DEPARTMENT OF VETERANS AFFAIRS PROVIDING CERTAIN VETERANS WITH A PRESCRIPTION-ONLY HEALTH CARE BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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DEPARTMENT OF VETERANS AFFAIRS PROVIDING CERTAIN VETERANS WITH A PRESCRIPTION-ONLY HEALTH CARE BENEFIT

TUESDAY, MARCH 30, 2004

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 10 a.m. in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Rodriguez, Snyder, Strickland, Boozman, Berkley, Bradley, Beauprez, Brown-Waite, and Hooley.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. Ladies and gentlemen, good morning. This is a hearing of the Subcommittee on Health of the Committee on Veterans' Affairs.

This morning the hearing will be on a prescription-only health care benefit for veterans. This is an information hearing, this is not a legislative hearing. We do not have a legislative proposal before us, although many legislative proposals have been offered to the subcommittee and to the committee in the past.

But as I recall, the history of those proposals, for one reason or another, they never quite filled the bill. And as a consequence, they did not go forward.

I have a prepared statement, which I will request be placed in the record as read. But to summarize the issue briefly, there are veterans today who are Medicare-eligible. There are veterans today who have access to health care through a provider other than the Veterans Administration who have been seeking access to the VA system for pharmacy benefits.

And in those cases, it has been the policy of the Veterans' Administration to schedule them for an examination, which sometimes takes several months, sometimes takes the better part of the year.

And yet, all these veterans really want is to access the VA for a pharmacy benefit so that their physician or their health care provider will manage their health care situation. But as veterans, they will take advantage of the VA pharmacy to acquire those prescription drugs. It is my understanding that on an annualized basis, the

cost of those additional examinations can exceed $1 billion—$1 billion.

And it seems to me that at a time when we are balancing the competition for scarce resources, that this duplication of effort makes little sense, and that if this committee and the veterans' service organizations and the Veterans' Administration could somehow get our heads together to frame a program that would be a cost-plus program so that these veterans—many of them sevens and eights—could access the system at cost, perhaps with an administration fee, that it would serve them very well, that it would not take away from those scarce resources that the Veterans Administration needs for its primary, secondary, and tertiary care programs, and it would accommodate those veterans who are currently waiting in line to try to get that pharmacy benefit.

So, this issue has preyed on my mind for several years. It seems that somewhere in all of this there must be a logical solution, and that is why I decided to proceed today, even absent a specific legislative proposal, to have this subject matter hearing on this subject.

And now, I would like to ask if my friend and colleague, Mr. Rodriguez, has an opening comment that he would like to make.

[The prepared statement of Chairman Simmons appears on p. 43.]

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to thank you for holding this timely hearing. And let me also just indicate that at the same time that the VA provides some prescription discounts for our veterans, it doesn't make any sense, as you have indicated, to have veterans out there that could have access to prescription benefit that have to go through a lengthy and unnecessary process. And I agree with you that we might be able to come up with some kind of compromise there, and be able to make something happen.

But it also doesn't make any sense that the VA has been able to also make some arrangements with the pharmaceutical companies to lower drug costs, but Medicare is not allowed to do that. It just doesn't make any sense.

Last year I know we had an opportunity to discuss various proposals to improve the availability and eligibility of pharmaceutical services provided by the Department of Veterans Affairs. I am a cosponsor of one of the measures that we discussed, which was filed by ranking member Lane Evans, which is H.R. 1309.

This bill would allow veterans, as Medicare beneficiaries, to purchase drugs prescribed by non-VA physicians from the VA. In testimony regarding Mr. Evans' bill, the VA stated that Mr. Evans' efforts to provide a less expensive alternative for Medicare-eligible veterans to obtain pharmaceutical drugs were unnecessary because the Medicare reforms were being developed at that time. Since we were looking at some kind of Medicare reform during that time, we postponed H.R. 1309.

Since Congress approved the Medicare legislation, however, the VA has completed an analysis of its impact on the VA and veterans, and determined that there is a very minimal impact. I am interested to hear, if in light of this finding, that the VA has reconsidered its position on H.R. 1309.

And also, Mr. Chairman, those who support H.R. 1309 decided to postpone decisions on the measure while we worked out the details of the prescription drug benefit that would be widely available to our seniors under Medicare. Unfortunately, as we—it must be pretty clear to everyone now even at this early date—that the bill Congress ultimately passed does not address the needs of all our seniors. And if it had, then we would not be having the discussions about the VA's role in helping our senior veterans.

In fact, the VA has been addressing this lack of prescription drug benefits with a transitional drug benefit offered to certain veterans whom it determined were likely to wait more than 6 months for an appointment. And so we still have situations where veterans have to wait 6 months, and somehow we need to figure out how we can fix this problem.

Of course, we also know that the problems with waiting times really must be addressed by Congress in appropriating more funds to the VA. And we all know that the staffing problems that exist are also serious.

In assessing any of the legislative proposals on the table, it is important to understand the demand for and cost of a the new benefit. The VA must have a way, outside of our normal appropriation process, to pay for a benefit that could conceivably double its pharmacy workload.

I know in Mr. Evans' bill, H.R. 1309, those funds come from Medicare. I think that could be an alternative that we ought to look at further and see how Medicare could play a role in funding prescription drugs for our veterans.

I look forward to the testimony we're going to be hearing from our three panels. Thank you.

[The prepared statement of Congressman Rodriguez appears on p. 46.]

Mr. SIMMONS. I thank the gentleman. And if we can proceed, we will hold further comments until our first panel, if that is agreeable.

Today, we will hear testimony in panel one from my friend and colleague, Ed Banas, who is commander of the Veterans of Foreign Wars, and a constituent living in eastern Connecticut. And I see Ed there.

He is accompanied by Dr. Cornelio Hong, a practicing physician from Norwich, CT, who has also served in uniform—I believe in the war in the Gulf in the early 1990s—and he will provide a practitioner's perspective on why VA should be providing a prescription drug service to our nation's veterans.

Following the first panel, we will be hearing from the Department of Veterans Affairs on its efforts to provide transition pharmacy benefits to ease the pressure on veterans while waiting for VA health care.

At this point, I will ask Dr. Hong and National Commander Banas if they would come to the witness table, and I thank them for their participation here today. The two of them have not only served their country with distinction in uniform, but they continue that service as members of the Veterans of Foreign Wars of the United States of America.

Welcome to you both, and Commander Banas, please proceed.

STATEMENTS OF EDWARD S. BANAS, SR., COMMANDER-IN-CHIEF, VETERANS OF FOREIGN WARS; AND CORNELIO R. HONG, M.D., NORWICH INTERNAL MEDICINE, NORWICH, CT

STATEMENT OF EDWARD S. BANAS

Mr. BANAS. Thank you very much. Mr. Chairman, members of this subcommittee, as the commander-in-chief of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our ladies' auxiliary, I would like to thank you for this opportunity to testify today.

It has indeed been an honor working with the members of this subcommittee, especially with the chairman, whom I am proud to call my Congressman and my friend. And I thank everyone on this committee and their hardworking staffs for the dedication to the important issues at hand.

The central issue of today's hearing, and the draft bill under consideration, the VFW Pharmacy Fairness Act is what can be done to improve veterans' access to pharmaceuticals. The Department of Veterans Affairs offers an outpatient prescription drug benefit to enrolled veterans as part of its uniform health care package.

Comparable to prescription drug plans offered by numerous health care insurers, this earned benefit is very important to many veterans, especially those without any prescription drug coverage.

Currently, VA provides a 30-day supply of pharmaceuticals for a $7 co-payment to enrolled veterans. The co-payment is waived for prescriptions related to treatment of service-connected disabilities. Additionally, veterans with a 50 percent or higher disability rating, or those who are indigent are not required to make co-payments.

Unfortunately, present department procedure drastically limits veterans' access to VA pharmaceuticals. Current law prohibits VA from filling prescriptions from duly licensed physicians who do not practice within the VA health care system.

Due to the lengthy delays in scheduling appointments, many veterans have turned to their private physicians outside the VA health care system. At its peak, there were nearly 300,000 veterans waiting 6 months or more for a medical appointment. We believe that many of these veterans became discouraged with the wait, and were effectively forced to seek care outside VA.

Even now, despite improvements, there are still thousands of veterans waiting 6 months or more for appointments. Many of them have established solid relationships in histories with their outside physician.

A veteran who obtains care from his or her private physician, whether for convenience, out of familiarity, or some other reason, is unable to have that prescription filled through VA, that veteran, despite already having a diagnosis, is forced to wait for an appointment with a VA physician who basically will provide the same battery of tests, the same exams, and eventually the same diagnosis as the veteran's private physician. Only then, after waiting months for a duplicative exam, can the veteran have VA fill that prescription.

