United States General Accounting Office

GAO

Report to the Chairman, Committee on Veterans' Affairs, House of Representatives

November 2002

VA HEALTH CARE

Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures

GAO-03-161

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-03-161, report to the Chairman, Committee on Veterans' Affairs, House of Representatives.

Why GAO Did This Study

The Department of Veterans Affairs (VA) spent about $3.0 billion on its outpatient pharmacy benefit in fiscal year 2001. After VA implemented the Veterans' Health Care Eligibility Reform Act in 1999, more veterans could use VA outpatient care, including the pharmacy benefit, than before. Increased eligibility contributed to a doubling of the number of Priority 7 veterans using VA health care. Priority 7 veterans are primarily veterans with higher incomes and no service-connected disability.

GAO was asked to report on Priority 7 veterans' use of the outpatient pharmacy benefit and VA's expenditures to provide this benefit. To do this, GAO reviewed VA pharmacy data on use and costs from fiscal years 1999 through 2001.

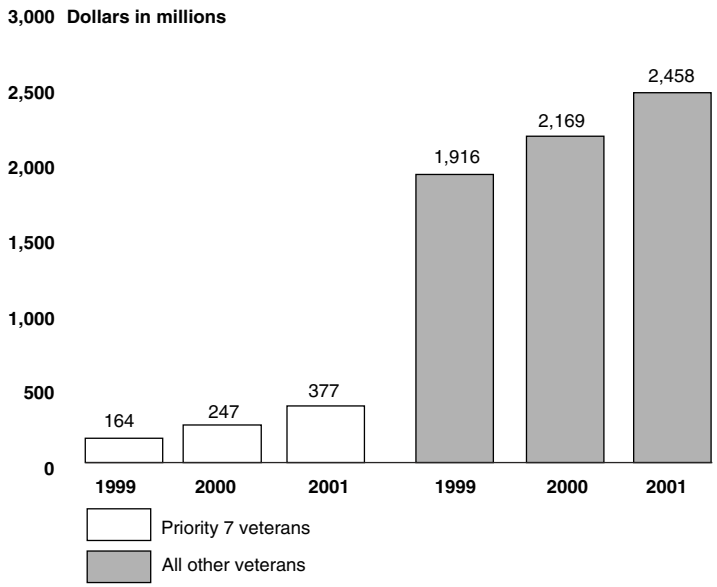
What GAO Found

VA spent $418 million on the outpatient pharmacy benefit for Priority 7 veterans in fiscal year 2001. VA pharmacy expenditures for Priority 7 veterans in this year were offset by copayments for drugs. In fiscal year 2001, VA collected approximately $41 million in drug copayments from Priority 7 veterans by charging $2 for a 30-day or less supply. This reduced VA's net expenditures to $377 million.

After VA implemented eligibility reform in 1999, Priority 7 veterans' use of the pharmacy benefit increased rapidly from about 11 million 30-day equivalents of drugs or supplies in fiscal year 1999 to about 26 million 30-day equivalents in fiscal year 2001. This resulted in more than a doubling of VA's net pharmacy expenditures for these veterans. Yet, net pharmacy expenditures for Priority 7 veterans remain a relatively small share of VA's total net spending for outpatient drugs and supplies. Most of VA's increased pharmacy spending during this period was for all other veterans--those with service-connected disabilities, low incomes, or certain other recognized statuses such as former prisoners of war. In fiscal year 2001, 87 percent of VA's net pharmacy expenditures were for these veterans.

VA agreed with GAO's findings regarding outpatient pharmacy use and expenditures.

Net Expenditures for VA's Outpatient Pharmacy Benefit Less Drug Copayments, Fiscal Years 1999-2001



Source: GAO analysis of VA data.

www.gao.gov/cgi-bin/getrpt?GAO-03-161.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

Contents

Abbreviations

DOD	Department of Defense
PBM	Pharmacy Benefits Management
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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United States General Accounting Office
Washington, DC 20548

November 8, 2002

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) spent about $3.0 billion on drugs, supplies, and other associated costs to provide an outpatient pharmacy benefit to veterans in fiscal year 2001.[1] VA's pharmacy benefit provides prescription drugs, over-the-counter drugs, and medical supplies to veterans receiving VA health care. VA's cost for providing the pharmacy benefit includes the cost of drugs and supplies, pharmacy personnel, and other operational expenses. In recent years, expenditures for the outpatient pharmacy benefit have become a larger portion of VA's medical care budget, rising from 12 percent in fiscal year 1999 to 14 percent in fiscal year 2001.[2] The number of veterans treated by VA has risen during this time from 3.1 million to 3.8 million, in part due to broadening health care eligibility that began in fiscal year 1999. One result of this broadened eligibility was an increase in the number of Priority 7 veterans treated—those veterans primarily with higher incomes and no service-connected disability.[3]

You requested that we provide information on the overall dimensions of Priority 7 veterans' use of the pharmacy benefit to better inform the Committee's oversight of VA health care. To better understand the impact of the growing number of Priority 7 veterans treated by VA, we examined

[1]In addition, VA spent approximately $250 million for inpatient drugs and supplies in fiscal year 2001.

