPACT OF EXPANDING VHA ELIGIBILITY TO ALL VETERANS

2
3 During the reference committee hearing, it was noted that the intent of Resolution 122 (A-09) was
4 to allow eligible patients access to the VA pharmacy benefit without requiring that they receive
5 medical care through the VA system. Under the current structure of VA health care, for most
6 veterans, VA providers must manage the health care of enrolled veterans, or “co-manage” the care
7 with a non-VA provider. To facilitate this care management, the VA uses My HealtheVet, a VA
8 Web site (www.myhealth.va.gov) that grants veterans, active duty soldiers, their dependents and
9 caregivers access to their online Personal Health Records and other information related to VA
10 benefits. Veterans also can use My HealtheVet to refill prescriptions online.

11
12 For veterans to have prescriptions filled by the VA that were prescribed by a non-VA provider,
13 they generally must be enrolled in VA health care and have an assigned Primary Care Provider.
14 These veterans must also provide their VA health care provider with their medical records from
15 their non-VA provider. Finally, the VA health care provider must agree with the medication
16 prescribed by the non-VA provider in order for the prescription to be filled at a VA pharmacy.

17
18 The traditional approach to give all veterans access to the VA pharmacy benefit has been viewed as
19 reopening enrollment for VA medical care among Priority Group 8 veterans. The VA estimates
20 that approximately 10 million veterans in Priority Group 8 are not currently enrolled. In its
21 December 2008 Budget Options document, the Congressional Budget Office (CBO) estimated that
22 reopening Priority Group 8 enrollment for five years, and then freezing new enrollments from that
23 group after 2014, would increase VA’s health care costs by roughly \$12 billion from 2010 to 2014
24 and \$29 billion from 2010 through 2019. In developing its cost estimate for reopening enrollment
25 for five years, CBO estimated that roughly 1.7 million new Priority Group 8 veterans would enroll
26 in the VA health care system by 2012, and that the VA would sustain the same costs for these
27 veterans as those currently enrolled in Priority Group 8.

28
29 If enrollment were reopened for Priority Group 8 veterans, CBO noted that most of these eligible
30 veterans would probably not seek care from the VA system. For those who choose to enroll, their
31 reasons for doing so would likely include reducing their out-of-pocket costs for prescription drugs.
32 Regardless, CBO stated that there likely would be a large increase of new enrollees in the VA
33 health system, which may result in longer wait times for many health care services, and enrolled
34 veterans may get referred to VA facilities further away from their homes to receive care. On the
35 whole, reopening enrollment could impact the care delivered to veterans in Priority Groups 1 to 7.

36
37 To lessen the impact on the VA’s primary care infrastructure, there have also been proposals to
38 create a stand-alone VHA pharmacy benefit, or require VA pharmacies to dispense medications on
39 prescriptions written by private physicians. Supporters of these alternatives note that these
40 approaches would streamline care provided to veterans, as veterans would no longer be required to
41 have a VA physician “co-manage” their care. Veterans, under these proposals, would have the
42 freedom to access their personal, non-VA physician and not have to seek redundant care that may
43 also be an inconvenient distance from their homes. Opponents have stressed that such proposals
44 have the potential to undermine the mission of the VHA, by transitioning the VHA from an
45 integrated health system to a drug store for veterans. Opponents also have noted that such
46 proposals may prompt additional confusion among veterans, who may increasingly seek care from
47 both VA and non-VA physicians. Opponents have stated that the proposal to remove the
48 requirement for veterans to have their care at least co-managed by a VA physician may undermine
49 the medical home model of the VA and the coordination of care provided to veteran enrollees, and
50 pose patient safety concerns. Finally, opponents note that the cost implications of these proposals
51 need to be considered.

1 MENTAL HEALTH ISSUES

2
3 The Council notes that Resolution 122 (A-09) originated from the psychiatric community. The
4 mental health services that are provided by the VHA medical benefits package include inpatient
5 and outpatient mental health services at VHA medical centers and community-based outpatient
6 clinics, counseling services for veterans provided at Vet Centers, and prescription drugs for the
7 treatment and management of mental health diagnoses.

8
9 Mental health diagnoses affect a sizeable number of VA enrollees and comprise a significant
10 amount of the VA health care budget. The VA estimates that in 2009, more than 20 percent of the
11 veterans accessing care had a mental health diagnosis. Approximately seven percent of VA
12 patients have been given a diagnosis of depression, and 14.3 percent of VA health care costs can be
13 attributed to veterans with depression. Schizophrenia affects 3.4 percent of veterans who use VA
14 health care services, and services for these veterans comprise 11.7 percent of total VA health care
15 costs. The Council notes that providing all veterans with access to the VA pharmacy benefit would
16 indeed provide another option for currently ineligible Priority Group 8 veterans with mental health
17 diagnoses who are aiming to reduce their prescription drug costs. However, it would not provide
18 them with access to the full spectrum of mental health services the VHA provides as part of its
19 medical benefits package.