I do not see the rationale for this. The duplication of service is a waste of time for the veteran, and absolutely a mismanagement of resources for the VA. In fact, in December 2000, the VA inspec-

tor general had projected that this redundancy of services would waste in excess of $1 billion a year. And we expect that this number would be fairly higher today.

When VA is currently unable to meet the demand for services, and it forces veterans to wait months for an appointment, it simply is irrational for VA to slide these veterans to the back of a growing line. They already have their diagnosis, they simply need to utilize the benefit that the VA provides.

And additionally, it does not make sense to sever the important relationships that many veterans have established with these outside doctors, the openness and trust that can come with familiarity can lead to optimal treatment and much better health care. VA should not impair these connections.

The VFW strongly supports a pharmaceutical benefit that allows all veterans optimum access to pharmaceuticals they need for their health and for their well-being. And given the current situation and the opportunity to potentially mitigate the impact of long waiting lines, and produce cost savings by streamlining and inefficient and an overly bureaucratic process, VFW supports the creation of an outpatient prescription benefit that would free up VA health care appointments and potentially reduce the backlog.

In addition, we support providing an outpatient medication benefit to Medicare-eligible category eight veterans who are currently precluded from enrolling in VA health care. The VFW, however, does not support requiring veterans to forego their earned VA health care in favor of Medicare.

Veterans are unique in that they have an entitlement to Medicare by way of financial contribution, and have also earned the right to VA health care through virtue of service to their nation. They must not be forced to give up these rights to either. The VFW will continue to fight for adequate appropriations to allow all veterans access to VA medical benefit packages.

And I see, as my light dwindles down, I am trying to make a point, Mr. Chairman, that just makes a very logical statement, and all one has to do is go to a VA hospital and participate in that program of primary care, and sense the frustration in the extra burden of monetary issues that are forced on the VA because of that when this simple procedure, allowing people who are licensed by the federal government all across America to write that prescription and alleviate a lot of pain and a lot of time for veterans who are requiring the care, and the people who are administering the services in the VA hospitals. Thank you.

[The prepared statement of Mr. Banas appears on p. 49.]

Mr. SIMMONS. Thank you, Ed, very much for your testimony.

And now, I will ask Dr. Hong to speak.

STATEMENT OF CORNELIO R. HONG

Dr. HONG. Thank you, Mr. Chairman and members of the subcommittee. I am an internist, and I have been in private practice for the last 28 years, except for that period in my life when I went to Desert Storm.

But in my 28 years of private practice, I have seen a few veterans that come to me, and more recently I have seen them going to the VA facility, just to have the prescriptions filled. A particular

case that I am going to bring to your attention today will probably illustrate my entire testimony. And this is an actual case, and actually a few other cases that I have seen in my practice.

Mr. M is 77 years old. He is a World War II veteran. He got out of the service in 1949. He has no service-connected disability, but he has diabetes, he has high blood pressure and high cholesterol level. It is a quite common diagnosis for a lot of us.

Now, 4 years ago, as his prescription costs escalated, and upon the advice of his barber, he enrolled in the VA. He continues to see me, as his primary care physician. But in order for him to get his prescription filled at the VA he has to also be seen by a VA physician.

Well, this worked quite well, for the fact that his prescriptions are what we would call as chronic medication prescriptions. And most of the time he would get a 3-month supply, and he would pay a co-pay, a $7 co-pay, for each 30-day supply. Unfortunately, if I were to change his prescription, he has to go back to his VA physician to get this prescription rewritten again.

Now, there were a few instances where we have discovered that there have been duplications of services, for instance ordering the same laboratory test, or sending him to the same consultant, such as, for instance, a cardiologist or a diabetes specialist. But all in all, we try to avoid such duplication.

Now, Mr. M has six different medications, and he pays a total of $42 per month as his co-payment at the VA. And this worked quite well with him, except that Mr. M, if we were to enroll today, he would be in priority level eight, and he would not have received any benefits whatsoever.

Now, this is in contrast to Mr. F, who also has the same diagnosis, who also is a veteran. Unfortunately, Mr. F did not enroll early at the VA facility. He, at this time, cannot enroll at all. And therefore, Mr. F is not receiving any VA benefits for the same illnesses and for the same service that he rendered in this country.

Now, Mr. F pays a total of $642 a month for his prescription, which he gets retail. Now, if Mr. F were to get the benefit of a cost medication from the VA, he would pay a total of $150 for the same prescription that he is now getting. This will make a huge difference in Mr. F's financial status in his family.

I am bringing these two cases together because this contrast, what Mr. F is up to at this time, and both cases illustrate completely what is going on with the veteran in this country and the relationship with the VA. Those listed in priority level eight after January 16, 2003 have no benefit whatsoever today.

Those that are already in the system, if you were to continue getting this benefit, he also has to first be seen by his private physician, and he needs to continue seeing his private physician for whatever changes in prescriptions he will be given by his private physician, which again, brings us this cascade of problems, namely it creates gridlock in the VA system. Two, there is duplication of services. And three, it adds cost to the already burdened VA system.

But most importantly, there is a delay in service. There is a delay in care. This veteran cannot get that prescription. If he were to come to me because he has pneumonia, and I have to write him

that antibiotic, this veteran already in the system cannot get that prescription filled in a VA pharmacy because of—that he has to be first seen by his physician.

Now, this bill would be a right step in the right direction, because it provides benefits to the veterans who are otherwise not receiving benefits in the VA facility, and it helps ease up some of the backlog. And most importantly, it also helps a group of veterans who are not otherwise receiving any care at this time. Thank you.

[The prepared statement of Dr. Hong appears on p. 53.]

Mr. SIMMONS. I thank the gentlemen for their testimony. Let me see if I can understand this situation involving Mr. F and Mr. M.

Dr. Hong, these are real people that are under your care, is that correct?

Dr. HONG. That is correct.

Mr. SIMMONS. These are no hypotheticals.

Dr. HONG. That is correct, they are not hypothetical.

Mr. SIMMONS. They are not hypothetical people. These are real people under your care. Currently, Mr. F, who is a priority eight veteran, would be paying $650 for his medications on the outside. Is that correct?

Dr. HONG. $642 on the outside.

Mr. SIMMONS. $642 on the outside. By that, I mean through the routine civilian health care provides.

Dr. HONG. Through the retail——

Mr. SIMMONS. The retail outlets. However, if he was able to access the VA for a pharmacy benefit, not for the, you know, all the bells and whistles but just for the pharmacy benefit, his costs, you estimate, would be reduced to around $150?

Dr. HONG. That is correct, sir.

Mr. SIMMONS. Yes. And yet Mr. M, who had either the foresight or the luck to get into the system when he could, pays a pharmacy benefit plus the full service benefit co-pay of around $42.

Dr. HONG. Forty-two dollars.

Mr. SIMMONS. For essentially the same prescription drugs.

Dr. HONG. Yes, sir.

Mr. SIMMONS. Now, the term I use is "fairness." Why is this fair, first and foremost? And secondly, why is this efficient? Is this a fair system, and is it an efficient system?

Dr. HONG. Well, one would say that it is not a fair system, because Mr. F is paying quite a lot today for him to get his prescriptions, whereas Mr. M, who is already in the system, is paying a co-pay only. And therefore, he is benefitting from the prescription benefit that he is getting.

Now, all veterans, I think, has—should get that benefit package, one way or the other. But unfortunately, Mr. F is screened out. And so, the system is not fair to him.

Mr. SIMMONS. So, the eligibility for access to benefits appears to be the same. They are both priority eight veterans.

Dr. HONG. They should be.

Mr. SIMMONS. But because of bad timing or bad luck, just, you know, Mr. F just didn't make the right decision at the right time, he is essentially shut out. And yet Mr. M, who had the foresight to get into the system at a certain point, before the system shut down, he is doing extremely well.

And yet, their eligibility for access to benefits, both are veterans, both are priority eight veterans.

Dr. HONG. Yes.

Mr. SIMMONS. But one is treated very differently from the other. Let me ask another question of Commander Banas. He referred to the inspector general's report, and this is a report that is dated December 20th of the year 2000.

And in this report, the issue of a pharmacy benefit only program is considered. And the Office of the Inspector General makes the statement, "We recognize that a decision to continue the current policies"—the current policies—"results in inefficiency and waste that we estimate annually costs the Department over $1 billion in resources that could be better used in the delivery of health care services to veterans."