[2]Drug expenditures are increasing in health care generally, not just in VA. Expenditures have risen for a number of reasons including increased use of drugs, the substitution of higher priced new drugs for lower priced existing ones, and more direct-to-consumer advertising by manufacturers.

[3]Priority 7 veterans are veterans who have either incomes or net worths above a certain threshold, no service-connected disability that results in monetary benefits from VA, and no other recognized statuses such as former prisoners of war. The income threshold was $23,688 for veterans without dependents in 2001. A service-connected disability is an injury or disease that was incurred or aggravated while on active military duty.

(1) Priority 7 veterans' use of the VA outpatient pharmacy benefit, (2) the amount of VA expenditures for providing this benefit to Priority 7 veterans, and (3) whether the proportion of Priority 7 veterans' pharmacy use varies across VA's 22 regional health care networks.[4]

To perform our work, we reviewed documents and analyzed data from fiscal years 1999 through 2001 that VA provided on the use of the pharmacy benefit, VA's expenditures, and revenues VA generated from copayments it charges certain veterans for drugs. We defined pharmacy use in 30-day equivalents to standardize drug and supply volume across fiscal years and networks because prescriptions can be written for different lengths of time such as 30, 60, or 90 days. We tested the reliability of the data and determined they were adequate for our purposes. We also interviewed VA officials at headquarters, other locations, and Network 2 (Albany) to better understand the pharmacy benefit and VA's data on pharmacy use, expenditures, and revenues from drug copayments. For a complete description of our scope and methodology, see appendix I. Our work was performed from March 2002 through November 2002 in accordance with generally accepted government auditing standards.

Results in Brief

Priority 7 veterans used 26.4 million 30-day equivalents of drugs and supplies in fiscal year 2001, up from 10.7 million 30-day equivalents in fiscal year 1999. During this period, the number of Priority 7 veterans VA treated doubled from about 400,000 to over 800,000. This growth was the most important factor contributing to the rapid increase in Priority 7 veterans' use of the pharmacy benefit. In addition, for Priority 7 veterans who received at least one drug or supply, the average number of drugs and supplies defined in 30-day equivalents increased from 33 to 38 per year.

VA spent $418 million on the outpatient pharmacy benefit for Priority 7 veterans in fiscal year 2001. These expenditures were offset by Priority 7 copayments for drugs. This offset reduced VA's net expenditures to $377 million in fiscal year 2001, more than double the amount VA spent for this purpose in fiscal year 1999. Moreover, the rate of growth for Priority 7 net pharmacy expenditures was more than four times that for all other veterans treated by VA. Even though net expenditures for Priority 7 veterans' use of the pharmacy benefit increased rapidly, the proportion of

[4]VA now has 21 networks. In January 2002, VA combined Network 13 (Minneapolis) and Network 14 (Lincoln) to form a new network.

VA expenditures for this purpose was only 13 percent of total net pharmacy expenditures in fiscal year 2001. By comparison, 22 percent of VA's patients were Priority 7 veterans in that year. The remaining 87 percent of net expenditures were for other veterans. Most of VA's increased pharmacy spending from fiscal year 1999 to fiscal year 2001 was for these veterans.

The proportion of pharmacy use accounted for by Priority 7 veterans varies substantially across the networks. Priority 7 veterans' use of the pharmacy benefit ranged from 9 percent of all drugs and supplies dispensed in Network 20 (Portland) to 29 percent of all drugs and supplies dispensed in Network 3 (Bronx) in fiscal year 2001. This unevenness in patient use results in disproportionately higher costs to treat Priority 7 veterans as a group in networks that have larger proportions of Priority 7 veterans. VA does not take this unevenness into account when providing financial resources to its networks each year.

In commenting on the draft report, VA agreed with our findings regarding outpatient pharmacy use and expenditures.

Background

The Veterans' Health Care Eligibility Reform Act of 1996 simplified eligibility standards for veterans in need of hospital and outpatient care.[5] Among other things, the act authorized VA to provide medical care services not previously available to veterans without service-connected disabilities or low incomes. As required by the act, VA established seven priority categories for enrollment to manage access in relation to available resources. A higher priority for enrollment is given to veterans who have service-connected disabilities, lower incomes, or other recognized statuses such as former prisoners of war. These higher priority enrollees are ranked in priority order from 1 through 6. The lowest enrollment priority is given to veterans not included in priorities 1 through 6, referred to as Priority 7 veterans. The act requires VA to restrict enrollment consistent with these enrollment priorities if sufficient resources are not available to provide care that is timely and acceptable in quality for all priority groups.