20
21 RELATED AMA POLICY

22
23 AMA policy has historically supported providing veterans with improved access to and quality of
24 health care services. Policy H-510.995 (AMA Policy Database) supports providing the VA with
25 sufficient funding to allow its hospitals and clinics to provide proper care to veterans. Policies H-
26 510.990 and H-510.991 advocate for alternative approaches to providing quality health care to
27 veterans, including increasing VHA flexibility to provide services, and an option similar to the
28 Federal Employees Health Benefit Program. Policy D-510.999 supports the AMA continuing
29 discussions at the national level with the VHA and the Centers for Medicare and Medicaid
30 Services, to explore the need for and feasibility of legislation to address VHA's payment for
31 prescriptions written by physicians who have no formal affiliation with the VHA. Policy
32 D-510.994 calls for the AMA to advocate for improved access to medical care in the civilian sector
33 for returning military personnel when their needs are not being met by resources locally available
34 through the Department of Defense or the Veterans Administration. Policy H-510.989 supports the
35 recommendations of the President's Commission on Care for America's Wounded Warriors report
36 "Serve, Support, Simplify."

37
38 With regard to prescription drug prices, several AMA policies oppose the use of price controls
39 within the health care system (Policies H-155.962, H-180.978, H-330.898[5], H-330.938, and
40 H-40.969[2]). Instead, AMA policy favors controlling prescription drug prices through market-
41 based strategies (Policies H-110.998, H-110.996, D-110.993, and D-110.997). Policy H-125.991
42 contains standards for the operation of prescription drug formularies and formulary systems.
43 Policy H-110.997 supports assuring patient access to necessary drugs. Policies H-110.997 and
44 H-125.984 address generic drugs offering a lower cost, therapeutically equivalent alternative to
45 brand name drugs. In terms of federal agency negotiation of prescription drug prices, Policy
46 D-330.954 supports giving the Secretary of the Department of Health and Human Services the
47 authority to negotiate contracts with manufacturers of covered Medicare Part D drugs.

1 DISCUSSION

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3 The Council notes that the prescription drug component of the VHA medical benefits package
4 provided to veteran enrollees comprises a major reason many veterans choose to enroll in the
5 VHA, which does often lead to a significant reduction in their out-of-pocket costs for prescription
6 drugs. The reason for the significant cost savings, however, is a direct result of the ability of the
7 VA to negotiate prescription drug prices, while it has access to federal ceiling prices. In addition, a
8 major contributor to the lower prescription drug prices is the use by the VHA of a national
9 formulary, which critics have cited as restrictive. The Council notes that AMA Policy H-125.991
10 supports standards for prescription drug formularies and formulary systems.

11
12 As the Council outlined, proposals that could extend the VHA benefit to all veterans who wish to
13 use it likely could have unintended consequences. Reopening enrollment for VA medical care
14 among Priority Group 8 veterans could jeopardize the care provided to veterans in Priority Groups
15 1 to 7. In addition, alternative expansion proposals have the potential to undermine care
16 coordination and the medical home model of the VHA, and pose patient safety concerns.

17
18 The Council stresses that AMA policy advocates for flexibility in and alternative approaches to
19 how veterans receive health care services. For those veterans who have chosen to enroll in VA
20 health care, the Council found it striking that the results of the 2008 VHA enrollee survey showed
21 that a significant percentage of current VHA enrollees were unaware of the prescription drug
22 benefit available to them as part of the VHA medical benefits package. The Council believes that
23 continued and strengthened efforts by the VHA are needed to reach out to this population to ensure
24 that they are aware of the medical benefits package available to them, including prescription drugs.
25 Similarly, continued communications to veterans currently eligible for but not enrolled in VA
26 health care can be of value, to ensure that they are aware of the options available to them to access
27 health care services and related benefits, including prescription drugs.

28
29 RECOMMENDATIONS

30
31 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
32 122 (A-09) and the remainder of the report be filed:

- 33
34 1. That our American Medical Association (AMA) reaffirm Policy H-125.991, which
35 contains standards for the operation of prescription drug formularies and formulary
36 systems. (Reaffirm HOD Policy)
37
38 2. That our AMA encourage the Veterans Health Administration (VHA) to continue and
39 strengthen its outreach and educational efforts to veterans already enrolled in the health
40 system of the Department of Veterans Affairs (VA) to facilitate increased enrollee
41 awareness of the comprehensive medical benefits package available to them, including the
42 pharmacy benefit. (Directive to Take Action)
43
44 3. That our AMA encourage the VHA to continue and augment its communications with
45 veterans currently eligible for but not enrolled in VA health care to maximize veterans'
46 choice of mechanisms through which they can access medical care and related benefits,
47 including prescription drugs. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be \$1,859 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.