It seems to me that we spend a lot of time in this committee, in this subcommittee and in the committee generally, and in the Congress, and a lot of time with the veterans service organizations, attempting to allocate resources to provide health care to our veterans, which I feel—and I think many of the members of this committee feel—that they have earned.

And yet, the VA inspector general's report says that the duplication of effort and the waste in re-examining costs us almost $1 billion a year. That's a lot of money to be used for another purpose. Mr. Banas, do you have a comment on that?

Mr. BANAS. Yes, I do. Mr. Chairman, you know veterans come from Park Avenues and park benches. And all one has to do is go to a VA hospital and sit back and casually observe, talk to people, and you will sense this redundancy, and you can understand how much time is wasted by the staff who are part of the organization in these individual VA hospitals.

And it just seems to me that all veterans are entitled to—this would basically be a self-sustaining thing, depending on how the Secretary would promote it. Even if it were through the cost of the individual drug at the cost to the VA, because drugs can cost from a penny for a prescription to whatever, you know, it's self-sustaining. It just gives the person the option to do that.

And when I say Park Avenue and park benches, those park benches need this very, very much. And when you have that delay in time, it can cause an adjustment or a loss of life, which Dr. Hong and I discussed of a veteran from Connecticut this morning. Because of a delay in an appointment, the man's cancer went from his lungs to his lymph nodes.

And you know, the VA is really never medically negligent, it's just issues of timing. And for me to see my own private doctor, I can do that after work in 15 minutes with an appointment. But to go to a VA facility, I have to give up an entire day almost for that 30-minute window. It just seems that this is the logical approach, sir.

Mr. SIMMONS. You made the comment—and I see the orange light—that the veteran already has his diagnosis, he already has a relationship with a doctor. And I think we all know that once those relationships develop, you feel comfortable with them.

So, why shouldn't they simply utilize the pharmacy benefit? And Dr. Hong made the comment that sometimes the doctors, the two

doctors, talk to each other. Is that a hard thing to do? Is that really complicated? I mean, I think that, from my perspective, if you have a primary care physician you would simply fill your prescription at VA pharmacy.

But let's say the VA wants to double-check or even talk with a primary care physician. Is that a hard thing to do? I mean, don't doctors talk to each other?

Mr. BANAS. I would imagine that it is, and I'm sure that Dr. Hong could answer that better than I, except that I know that he is a true veterans' advocate, and takes that extra step to clarify something with a VA physician on behalf of his patient.

Mr. SIMMONS. So he does communicate with the VA doctor. I thank you both, I see the red light, and I defer now to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. Let me, first of all, thank you for being here and talking about this key and important issue. And I agree with you, that it just doesn't make any sense that, you know, if I want to see my private doctor and then still go—try to get my prescriptions, that I should be able to do that.

And you also mentioned that you would also be supportive of the idea of looking at a reimbursement from Medicare. Have you all looked at the H.R. 1309 bill by Lane Evans that allows that opportunity, and are you in favor of that?

Mr. BANAS. To be honest with you, sir, I don't have enough knowledge about that bill to develop a discussion with you.

Mr. RODRIGUEZ. Okay. My understanding is it allows an opportunity for veterans, under Medicare, to be able to get that prescription, and for it to be reimbursed through Medicare. And so we were trying to get that done as quickly as possible, and that is under H.R. 1309.

Let me ask you also—and I am not familiar with this other bill, either, but Senator Specter's S. 1153, yours sounds very similar to that. Is that—is your bill, or what you are looking at, comparable to S. 1153, the Senate bill, or——

Mr. BANAS. I don't know that.

Mr. RODRIGUEZ. Okay, thank you. Are you getting anyone to file a piece of legislation that basically incorporates what you're talking about?

Mr. BANAS. I hope so.

Mr. RODRIGUEZ. Okay.

Mr. SIMMONS. Would the gentleman yield for 30 seconds?

Mr. RODRIGUEZ. Yes.

Mr. SIMMONS. I provided Commander Banas with a concept, with an idea, which was the issue of a cost-plus pharmacy benefit. But because there is other legislation out there, and because we didn't want to key on any particular draft, we made the decision to try to have this as a subject matter hearing, as opposed to legislative.

Mr. RODRIGUEZ. Okay.

Mr. SIMMONS. And that is why we don't have a document in front of us, and probably why he isn't prepared to respond.

Mr. RODRIGUEZ. Yes, maybe you—it might not be appropriate, but maybe for the other two panels or for our staff, getting some kind of assessment in terms of possible cost to allowing that, be-

cause you mentioned that we might save $1 billion because of the fact that we wouldn't have to duplicate. And I would like to, you know, maybe just get some estimates of cost.

And I personally just philosophically agree that we ought to be providing prescription drug coverage for our veterans, and we're not anywhere close to responding to the needs of our veterans, based on the number that we service now.

And I also agree totally that in some cases, people want to see their personal physician and develop that relationship with their personal physician, but that they should be able to come to a VA hospital, VA clinic, or VA pharmacy to be able to get other types of services. So I agree with the concept. Thank you very much.

Mr. BANAS. Thank you.

Mr. SIMMONS. I thank the gentleman, and I agree with him completely, that these are questions we should put to the subsequent panels. Next, we have Mr. Beauprez.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman, and thank you for holding this hearing. Certainly since I have been on the committee, I think this subject has come up over and over and over again, and we continue to wrestle with the challenges, both as they affect cost and timing and access for our veterans, and the burden on the system, in total.

I think the—I think both witnesses have framed the situation very well, and I thank and compliment them both. And with your questioning, I think we have gotten further enlightenment.

I will forgo any additional questions. I am looking very much forward to our second panel, and Dr. Perlin, and seeing if we can maybe start to hone in on a solution. So, with that, I will yield back, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you very much, Mr. Chairman, for holding this very important hearing. I am going to ask that I have permission to submit my opening statement for the record, and just say a very few words.

First, Commander and Doctor, I appreciate your comments very much, and I agree wholeheartedly with what you're suggesting. You might be interested to know that even though the veterans in my district—and I've got the fastest- growing veterans population and the fastest-growing senior population in the United States—even though we don't have a veterans hospital yet or a veterans outpatient clinic or a veterans long-term care facility, what we do have is an increase in the past year, 21 percent increase, in the number of prescription drugs filled in the facilities that we do have for our veterans.

In the first 4 months of this fiscal year, the VA pharmacy and clinics have filled over a half-a-million prescriptions for southern Nevada veterans. I know that they are—we are—in desperate need of providing prescription medication to all of our veterans, including our priority eights.

I also find it—I agree with what you say, Commander, that veterans shouldn't have to choose between Medicare and a prescription medication benefit under the VA system. They are entitled to both, and they should not have to choose.

I don't think there is much faith in the prescription medication benefit that we passed a mere 4 months ago. I think our veterans realize that they need to get their health care needs met and their prescriptions filled at the VA clinics and hospitals.

And I'm married to a nephrologist who has many veterans as patients, and while you may be able to get in to see your doctor in 15 minutes, I can tell you in Las Vegas, because we have a health care crisis, that it takes people—unless they have an emergency, it will take them 3 months to get in to see a regular doctor in Las Vegas.

So they are really caught in the cross-hairs, because they have a very—an inordinately long waiting list at the VA, and almost an inordinately long wait, if they want to go see their doctor. To have to do that twice is unconscionable.

So I thank you for being here, I support what you're suggesting, and I look forward to working with you to make this dream a reality.

[The prepared statement of Congresswoman Berkley appears on p. 48.]

Mr. BANAS. Thank you.

Mr. SIMMONS. I thank the lady. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you, Mr. Chairman. I certainly want to thank the panelists who are here for this segment. My questions are actually for the VA, Mr. Chairman, but I did want to say that it was very informative.

Mr. SIMMONS. Thank you. Ms. Hooley? Excuse me, I apologize. Mr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Commander Banas, I appreciate your—both of your—testimony today. There is—the whole issue of prescription drugs has occupied a lot of attention by anyone who cares about health policy for a long time, including the Congress. And the Congress passed the Medicare prescription drug bill with a lot of controversy here a few months ago.

You don't have much hopes for that of solving this problem, if I read your opening statement correct, is that——

Mr. BANAS. No, I basically am saying that every veteran is entitled to the services that are provided by the VA, and I basically came here to make a statement, sir, that says that any licensed physician who is federally licensed I the United States of America and can prescribe a drug for me should be able to communicate that to a VA facility pharmacy and allow me to have my drugs in a timely fashion and eliminate a lot of bureaucracy in between.

Dr. SNYDER. No, I understand that. It's just that if—I think my guess is—well, I will just read your statement. You say, "Although many veterans will be eligible for these Medicare Prescription Drug Improvement Act reforms, the complexity of the many types of coverage available under the plan, as well as the large gaps in coverage, make it an unattractive alternative for most veterans."