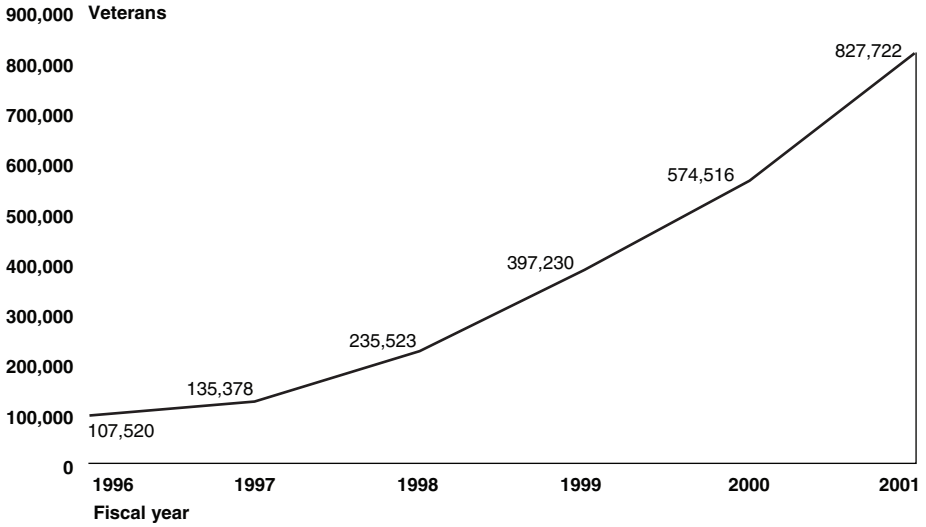
The new enrollment system, implemented in fiscal year 1999, resulted in the expansion of medical benefits to some priority groups, including Priority 7 veterans. Before eligibility reform, most veterans now classified

[5]Pub. L. No. 104-262 §§ 101, 104.

as Priority 7 veterans could only receive VA outpatient services, including prescription drugs, if these services were related to hospital care received at the VA. Priority 7 veterans can now receive prescription drugs, over-the-counter drugs (e.g., aspirin, cough syrup, vitamins) and medical and surgical supplies (e.g., syringes, alcohol wipes) on an outpatient basis. To obtain these drugs or supplies, veterans must be enrolled in and receiving health care at VA. If a veteran has a prescription from a non-VA provider, the VA pharmacy will only provide the drug or supply if the prescription is rewritten first by a VA provider except in certain circumstances such as when VA has a sharing agreement with the Department of Defense (DOD). Some veterans, including Priority 7 veterans, are charged a copayment for drugs, which VA increased in February 2002 from $2 to $7 for a 30-day or less supply of drugs. There is no copayment for supplies.

The number of Priority 7 veterans treated has increased significantly and represents the most rapidly growing share of the veterans VA treats. From fiscal year 1996 through fiscal year 2001, the number of Priority 7 veterans treated has increased by almost eightfold (see fig. 1). Priority 7 veterans represented 22 percent of VA's workload in fiscal year 2001. According to VA projections, growth in Priority 7 workload is expected to continue to increase at least through fiscal year 2010.

Figure 1: Growth of Priority 7 Veterans Treated, Fiscal Years 1996 through 2001



Note: Because the Priority 7 classification was not developed until fiscal year 1999, we used VA's previous classification that most closely represents this priority group, Category C. The Category C data we used for fiscal years 1996 through 1998 slightly underestimate the number of Priority 7 veterans for those years.

Source: VA.

Priority 7 veterans over the age of 65 have contributed the most to this growth in VA patient workload. Between fiscal years 1999 and 2001, the proportion of Priority 7 users age 65 or over grew from 52 percent to 65 percent. In contrast, the proportion of veterans age 65 or over among other veteran users grew from 45 percent to 47 percent during this period. Older Priority 7 veterans could be attracted to VA because many persons in this age group lack or have limited prescription drug coverage from other sources. Medicare, the federal health financing program and the primary health insurer for persons over the age of 65, has a restricted outpatient prescription drug benefit.[6] Over one-third of Medicare beneficiaries have no prescription drug coverage, and those beneficiaries