As I read your statement, you were saying that Medicare-eligible veterans, if it was an attractive alternative, and they could get

their coverage elsewhere, they probably wouldn't even be lining up at the VA for their prescriptions. Is that what you considered an unattractive—in your words—an unattractive alternative for most veterans? And I was just wanting you to amplify on that.

Mr. BANAS. Well, I don't find it to be unattractive, I just find it—I perceive this as part of—a necessity on behalf of veterans who are not monetarily capable of getting their medicines in other ways, and that this is just a direct focus to a proper plan.

Dr. SNYDER. No, I understand that. I want to be sure—all right, thank you. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Ms. Hooley.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair, thank you for having this hearing today. Mr. Hong, just a quick question. I appreciate your testimony. I support allowing when a veteran can't get in to see a veteran doctor, that they have an ability to at least get their prescription drugs.

And Mr. Chair, I hope that—I have also introduced a bill, as have many other people—I hope that we can look at some of those bills and see if we can combine those and actually introduce a bill later on, after this hearing. Because I think it is critically important, again, that we treat our veterans—we said we were going to give them health care. The very least we could do is make sure that they get prescription drug benefit.

Commander Banas, again, thank you for being here. What I hear is—and I guess I want to know how you would respond—that people say, "Well, the VA should be spending its money on serving veterans currently in the system, and reducing their waiting time, instead of providing a prescription-only benefit.

Do you think it's possible, under the current budget, the VA could achieve all of these goals, and——

Mr. BANAS. Yes.

Ms. HOOLEY. Okay.

Mr. BANAS. Yes, ma'am, because if this were—depending on how the Secretary would approach this, if it's on a cost basis, if you have the $7 fee for prescription, or if he chose to make a medicine that cost the VA $49 the cost of that medicine to the veteran, it's a self-sustaining thing, and it's not an issue of affecting the budget in that perspective.

It would save an immense amount of money in the human side, when you look at—you know, if you take a VA dollar, you have $.25 of that dollar that goes to the unions or to the people who treat and care for the people, it just unloads a lot of time. It takes a lot of the burden off of the back of the VA, in that perspective.

Ms. HOOLEY. Well, I hope we can accomplish this. I think it would be a giant step forward.

Mr. BANAS. I believe it would be.

Ms. HOOLEY. Thank you both for being here.

Mr. BANAS. Thanks.

Dr. HONG. Thank you.

Mr. SIMMONS. Thank you very much. Mr. Strickland.

OPENING STATEMENT OF HON. TED STRICKLAND

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Chairman, I am not terribly good at math, but I believe under the scenario that was outlined regarding Mr. F and Mr. M, Mr. F pays $5,904 more per year than an individual who has provided comparable service to his country.

Now, that is unreasonable. It is unfair. It is irrational. And I think the veterans have a right to expect us to fix that problem.

Also, according to my calculations, you can make as little as $24,000 a year and be a priority eight veteran. So that means that more than one-fourth of a priority eight veteran's total income may be going just for the medicine. And you have said something here that I think is startling.

Doctor, in your professional opinion, a veteran lost his life because cancer went from lungs to lymph nodes due to a delay in receiving care. I mean, that is something that ought to make all of us incredibly concerned.

And if I could just say one more thing, Medicare is—you know, the Medicare bill begins in 2006, the discount card is due this summer. My understanding is that the projections, that the cost of prescription drugs next year is projected to increase 18 percent. So, I mean, when and where is it all going to end?

I think—Mr. Chairman, I know where you are on this issue. I have no—you know, the problem is in this committee we preach to the choir. And somehow we have got to penetrate the larger Congress about these problems. Because I think we all understand the problem.

But to hear you say that you are aware and that you have discussed with the commander a veteran whose cancer spread perhaps because of a delay in treatment, is just unacceptable that is—something has got to be done about that. Would you respond to that?

Dr. HONG. Yes, sir. The case that we talked about, we talked about the delay, probably has got nothing to do with the prescription drug benefits, but it is just one particular issue that happened in a VA facility.

But I want to expand further about Mr. F, because I talked about his prescription bill, which cost him $642 a month. Now, obviously, at this time he cannot get into the VA, because he has already been shut out. Had he been able to get into the VA, he would just have paid something like $42 a month.

But if this bill should pass, Mr. F would pay $154.95 for the same prescription, though the VA at cost, and it would provide him a substantial savings. And these are the kind of benefits that we're asking for from this committee. It's a benefit for veterans that have already been excluded, that at this time are not getting anything at all. And there is a substantial amount of those veterans.

This is not going to change the entire VA system. It's not going to add any more money, or it's not going to make the VA spend more money for these VA that are not receiving anything at this time, it is just giving them the benefit at cost of what it would cost the government to provide them those prescriptions.

The Department of Defense and the VA are in a very, very unique position. They can get these medications a lot cheaper than they would be able—than retail pharmacists would be able to get,

a substantial amount of savings that could be passed on to these veterans that are, at present, not getting any benefit whatsoever.

Mr. STRICKLAND. So, Doctor, would you—given that scenario, would you say that the VA would not have to spend more money?

Dr. HONG. The VA would not have to spend any more money.

Mr. STRICKLAND. So I can't imagine anyone thinking this is a bad idea, except maybe the pharmaceutical companies that would like for that veteran to go to a private pharmacy, or, you know, another source so that they would have to pay more. That is interesting. Now——

Dr. HONG. Well, it would give you—it would raise that question that of if the veteran is not going to get it from the retail pharmacy and get it from the VA facility, then it would certainly cut back some of those——

Mr. STRICKLAND. The pharmaceutical industry would get less money, I would assume.

Dr. HONG. Probably yes, sir.

Mr. STRICKLAND. I appreciate the smile on your face, Doctor. Thank you.

Dr. HONG. Thank you.

Mr. SIMMONS. Thank you, Mr. Strickland. And I appreciate your remarks. In particular, as the panel has presented, your concept, it's very simple. And I remember from my Army days, my drill sergeant saying, "Keep it simple. Keep it simple, stupid." And I guess that's what we're trying to do here, is to come up with something simple that doesn't create a burden, but helps those veterans in need. Mr. Boozman?

Mr. BOOZMAN. Nothing.

Mr. SIMMONS. Mr. Bradley?

Mr. BRADLEY. Same.

Mr. SIMMONS. Okay. Gentlemen, does anyone have an additional question for our panel? I know that Dr. Hong is on his way to a family vacation, so I don't want to delay him too long. Any further questions?

[No response.]

Mr. SIMMONS. Hearing none, thank you both very much for being here today. We truly appreciate your testimony.

The next panel involves Dr. Jonathan Perlin, who is a medical doctor, Deputy Under Secretary for Health, testifying on behalf of the Department of Veterans Affairs. Dr. Perlin is accompanied by Michael A. Valentino, the VA's chief consultant for pharmacy benefits management, and Barbara J. Manning, program analyst for VHA's policy and forecasting service.

I welcome all three of you to the panel, and I would ask Dr. Perlin if he would proceed.

STATEMENT OF JONATHAN B. PERLIN, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL A. VALENTINO, CHIEF CONSULTANT, PHARMACY BENEFITS MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND BARBARA J. MANNING, PROGRAM ANALYST, POLICY AND FORECASTING SERVICE, DEPARTMENT OF VETERANS AFFAIRS

Dr. PERLIN. Good morning, Mr. Chairman, Mr. Rodriguez, members of the committee. I am pleased to be here with you this morning to testify on our transitional pharmacy benefit program, which I will refer to as TPB.

In recent years, the VA has been challenged to meet the demand for medical care services, especially in some areas of the country. VHA has worked diligently and aggressively to reduce the list of patients waiting for their first clinic appointment. As a result, I can report that VA's efforts and improvements in managing clinic wait times have been substantial.

Despite this progress, however, some geographic areas continue to have wait lists for primary and specialty care appointments. To respond to concern that some veterans endure a financial burden for required prescriptions while waiting for a VA appointment, VA implemented the transitional pharmacy, or TPB, program.

Under this program, VA fills prescriptions from private physicians until a VA physician examines the veteran and determines an appropriate course of continuing treatment. This benefit was made available to veterans who were enrolled and requested their initial primary care appointment prior to July 25, 2003. And as of September 22, 2003, had still been waiting more than 30 days for their initial primary care appointment.

Generally, we found that veterans appreciated the benefit. However, total participation was lower than expected. Due to the rapid start-up of the program, and the lack of existing software support, there were challenges in accurately identifying TPB program participants and the associated workload.

However, we do know that 8,298 veterans, who are about 20 percent of the 41,167 eligible veterans on waiting lists at that time, opted to use the TPB benefit program.

In addition, because the TPB non-formulary prescriptions necessitated the VA pharmacist contact the private physicians to suggest TPB formulary alternatives, there was a significant increase in the labor and time required to process prescriptions.

In contrast to the 3 percent non-formulary prescriptions in VA comprehensive care, 42 percent of prescriptions initially written were for non-formulary agents. Pharmacists' negotiation with private physicians reduced this to 27 percent non-formulary.

Due to congressional and veteran interest in a VA prescription-only benefit, Secretary Principi requested that VHA survey veterans' attitudes toward a potential prescription-only benefit. The survey was designed to provide data to support the development of sound actuarial projections for enrollment, utilization, and expenditures for a prescription-only benefit.

VHA commissioned a survey of 1,800 veterans by phone in January and February of this year. Veterans were asked whether they would choose to enroll in a prescription-only benefit. Veterans were

also queried to explore the impact of different co-payment levels on their choice. We collected data to enable us to identify those characteristics that influenced veteran responses.

We presented some preliminary results in our formal testimony and at an impromptu staff briefing yesterday. However, more in-depth analysis of the survey results is necessary to fully understand and quantify the implications with regard to potential enrollment and cost for the prescription-only benefit.

Let me share some summary statistics. Eighty-nine percent of enrollees would choose comprehensive VA care over a prescription-only benefit. More non-enrolled veterans would choose comprehensive VA care—42 percent—than would choose prescription-only benefit—19 percent.

Twenty-nine percent of non-enrolled veterans said they were likely to enroll in VA for health care, but not prescription-only benefit. Thirteen percent of non-enrolled veterans expressed interest in both VA health care and a prescription-only benefit, and seven percent expressed interest in this prescription-only benefit, but not VA health care.

Interest in the prescription-only benefit drops when specific co-payments are mentioned. When offered with a co-payment of $10 or less, only 6 percent of enrollee users, 14 percent of enrollee non-users, and 15 percent of non-enrolled veterans are likely to enroll.

Based on our experience with the transitional pharmacy benefit, per enrollee drug costs and administrative costs could be expected to be higher, due to the adverse selection of sicker patients, the higher drug utilization associated with those patients, and significant numbers of off-formulary scripts, or prescriptions, expected when VA fills prescriptions written by private providers.

VHA staff, with assistance from a private sector actuary who develops enrollment and expenditure projections for VA health care are currently analyzing the results of the survey in greater detail now. When this analysis is completed, we will brief the Secretary on the results of the survey, and publish a final report.

In conclusion, the transitional pharmacy benefit program reduced the financial burden of prescription medications for patients waiting longer than 30 days for an initial primary care appointment. It increased their ability to accommodate new enrollees. The temporary program also provided valuable information about the increased labor requirements and non-formulary drug costs associated with filling prescriptions from non-VA physicians.

Mr. Chairman, in closing, I believe that VA is one of the leading health care providers in the United States, in terms of safely, effectively, and efficiently, integrating the provision of pharmaceuticals in its comprehensive patient treatment programs. VA continues to study alternative models for provision of a prescription benefit for veterans.

This completes my statement, sir, and my colleagues would be happy to answer any questions that anybody might have. Thank you.

[The prepared statement of Dr. Perlin, with attached survey questionnaire, appears on p. 58.]

Mr. SIMMONS. Thank you very much for that testimony, and I thank the VA for engaging in this exercise, not only providing the

temporary benefit for those folks, those veterans waiting on the list more than 30 days, but also for doing the study.

As I read the—your testimony on the program, you did encounter increased labor costs when a veteran was accessing the formulary for, let's say, a non-generic drug or a drug that was not on the formulary. Therefore, you had to process that, and that was an increased cost.

Dr. PERLIN. Yes, sir. Let me define some of the terms. The formulary is that list of drugs that we review in VA and we will use for VA patients. We make choices in that, in not choosing all medications, but within a class of drugs.

For drugs that are similar, let me just use a soft drink metaphor, Pepsi or Coca Cola. If they are really identical, we will choose the one that's equally effective. If one is better, we will choose the one that is more effective. But if two are equal, we will choose the less expensive.

By doing that, our research has certainly gone farther in terms of the treatment of all veterans, or the treatment for any particular veteran. But we have been able, by virtue of doing that, and despite the tremendous inflation the order of which Mr. Strickland mentioned—I think he said 18 percent next year—to, over the past 4 years, have increases of really less than 10 percent, despite more drugs per patient and increased ingredient costs per patient.

So, we have been really able, with a scientifically managed formulary process, to control our costs to make sure veterans get the best possible medications.

Mr. SIMMONS. I appreciate that. I think that, as I understand what Commander Banas and Dr. Hong are saying is what they feel is that for those—certainly most veterans want full health care, and they want the pharmacy benefit that goes with it.

But as you know, we have a situation today where not all veterans can access the system. Given that situation, how do we accommodate those veterans who have standard pharmacy costs for chronic disease management and illnesses? Do they have an opportunity to access the system?

As I understand your program, you did encounter some labor costs related with managing this new temporary benefit. But if we're talking about a proposal that is cost-neutral, then those would be absorbed in an increased co-pay for the priority sevens and eights, presumably, or in some other mechanism to keep that revenue-neutral. Is that beyond the realm of possibility, in your view?

Dr. PERLIN. I think the transitional pharmacy benefit was very educational, in terms of learning how costs would be generated.

We, obviously, were less effective, in terms of negotiating back to our own formularies, than we might have been. So I think we can agree that we can anticipate a greater reliance on non-formulary medications. That would certainly be a higher cost.

We are very fortunate in VA—and if anyone hasn't seen it, I invite you to join me at Washington's VA to see our electronic health record. This really is critical in terms of keeping the costs tight, the cost management tight, and providing safety and quality. All of the prescriptions are entered electronically, whereas any one of us in

America could expect a chance of having orders entered electronically of about eight percent.

In VA, 94 percent of all pharmacy orders today are entered electronically, often with decision support, assuring right medication, most often with—error checking, assuring that the patient doesn't have an allergy. That electronic information comes across to automated robotic dispensing, and ultimately to outpatient pharmacy management.

My point is that there is this incredible opportunity for quality, safety, and efficiency, by virtue of having everything electronic. So a second feature of cost would be the management of paper that, unfortunately, we could not manage electronically.

Theoretically, sir—and to the point of your question—could something be done that's cost-neutral? And I'm just speaking personally. If these other costs were considered—and you know, I think none of us would want to do anything that diminished care to those most vulnerable: service-connected disabilities, those who were impoverished—if there were firewalls to assure that those were never—I think that the logic would speak for itself.

Mr. SIMMONS. So the answer is yes?

Dr. PERLIN. With those provisions, sir, I would have to agree with you.

Mr. SIMMONS. The answer is yes, and I thank you for that. And I realize you caveated your response by saying "speaking personally," and I appreciate that. And we all know what that means.

I would love to visit your facility, and I think it's—my understanding is the way VA runs its pharmacy business, it's high-tech, and it's state-of-the-art, and there is no doubt about that. And I would love to see how you do those electronic entries. I think that would be very important.

At the same time, my fundamental concern here is how can we provide a fair pharmacy benefit for those veterans who have served who are kept out because, basically, of a regulatory decision? How can we provide them with fair access? And you heard the previous panel, so you know what we're getting at.

On the survey, I find it interesting and useful, and I think that the survey respondents told us what we probably already know, which is most veterans want the whole enchilada, if you will. But for those veterans who are out of the system and looking in, I think what we discovered was that 19 percent are interested in choosing a prescription-only benefit. From a percentage standpoint, that's a low percentage.

But if you factor it out to the total veteran's population, that is four million veterans, so that's not an insignificant number of people who are saying to you, through your survey, "You know, I've got my own doctor, I've got my own situation, but I really would like a pharmacy benefit, and as somebody who has worn the uniform, I think I have earned that."

So, I think that is a significant number of veterans. And I see the red light, so I defer to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Let me, first of all, thank—and as the chairman has indicated, I think the majority would prefer everything, but I would have some concerns with the

survey that you did, because I know that the proposal also talked about the disparity of services from one region to another.

And so, if I don't have access to health care in one area, well heck, I'm going to say I will be okay with just getting prescriptions if I could get that. And so, depending on where exactly it's at, I don't know if your survey, pinpoints maybe by members' congressional districts, I think that would probably mean a lot more. So if you have that in that form, I would be interested in that.

Because if they say they don't particularly care for that and they have got a major hospital there, then I would be interested to know that. But if they don't have any services available, then they might say, "Well, at least I can get something."