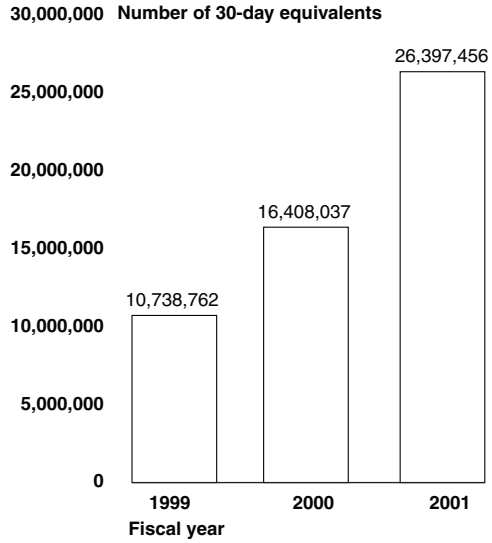
[6]Medicare's benefit largely covers those drugs that cannot be self-administered or require certain medical equipment to be administered. Medicare part B (which covers physician and other outpatient services) covers roughly 450 drugs that amounted to almost $4 billion including beneficiary copayments in 1999. See U.S. General Accounting Office, *Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Cost*, GAO-01-1118 (Washington D.C.: Sept. 21, 2001).

with coverage are sometimes exposed to gaps in coverage and high out-of-pocket costs.[7]

Priority 7 Veterans' Use of Pharmacy Benefit Has Grown

Priority 7 veterans' use of the pharmacy benefit has more than doubled from fiscal year 1999 to fiscal year 2001 (see fig. 2). Their use included prescription drugs, over-the-counter drugs, and supplies each defined in 30-day equivalents. In fiscal year 2001, 82 percent of the items were prescription drugs.[8]

Figure 2: Growth in Priority 7 Veterans' Use of the Pharmacy Benefit, Fiscal Years 1999 through 2001



Note: Drugs and supplies are measured in 30-day equivalents.

Source: GAO analysis of VA data.

[7]See Mary A. Laschober, Michelle Kitchman, Patricia Neuman, Allison A. Strabic, *Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999*, Health Affairs (Feb. 27, 2002) and U.S. General Accounting Office, *Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives*, GAO-02-533T (Washington, D.C.: Mar. 14, 2002).

[8]In addition to prescription drugs, 14 percent of the prescriptions were for over-the-counter drugs, 4 percent for supplies, and less than 1 percent for other drugs such as medicines used in research studies, and drugs whose classification was not listed in VA's pharmacy database.

The most important factor contributing to Priority 7 veterans' increased use of the pharmacy benefit was the increase in the number of Priority 7 patients treated between fiscal years 1999 and 2001. We estimate that about 74 percent of the increase in Priority 7 veterans' use of the pharmacy benefit resulted from the increase in Priority 7 veterans treated. This estimate held constant the number of drugs and supplies provided per veteran and the proportion of veterans using the pharmacy benefit.

Two other factors contributed to the growth in Priority 7 veterans' use of the pharmacy benefit. The most important of the two was an increase in the number of drugs and supplies used per Priority 7 veteran. During this period, for Priority 7 veterans who received at least one drug or supply, the average number of drugs and supplies defined in 30-day equivalents increased from 33 to 38 per year. The other factor was an increase in the proportion of Priority 7 veterans using the pharmacy benefit from 81 to 83 percent.

For similar reasons, other veterans' use of the pharmacy benefit also increased during this period. An increase in the number of these veterans accounted for about 53 percent of the increased use of the pharmacy benefit. Another contributing factor was the increase in the average number of 30-day equivalents per year provided to these veterans, which rose from 49 to 53. Finally, the proportion of these veterans using the pharmacy benefit increased from 87 to 89 percent.

VA Spent Over $400 Million on the Outpatient Pharmacy Benefit for Priority 7 Veterans

VA spent $418 million on the outpatient pharmacy benefit for Priority 7 veterans in fiscal year 2001 (see table 1),[9] more than double the amount VA spent for these veterans' drugs and supplies in fiscal year 1999. Moreover, the rate of growth for Priority 7 pharmacy expenditures was more than four times that for other veterans. The primary factor responsible for this growth in spending for Priority 7 veterans is the increase in the number of Priority 7 veterans using the pharmacy benefit. Growth in pharmacy expenditures would have been higher if VA had not been able to keep the

[9]VA's Office of Inspector General estimated that VA's direct cost of pharmaceuticals was $200 million in fiscal year 1999, based on projections using Network 8 (Bay Pines) experiences. For a description of its methodology, see Office of Inspector General, Department of Veterans Affairs, *Audit of Veterans Health Administration (VHA) Pharmacy Copayment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans*, Report Number 99-00057-4 (Washington D.C.: Dec. 20, 2000). We were able to develop a more precise estimate by using pharmacy data from all of VA's networks.

average expenditure for a 30-day supply of drugs and supplies relatively constant between fiscal years 1999 and 2001.[10] During this period, VA spent on average about $17 each year for a 30-day supply of drugs and supplies for Priority 7 veterans. Excluding pharmacy personnel and other operational expenses, VA spent about $12 to $13 on average for a 30-day supply of drugs and supplies for these veterans between fiscal years 1999 and 2001.