I am also interested in, how you advertised for those that have to wait 6 months or so, and you might be able to comment on how you reached out to those individuals, and how you informed them about eligibility to qualify for those, prescription drugs.

Dr. PERLIN. Well, thank you sir, and let me agree that the information you request by district would likely vary geographically—let me ask Barbara Manning if we can actually prepare that, certainly by state, anyway.

Ms. MANNING. For the prescription-only survey, we have a—we don't have a large sample size. It was really designed to give us national-level responses. And so, you——

Mr. RODRIGUEZ. Do you know what the sample size was, and——

Ms. MANNING. Eighteen hundred vets.

Mr. RODRIGUEZ. Eighteen hundred throughout the country, or just a region?

Ms. MANNING. Throughout the country. There were 600 enrollee users, 600 enrollee non-users enrollees who did not use any health care in 2003, and 600 non-enrolled veterans. And those allow credible sample sizes at the national level.

Dr. PERLIN. There is a 95 percent confidence interval at those numbers at the national level. There is a two percent margin of error in either direction—in terms of enrollees, 600 non-enrollee patients—I'm sorry, enrollee patients, 600, and 600 others who were enrolled but not using the system. So, four percent confidence or margin of error around each of those numbers. But the numbers have a greater margin of error as they get down to lower rates, but we will put together whatever information we can.

Let me come to your other part of your question, sir, which was the question of how we reached out to those veterans who were, in fact, eligible. We actually used our waiting list information to identify all individuals who were potentially eligible, and we took that run and we mailed a letter to each and every individual, the best address that we thought we had for that individual, to notify them of this benefit.

During that period of time, I am pleased to report that there was substantial progress on the waiting list. Regarding the way that particular benefit was framed, it was a group of individuals who had been waiting, as of a certain point.

The idea of this was that we really wanted to learn about the use of the benefit itself, and so it was sort of circumscribed, because I think the study of a decade ago really—their own experience, if you build it they will come, and that's a good thing. But we wanted to

learn before we unleashed, and what we learned was a great deal that we can discuss today about who we would use.

But it was a limited number of individuals. The initial pool actually decreased substantially between the time of the announcement of the benefit and when the benefit actually started. Despite a letter to each individual, we're pleased to have made great progress on the waiting list for that. I think the committee knows and appreciates—and we appreciate your support in working down the waiting list. We still have, as you note, some geographic challenges there.

Mr. RODRIGUEZ. We have a serious problem. You know, I know in the border—they were just telling me about another study that was done on the Mexican border, in McAllen, and that area in Hidalgo County, and they identified that 50 percent of the people were getting their prescriptions from Mexico, 50 percent of those without insurance.

And so it was individuals that didn't have any insurance that were going to Mexico. So we got a real problem in this country, in terms of not being able to provide access to good prescription drugs not to mention for our veterans, also.

Let me ask you, because I know on H.R. 1309, that we wanted to push forward, one of the arguments was to wait and to see what we were going to do with the Medicare bill. We have already done that. Do you have any comments on that, because I know that there are some huge gaps there, and I don't know if it's going to help any of our veterans, but have you all done any assessments on that?

Dr. PERLIN. Well, thank you, sir. We were actually trying to put together some information from our private sector actuary on the effect of the Medicare bill on VA use. It's a little bit difficult to try to second-guess, because as you know, the final regulations haven't been published.

Preliminary evidence suggests that there may not be tremendous differences, but I would be remiss in overstating what we know thus far. We anticipate a report from our actuary in about 4 weeks, just based on some current assumptions and an analysis about 4 weeks after that, we would be pleased to share with committee and staff.

Mr. RODRIGUEZ. Just going to close that, we have gotten an indication that the VA officials have reviewed H.R. 1309 and have determined that it contains no provisions that will impact on the VA's pharmaceutical procurement costs.

Dr. PERLIN. Thank you.

Mr. SIMMONS. I thank the gentleman. We will anticipate, then, getting that actuarial analysis in about 4 weeks. Is that correct?

Dr. PERLIN. That's right. Eight weeks total. We should get back some raw numbers in total, and then have for analysis——

Mr. SIMMONS. And it's my understanding you're also waiting for some final actuarial analysis on your survey results.

Dr. PERLIN. Yes, sir.

Mr. SIMMONS. If we could have that as well.

Dr. PERLIN. Absolutely. And as you suspect, the two are interlinked.

Mr. SIMMONS. Thank you. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you very much. Thank you, for the entire panel, for being here.

In reading the testimony on page 6, it says, "Seventy percent of enrollees say they intended to use VA as primary source of care or back-up to non-VA care."

Dr. PERLIN. Yes.

Ms. BROWN-WAITE. Could you break that 70 percent down? In other words, how many of them are going to use the VA as primary care, or how many of them are going to use it as back-up to non-VA care?

Ms. MANNING. Okay. A little background. We, every year, do an enrollee survey. That has a huge sample size of about 38,000. We, this year, asked them a new question, which was, "How do you intend to use VA in the future?" And 70 percent of enrollees said that they intended to use VA as a primary source of care or a back-up.

Ms. BROWN-WAITE. If I may continue, Mr. Chairman? But that's exactly the question. How many of that 70 percent are using the VA as a primary source versus a back-up? There is a big difference.

I know in my area, for example, on Monday a veteran may go to a veterans' clinic, and the following Monday he uses Medicare, he or she uses Medicare. Tell me what percentage are using the VA solely as the primary care. I'm from Florida, I have a very high senior population.

Ms. MANNING. I can provide it. I don't have that with me today, but I certainly can provide it. I have it broken out. We tried to provide a very sort of high-level analysis today, and we would be glad to provide it later.

Dr. PERLIN. This survey is brand new. Let me get back to you with our survey of utilization and reliance. Just as the discussion this morning has—we discussed about the opportunity for veterans potentially to use benefits and Medicare, or in VA, I think we're well aware that veterans are using health care in multiple sectors simultaneously. So, let me get back to you, if I may, with information for the record on the reliance outside of VA and within.

One statistic that I can share with you this morning is that on our previous surveys, the veterans who indicated their use, their intention to use VA for primary care and prescriptions, 25 percent went on to use subspecialty care or inpatient care.

And so, sometimes on the surveys there is the asterisk. I think we have to be aware of is that the initial intent to use only for a prescription or as a back-up is often overtaken by reality, which may be a finding of really liking the integrated and comprehensive care, or other economic circumstances.

But many who come initially for one reason end up using a broader array of services than perhaps they anticipated.

Ms. BROWN-WAITE. Could you also break down that statistic to the VISN eight area? I would like it for nationwide and also for the VISN eight area, if you have that kind of specificity.

The other thing is that the survey that you took indicated that 89 percent of enrollees would choose comprehensive VA health care over the prescription-only benefit. Did your survey attempt to distinguish between those veterans who are enrolled in a region that have long wait times, versus a veteran able to obtain fairly prompt care?

And if not, would you imagine that this would be a substantial factor in a veteran's choice? In other words, if he or she can get in fairly soon, does that influence their choice?

Dr. PERLIN. I think your question is very well taken, which is that one might rationally be expected to have a greater interest in pharmaceuticals if they are enduring a very long wait. And in fact, that entirely was the intent behind the transition pharmacy benefit, not to penalize someone for our own inability to accommodate them in a timely fashion, relief of economic burden.

At this level, the survey was really done to take stock of the general interest by three groups: by those veterans who are using the system, to address some of those questions raised, whether veterans who are actually in the system came in just for pharmacy benefit or, in fact, want other care; if those individuals who are enrolled but not using the system, who may in one sense have VA or be conceptualizing of VA care as a back-up; and those individuals who are currently not enrolled. And the survey doesn't distinguish at that level. But your point is well taken.

Ms. BROWN-WAITE. One other question. Many officials in VA privately tell me that they believe that it's 50 to 60 percent of duplication of effort in certain regions, particularly in regions where there are more seniors.

Therefore, I am really interested in the break-out of the VISN 8. And also, could I have a complete list of the survey questions?

Dr. PERLIN. I would be pleased to submit that today, for the record.

Ms. BROWN-WAITE. That would be great, thank you. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. And I think the survey questions are in the possession of the subcommittee staff. If not, they will certainly get them to you. Ms. Hooley?

Ms. HOOLEY. Thank you, Mr. Chair. Dr. Perlin, we have been talking about—for a long time talking about—VA pharmacy benefits. And we don't know yet how Medicare is going to impact our veterans. And that's going to—what did you say? How long is that going to be before that comes out, do you think?

Dr. PERLIN. About eight weeks before we have some preliminary—based on regulations.