Table 1: Expenditures for VA's Outpatient Pharmacy Benefit, Fiscal Years 1999 through 2001

Dollars in millions			
Outpatient pharmacy expenditures	**1999**	**2000**	**2001**
Priority 7 veterans	$178	$271	$418
All other veterans	$1,977	$2,245	$2,554
Total	**$2,155**	**$2,516**	**$2,972**

Note: The categories include expenditures for drugs and supplies, pharmacy personnel, and other operational expenses. The expenditures do not include offsets from drug copayments.

Source: GAO analysis of VA data.

VA's expenditures for the pharmacy benefit are offset by Priority 7 veterans' copayments for drugs. This offset reduced VA's net expenditures to $377 million for providing drugs and supplies to Priority 7 veterans in fiscal year 2001 (see table 2). VA collected approximately $41 million in drug copayments from Priority 7 veterans in fiscal year 2001 by charging $2 for a 30-day or less supply.[11] VA copayment collections will offset net pharmacy expenditures even more for Priority 7 veterans in the future because the copayment amount increased to $7 in February 2002. If the copayment had been $7 in fiscal year 2001, VA could have collected about $100 million more from these veterans.

[10]VA has taken a number of actions to reduce pharmacy spending. These actions include the establishment of formularies, use of different contract arrangements to purchase drugs, use of mail-order pharmacies, and use of joint procurement with DOD. See U.S. General Accounting Office, *VA and DOD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges*, GAO-02-969T (Washington, D.C.: July 22, 2002).

[11]VA collected about 90 percent of what it billed from drug copayments in fiscal year 2001.

Table 2: Net Expenditures for VA's Outpatient Pharmacy Benefit Less Drug Copayments, Fiscal Years 1999 through 2001

Dollars in millions			
Net outpatient pharmacy expenditures	**1999**	**2000**	**2001**
Priority 7 veterans	$164	$247	$377
All other veterans[a]	$1,916	$2,169	$2,458
Total	**$2,080**	**$2,417**	**$2,835**

Note: Numbers in table may not add to total outpatient pharmacy expenditures because of rounding.

[a]Veterans with service-connected disabilities rated greater than 50 percent, receiving drugs for service-connected conditions, or with incomes lower than the VA pension level are exempt from paying drug copayments.

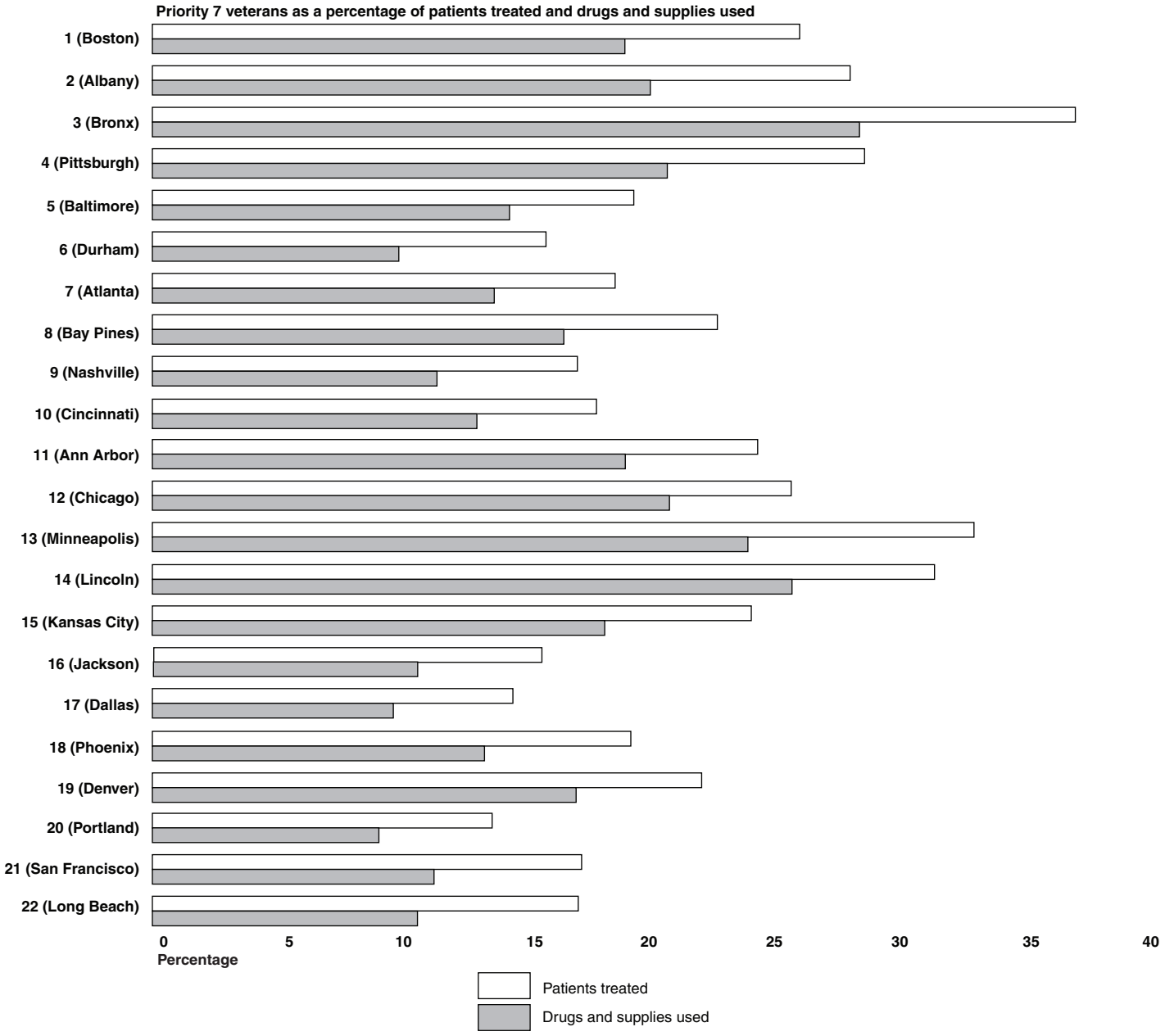
Source: GAO analysis of VA data.

Even though net expenditures for Priority 7 veterans' use of the pharmacy benefit have more than doubled from fiscal year 1999 to 2001, the proportion of VA expenditures for this purpose was only 13 percent of total net pharmacy expenditures in fiscal year 2001. By comparison, 22 percent of VA's patients were Priority 7 veterans in that year. The remaining 87 percent of VA's net spending for the pharmacy benefit was for other veterans. This amounted to about $2.5 billion. The rate of growth in net pharmacy benefit expenditures for Priority 7 veterans was more than four times that for other veterans from fiscal year 1999 to fiscal year 2001, but the net increase in spending for Priority 7 veterans represented only 28 percent of all increased spending during that period.

Proportion of Priority 7 Pharmacy Use Varies Substantially Across Networks

The proportion of pharmacy use accounted for by Priority 7 veterans varies substantially across the networks. Priority 7 veterans' use of the pharmacy benefit ranged from 9 percent of all drugs and supplies dispensed in Network 20 (Portland) to 29 percent of all drugs and supplies dispensed in Network 3 (Bronx) in fiscal year 2001. The unevenness among networks in Priority 7 veterans' use of drugs and supplies tracks closely with the unevenness among networks in Priority 7 patients treated (see fig. 3).

Figure 3: Priority 7 Veterans by Network: Proportion of Patients Treated and Drugs and Supplies Used, Fiscal Year 2001



Note: Drugs and supplies are measured in 30-day equivalents.

Source: GAO analysis of VA data.

This unevenness in patient use results in disproportionately higher costs to treat Priority 7 veterans as a group in networks that have larger proportions of Priority 7 veterans. As we discussed in a prior report,[12] VA does not take this unevenness into account when providing financial resources each year to its networks. VA provides financial resources to its networks based primarily on the number of patients the networks treat, but VA excludes most Priority 7 veterans in determining the number of patients treated. Initially, VA excluded most Priority 7 veterans in this process because of their small numbers and the expectation that collections from these veterans for drug copayments and from third-party payments from their health care insurance plans, where applicable, would cover the majority of Priority 7 veterans' costs. However, collections covered only 24 percent of Priority 7 veterans' costs in fiscal year 2000. We recommended that VA include all patients that it serves in its network resource allocation model. Although VA concurred, it has not implemented this recommendation.

Agency Comments and Our Evaluation

In commenting on the draft report, VA agreed with our findings regarding outpatient pharmacy use and expenditures. VA noted that the key factor in increased outlays for pharmaceuticals from fiscal year 1999 to 2001 was the increased number of veterans treated, rather than other factors such as medication inflation or intensity of therapy.

VA also commented on the policy implications of filling privately written prescriptions, which was recommended in a VA Office of Inspector General (OIG) report we cited. However, we included the OIG report for the sole purpose of citing its estimates of the direct cost of pharmaceuticals based on work in Network 8 (Bay Pines). We did not address other issues in the OIG report that VA discussed in its comments.