Ms. HOOLEY. How much does the VA save by negotiating the cost of their drugs, would you say, over the average price, if I go to my neighborhood drugstore?

Dr. PERLIN. I'm going to turn this question over to Mike Valentino, director of our pharmacy benefit program.

Ms. HOOLEY. Good.

Mr. VALENTINO. Thank you.

Ms. HOOLEY. Welcome.

Mr. VALENTINO. Thank you. It really varies. It really varies by drug class. And the first discount that we get is a statutory discount through the federal supply schedule which is a 24 percent discount off of the non-federal average manufacturer's price.

Ms. HOOLEY. Okay.

Mr. VALENTINO. So that's where we start. And then we are able to derive additional discounts through our formulary management process. As Dr. Perlin mentioned, there are situations within a par-

ticular therapeutic drug class where there are multiple alternatives that are substantially safe and effective, and we may choose Coke and not the Pepsi.

In those situations, the discounts vary, depending on how similar the drugs are and how many alternatives there are. But our experience has been anywhere from 25 to 50 percent additional discounts. And the range is wide, and it's very situation-specific.

Ms. HOOLEY. So, if you have certain circumstances that there is only two drugs, you're obviously going to pay more for those. If there are four or five, you can then really knock those prices down.

Mr. VALENTINO. Yes, ma'am. And when there are two drugs, we would be more towards the lower range.

Ms. HOOLEY. Right.

Mr. VALENTINO. The 25 to 50 percent, as opposed to the upper range, where there may be six or seven or eight drugs.

Ms. HOOLEY. Okay. Thank you very much.

Mr. SIMMONS. Mr. Boozman?

Mr. BOOZMAN. Yes. In reading and listening, there is the implication that there is an increased cost by conversion problems, you know, when things aren't on the formulary and stuff.

I guess, you know, there are a significant number of people that go to their Medicare doctor, get a prescription, go to the VA, see the VA doctor. How is that any different than him doing the conversion process, versus—I mean, I don't understand that.

Dr. PERLIN. Mr. Boozman, your question is very well taken. That conversion process would happen, actually, by a physician or pharmacist.

Let me use an example. And I am proud to say that I continue to see patients over at Washington VA. And if a veteran came in with one anti-hypertensive and we had an equivalent to that but it wasn't the one that was initially prescribed, we would talk about that, perhaps the pharmacist would talk about it.

It's a little bit easier to manage not one-to-one, because the communication is not intermediated. In terms of a physician calling in from the outside and talking to a pharmacist in the VA, you know frankly, they are less apt to be convinced. I want my patient to have this, not that.

And I mean, we don't choose arbitrarily. We really choose those drugs that are either proven to be more effective, or equally effective and less expensive. So we have—we absolutely value the ability to save our resources for veterans by making sure that, given all else being equal, we have the best and least expensive drugs.

Mr. BOOZMAN. So, if they see their Medicare doctor, and then they go to the VA, do they see a VA physician?

Dr. PERLIN. Yes, they do, sir.

Mr. BOOZMAN. Okay. Now, does that VA physician, will he switch them himself to the formulary, or does he go back to the doctor and——

Dr. PERLIN. Generally, the physician will switch the patient there. It becomes not negotiated, but reasonable, and——

Mr. BOOZMAN. Okay. Is there any—as opposed to doing it the other way, you have a less percentage. I mean, did you figure in the amount of doctor time? I mean, what's the cost savings of that

patient not seeing a doctor, versus talking to a pharmacist on the phone?

Dr. PERLIN. Right. Clearly, one would have to account for the time that would be used to make the transfer by the physician in a clinic visit versus a pharmacist by phone.

In this instance, I absolutely agree that there is an offset there. The concern is that the doctor, by virtue of the ability to autonomously switch to an identical agent, is able to effect the decision—end up with two to three percent being within formulary.

The negotiation often times—and you can imagine the telephone tag, and the amount of labor, and the frustration —only resulted in coming down to about 27 percent.

Mr. BOOZMAN. Right. But the question is, you know, what is the savings compared to paying the doctor, using his time, versus the other?

Dr. PERLIN. Yes, I——

Mr. BOOZMAN. Now, you know, I know the others might be a little more hassle, you know, but the bottom line is it's got to be cheaper to do it the other way.

The other thing is is that the—you know, what you hear all the members talking about are the wait times. And then again, that's got to directly affect the wait times, when you've got a physician dealing with someone that wants to be in the VA system that hasn't seen another doctor, as opposed to feeling like they have got to run and—see what I'm saying?

Dr. PERLIN. Right. I think there is a trade-off of cost. I wouldn't want to over-estimate it. I know we have had some ongoing discussion with the Inspector General, and the report was referenced earlier. That was a bit of an anomaly. That was extrapolated from Florida, a group that was systematically different. The savings were overstated substantially.

Mr. BOOZMAN. Well, I think, too, you have to look at where you do your survey. Now, if you do it in a rural state, like Arkansas, where people have to travel, okay, versus the other, you're going to have much higher use of them using their Medicare physician in their home town, mailing in their prescription, and I'd say the cooperation rate will be pretty good if it saves them, you know, a several-hour trip in some cases.

But it just makes sense. How many patients do you feel like that are seen in the VA just because of the prescription drug benefit?

Dr. PERLIN. Clearly, there is—seeing patients, and augmenting the survey with my own real-life experience, there are some small number who, by virtue of really the oppressive costs, given their financial circumstance, come to VA to get those prescriptions.

And I think in the transition pharmacy benefit, perhaps one of the greatest learning points was the fact that that number that ultimately used that benefit was not terribly different than the number the survey and the preceding surveys of enrollees suggested.

And so, somewhere in rough terms, between 10 and 20 percent, that number—the thing that concerns me about that is the number expressing interest went down substantially when a co-pay were part of the equation. And so we would need to consider that.

Mr. BOOZMAN. What are we hearing, as far as—you know, we have had several testimonies, as far as, you know, the people that

use the VA and have dual doctors and things for the prescription drug benefit. It's significantly higher than that, isn't it?

Mr. BRADLEY. Thank you, Mr. Boozman. We have had testimony from both the Secretary and the Under Secretary for Health concerning this topic and both of them have acknowledged there is a significant demand by veterans for a prescription-only benefit. But I do recall the Secretary testifying that he did not think it was a overriding situation in regard to VA demand for care.

Mr. BOOZMAN. Okay. What I would like is the—again, in your calculations—I really would like to see the doctor time, as far as money figured in, okay? And then also, some sort of a prediction that if you did cut it 10 or 15 percent, if you eliminated 10 or 15 percent of those visits, what that would do to the wait times in some areas of the country.

Dr. PERLIN. Great, thanks.

Mr. BOOZMAN. Thanks.

Dr. PERLIN. With your permission, we would include also the expected participation, if that were an option.

Mr. BOOZMAN. Yes, and again, I think you need to look at various areas of the country, as far as this—a real metropolitan area.

Dr. PERLIN. Right. The survey, just for the record, was a nationally representative sample. But I do appreciate your point about systematic differences between urban and rural areas in some of those circumstances.

Mr. SIMMONS. Dr. Snyder?

Dr. SNYDER. Thank you, Mr. Chairman. Doctor, you had—I think when you were talking with Mr. Strickland—talked about your, the VA's, pharmaceutical inflation rate of being around 10 percent for the last 4 years, is that correct?

Dr. PERLIN. That is correct, sir.

Dr. SNYDER. That's an annualized rate?

Dr. PERLIN. No, that is over the entirety of the 4 years.

Dr. SNYDER. Really?

Dr. PERLIN. We have, over a period of 51 months, gone from about $13 to about $14.50 on—as an average total for a 30-day equivalent cost. Is that right, Mike, the number?

Dr. SNYDER. That's almost magic.

Mr. VALENTINO. Yes, that's correct.

Dr. PERLIN. Well, for the magic—you know, I'm glad, thank you for that, we're very proud. And as you have seen, this has been taken note of in *Time Magazine* and *USA Today*.

Dr. SNYDER. Yes.

Dr. PERLIN. And it's really this combination of efficiency and some of the processes with the automation and the ability to manage the utilization, making sure that the veterans get the best there, and——

Dr. SNYDER. Is there any other plan, public or private, in the country that's doing that well?

Mr. VALENTINO. Not that we're aware of, sir.

Dr. SNYDER. Yes, I'm not either. I want to ask you, one of the things about—in the spirit of efficiency, also. You have the doctor fill out a form. Why does the doctor have to fill out a form?

Dr. PERLIN. That has to do with the fact that, in point of fact, we have not operated as a pharmacy before. And I assume the form you're referring to is in terms of the transitional pharmacy benefit.