VA agreed that Priority 7 veterans' use of the pharmacy benefit varies across networks and that most of these veterans are not included in its workload calculation when allocating financial resources to its networks. Although VA concurred with the recommendation in our February 2002 report to better align measures of workload with actual workload served, regardless of veteran priority group, it said it is considering how best to address this recommendation. VA continues to be concerned that

[12]See U.S. General Accounting Office, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, GAO-02-338 (Washington D.C.: Feb. 28, 2002).

inclusion of Priority 7 veterans in the workload calculation would create financial incentives for networks to seek out more Priority 7 veterans and come at the expense of service-connected and low-income veterans. As we noted in the prior report, networks with a disproportionate number of Priority 7 veterans already have fewer resources to treat service-connected and low-income veterans on a per-patient basis. Including Priority 7 workload in fiscal year 2003 allocations to networks would provide more comparable resources for treating service-connected and low-income veterans in all networks. VA's comments are in appendix II.

We are sending copies of this report to the Secretary of Veterans Affairs, interested congressional committees, and other interested parties. This report is also available at no charge on GAO's Web site at http://www.gao.gov. In addition, we will make copies of the report available to others upon request.

If you or your staff have any questions about this report, please call me at (202) 512-7101. Another contact and key contributors are listed in appendix III.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Scope and Methodology

We reviewed the Department of Veterans Affairs (VA) outpatient pharmacy benefit for fiscal years 1999 through 2001 and focused on Priority 7 veterans treated by VA to examine (1) Priority 7 veterans' use of the VA outpatient pharmacy benefit, (2) the amount of VA expenditures for providing this benefit to Priority 7 veterans, and (3) whether the proportion of Priority 7 veterans' pharmacy use varies across VA's 22 regional health care networks.

To address these objectives, we obtained documents and data on the use of the VA pharmacy benefit and expenditures from fiscal years 1999 through 2001 primarily from four VA offices. From the Veterans Health Administration's (VHA) Office of Policy and Planning we obtained the numbers of enrollees and veterans treated by network and priority group. Based on our request, this office also provided data on veterans' enrollment status to VA's Pharmacy Benefits Management (PBM) Strategic Healthcare Group to match with its pharmacy data. VA's PBM Strategic Healthcare Group provided a summary dataset that detailed pharmacy use and expenditures for drugs and supplies by veterans' enrollment status from fiscal years 1999 through 2001. VHA's Revenue Office in the newly created Chief Business Office provided data on the amount of collections VA obtained from veterans' copayments for drugs. This office also provided information on the costs of pharmacy personnel and other operational expenses. VA's Decision Support System program office in Bedford, Massachusetts verified these numbers.

To do our analysis, we used the number of 30-day equivalents instead of the number of unique prescriptions to measure pharmacy use based on guidance provided by officials from VA's PBM Strategic Healthcare Group. The 30-day equivalent measure standardizes drug and supply volume, which is necessary because veterans can receive prescriptions in various days of supply including quantities sufficient for 30, 60, or 90 days.

To determine the total cost of VA's outpatient pharmacy benefit we added the cost of drugs and supplies obtained from VA's PBM Strategic Healthcare Group with personnel and other operations costs that we obtained from VHA's Revenue Office. To calculate VA's personnel and operations costs, we multiplied the number of unique prescriptions dispensed times $7.28 for fiscal years 1999, 2000, and 2001. VA calculated the $7.28 figure using fiscal year 2000 data to estimate expenditures based on factors including: (1) salary costs of pharmacy personnel who dispense the prescription, consult with veterans about their prescription, and support the pharmacy operations, (2) materials needed to fill the prescription including bottles and drug labels, (3) a share of the facilities'

overhead, often allocated based on square footage, including electricity and maintenance, and (4) a share of headquarters' overhead and expenses. To reduce rounding error in our estimates of VA's personnel and operations costs, we recalculated the $7.28 estimate with information provided by VA and used the precise number in our calculations.

We tested VA computer-based data used in our analysis and concluded that they were adequate for our purposes. To do this, we assessed the reliability of data that we obtained from VA that were used in our analyses. When we identified inconsistencies between databases, we tried to resolve them by interviewing officials responsible for creating or maintaining the databases, updating the databases with additional information VA provided, and requesting special data runs with parameters that we specified.

We interviewed officials in VHA's Office of Policy and Planning who were knowledgeable about VA's enrollment database to assess its reliability. They told us that when they analyze data in which some veterans do not have an enrollment priority indicated in the database, for analytical purposes they assign a priority to these veterans using a computer algorithm. This algorithm assigns a priority to veterans who do not have one in the database. In most cases, the algorithm assigns the priority the veteran had in the previous year. VA officials told us that it is necessary to use such an algorithm because a veteran's priority could change, for example, because of a change in income. When the information is not updated soon enough in a database, no priority status is indicated. In such cases, we relied on data provided to us by VA that used its algorithm to identify the number of Priority 7 veterans using the pharmacy benefit.

We took several steps to validate that the pharmacy data provided by VA's PBM Strategic Healthcare Group accurately portrayed the use of the pharmacy benefit and its expenditures. We interviewed officials from VA's PBM Strategic Healthcare Group and a pharmacy official from Network 2 (Albany) to determine if price data for drugs and supplies are automatically updated. We found that VA does not have a mechanism to automatically update prices in the PBM pharmacy database. Because we used these price data to develop our estimate of expenditures, we tested the reliability of this field in the PBM pharmacy database. To do this, we took a random sample of 20 prescription records from a random sample of 33 VA drugs or supplies. For each prescription record in the sample, we compared the price in the PBM pharmacy database with the lowest price that VA would have been able to purchase the drug or supply for on that date. We determined the lowest price for the date it was dispensed by

using VA's database of contract prices for drugs and supplies. We then calculated the total expenditure for each drug or supply to determine whether the expenditures for these drugs or supplies were over- or understated. We determined that VA's numbers for total drug and supply expenditures for Priority 7 veterans were accurate for our purposes.

We also conducted a literature review of works published within the last 3 years. The literature search included the MEDLINE and AGELINE databases and relied on publications from other federal agencies. The search focused on finding information regarding prescription drug prices, current clinical practice regarding the use of prescription drugs, and insurance coverage for prescription drugs, particularly for persons over the age of 65.

We performed our review from March 2002 to November 2002 in accordance with generally accepted government auditing standards.

Appendix II: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 31, 2002

Ms. Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues
Health Care Team
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA HEALTH CARE: Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures*** (GAO-03-161) and agrees with your findings and conclusions. GAO's report validates that the key factor in increased outlays for pharmaceuticals in FY 1999 to 2001 relates primarily on the increased number of patients treated receiving medications, rather than such other factors as medication inflation or intensity of therapy. While those factors are drivers, the report clearly shows that the overwhelming increase in pharmacy costs results from the increase in the number of patients treated. In the case of Priority 7 veterans, an estimated 74 percent of the increase in use of pharmacy benefits is due to the increase in the number of those veterans being treated by VA.

GAO cites an FY 2000 Office of Inspector General (OIG) report that recommended VHA consider filling privately written prescriptions. The then Under Secretary for Health stated that concerns about quality of care, financial and workload implications, and the still unknown consequences of Medicare drug benefit legislation precluded concurrence with the OIG's recommendation. Although the policy implications of several variations of pharmacy-only benefits are currently being considered in VA, the concerns cited in response to the OIG's report are still valid. Also, in the OIG's report, it does not appear that all of the associated costs of processing and filling prescriptions were fully addressed. The Veterans Health Administration's (VHA) ability to meet the capacity to fulfill the potential workload were OIG's recommendation implemented is a serious concern. This concern is heightened by plans for VA and the Department of Defense to use existing excess capacity at VA's Consolidated Mail-Out Pharmacies.

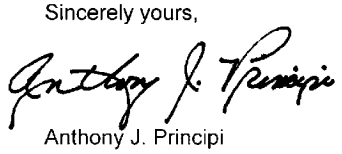
GAO also points out that both VA's Inspector General and GAO have recommended in their previous work that VA address the variations in the proportion of Priority 7 veteran use of VA pharmacy benefits across networks. They recommended including all Priority 7 veterans not currently in the Basic Vested Care category to better align actual enrollment and the allocation of resources in each network. Such inclusion would create financial incentives to seek out more Priority 7 veterans instead of

veterans with service-connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless) -- veterans who comprise VA's core health care mission.

VA must also consider that allocating these resources is a zero sum circumstance. Increased resources for Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. Allocation of resources to areas with a disproportionate percentage of Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and low-income veterans. VHA is carefully weighing how to best address OIG's and GAO's report recommendations. Earlier this month, the RAND Corporation issued a report on VERA, and VHA is currently evaluating it. The report should assist VHA in making decisions on VERA in time for the FY 2003 allocation.

Thank you for the opportunity to comment on your draft report.

Sincerely yours,



Anthony J. Principi

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Musselwhite, (202) 512-7259

Acknowledgments

In addition to the contact named above, Thomas A. Walke, Matthew L. Puglisi, Kristin M. Wilson, and Vanessa R. Taylor made key contributions to this report.

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