Dr. SNYDER. Yes, I'm sorry, the transitional pharmacy——

Dr. PERLIN. To require information.

Dr. SNYDER. Why can't the patient just show up with prescriptions? Why does there have to be another—and what good does that form do you? How is that form used?

Dr. PERLIN. That actually happens behind the scenes when one of us would take our prescription to a pharmacist. The pharmacy would actually have that in their databanks, by virtue of doing a whole lot of business. This was really our first time interacting with private-sector physicians.

I'm going to ask Mike to elaborate on the requirements for filling prescriptions in that regard.

Dr. SNYDER. Well, I just—I'm just trying to understanding why, if I'm a doctor and I write a prescription, you've got a database of the licensed physicians in this state, why, if I look at that, as long as there is not a suspicion that it's a forged pharmacy, why—what are the advantages of having another form to fill out that says whatever it says?

Mr. VALENTINO. Actually, we in VA do not have those types of databases. We have data on our own providers, and perhaps fee basis providers that we do use.

It also allows us to collect some basic information on that patient that we may not have until they have their first appointment, allergy information, for example. So it's just an effort for us to gather baseline information on the physician and patient that will allow us to provide the prescription to them.

Dr. SNYDER. Okay. It's not clear for me that there is actually any decision-making that changes because of this form that comes in with the patient.

Mr. VALENTINO. No, sir.

Dr. SNYDER. Well then, it's just—I would think it would be a waste of time, but maybe not.

I want to ask about the formulary. Forty-two percent were non-formulary drugs, and your statement is less than 3 percent for your VA physicians. Is that—in order for a VA physician to do something like a non-formulary drug, do they have a separate form they have to fill out to go off formulary?

If that's the case, then was there—when this plan was put together, was there any thought of—I assume your formulary is online some place, and you just say, "Hey, we're going to fill your prescriptions, Doc Snyder, you're sitting out there Arkansas, you fill it with a formulary drug or we don't fill the prescription."

Dr. PERLIN. Yes, sir. Thank you for that suggestion. I made it myself. And we actually, in the mail-out, had a list of our top 100 prescriptions, the most common things, *know,* the anti-hypertensive, those sorts of things, and we referenced a website that had the transition pharmacy benefit on it.

But I can tell you, having—I cut my teeth in VA, I went to private sector and academia, came back to VA—a clinician in practice such as yourself is inundated by multiple formularies. And despite the desire to be sensitive to the patient needs, the experience is

that the clinicians often write a script and let the negotiation fall out later.

And so, despite our best efforts of posting a website with the prescriptions, arming the patients with a list of top VA formulary choices, we still have this reconciliation to do.

Dr. SNYDER. It also brings up the point of the fact that you use your formulary, and I personally don't have many complaints of veterans about not being able to get the medicines they want, and then your inflation rate is so low, and yet—I mean, that's—I would not have expected that 42 percent of the prescriptions coming from the private sector would be non-formulary drugs, which may account for why the cost is going up in the private sector.

Dr. PERLIN. I think that's a very good point, because, in fact, in some areas such as a class of beta blockers or calcium channel blockers, there are so many different agents that the opportunity to prescribe something that's not is pretty substantial. Mike, you want to——

Mr. VALENTINO. Yes, I think that, we have done a good job with the contracting of our drugs, but I think we have realized a very large portion of our savings through developing evidence-based prescribing guidelines. And we really do take a hard look at what the medical evidence and literature says, in terms of safety and efficacy, which is many times, a much different message than the marketing and advertising information that's available.

Dr. SNYDER. They may look at what's available in the sample room.

The last question I wanted to ask was is there anything in your written statement today that we ought to know about that was not included in your written statement, for those of us on the committee and the staff that are trying to make decisions in these areas? Is there anything that we ought to know about that is not in your written statement?

Dr. PERLIN. Well, thank you. A couple of comments. First, one of the things that one would want to consider is not creating a paradox where veterans who might use a pharmacy-only benefit would have access to a formulary that would actually offer choices that we couldn't offer to those individuals who receive comprehensive care. It would create a strange juxtaposition of those individuals with service-connected disability, et cetera, unable to access certain sorts of pharmaceuticals.

The reason this is concerning is because—to use your word, sir—the "magic" that's been worked, in terms of having a formulary, has been both effective and efficient, has been really by having a close and a limited formulary. So that's not in our statement and is a consideration of these sorts of benefits. I would ask you to please consider that aspect. Thank you.

Mr. SIMMONS. Thank you. We have all heard the buzzer. There is a 15-minute vote on the journal and a 5-minute vote on the Thompson motion.

I guess my thought is that if I continue to march here with the next panel for another 5 or 6 minutes, we can recess and then I will return. I hope my colleague from Texas will be able to return to give the last panel full attention.

But I did want to suggest, for the record, that the Office of Inspector General report be submitted into the record, and I make the comment that the Under Secretary for Health commented under paragraph five that "We agree with your findings that the cost of providing prescription drugs to priority group seven veterans continue to escalate, and that current laws and practices lead to redundant evaluations that impact the timely delivery of service to other enrolled veterans."

So, I think that back in the year 2000, the VA did identify the bones of the problem that we're discussing now. I agree that VA has made some dramatic improvements in how it functions. What we're looking at is broadening the scope of those who can take advantage of that.

And on that basis, I appreciate very much your testimony, and would consider actually coming down to the Washington VA to see how you do it, and bringing as many of my colleagues as are interested to come along for an hour or so, probably after the Easter recess. With that, I thank you for your testimony and would ask the third panel to prepare themselves.

Dr. PERLIN. Thank you, sir.

Dr. SNYDER. Thank you.

Mr. SIMMONS. Panel three involves testifying for the Vietnam Veterans of America, Mr. Rick Weidman, who is director of government relations, William Carl Blake, who is the associate legislative director of the Paralyzed Veterans of America. And representing the Disabled American Veterans is Ms. Joy J. Ilem, the assistant national legislative director.

Mr. Peter S. Gaytan is testifying on behalf of the American Legion, and functions as the principal deputy director of veterans affairs and rehabilitation division for the American Legion. And Mr. Richard Jones is the AMVETS national legislative director, and he is presenting testimony for AMVETS.

How much time do we have on the vote, does anyone know? Ten minutes. Ten minutes left. We have 10 minutes. So do we have a fast talker, or somebody with a short statement? I leave it to you to flip the coin and see who goes first. Thank you very much. Put on your microphone, and here we go. Thank you.

STATEMENTS OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION; RICK WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF PETER S. GAYTAN

Mr. GAYTAN. Mr. Chairman, thank you for allowing the American Legion to reaffirm its position on a prescription-only health care benefit for certain veterans.

The American Legion believes VA's pharmacies are very much a part of its integrated, holistic approach to medical care. VA's phar-

macies were established to support the nation's largest health care delivery system, and were never intended to become a mail order prescription house or the corner drugstore.

The American Legion is concerned about the overall cost of VA filling a larger number of prescriptions. With the increase in enrollments since the implementation of the Veterans Health Care Eligibility Reform Act of 1996, and a projected actual increase in utilization by a traditionally older, sicker population, additional funding and pharmacy personnel will be required to meet the demands of any such benefit.

A permanent prescription-only benefit would certainly increase the VA's pharmacy costs considerably. VA's pharmacies are already overtaxed, given that over four million veterans currently receive their prescription medications through VA. Even without enactment of a permanent prescription-only benefit, VA expended $2.8 billion in outpatient pharmacy.

This share is due to many factors, including increased enrollment, medical inflation, and new drug therapies. Mr. Chairman, while the American Legion agrees with the need to ensure veterans receive prescriptions in a timely manner, we fear the possible detrimental effects a prescription-only benefit may have on the overall delivery of health care by VA.

Veterans must be able to have their prescriptions filled through VA without having to join the line of more than 30,000 veterans currently waiting for appointments. It is our hope that the report on the status of the transitional pharmacy benefit presented here today will provide some insight into the effectiveness of such a plan.

The American Legion stands ready to assist this subcommittee and VA in developing a pharmacy benefit that will improve the current VA pharmacy plan without creating new liabilities for the VA health care system. Thank you again for this opportunity to join in this informational hearing on behalf of the members of the American Legion.

[The prepared statement of Mr. Gaytan appears on p. 72.]

Mr. SIMMONS. Thank you, Peter. And I think at this point we will go into recess, if that's agreeable to the panel. And we will be back shortly. The subcommittee stands in recess.

[Recess.]

Mr. SIMMONS. The subcommittee will come to order, and I thank Mr. Gaytan for his testimony. Who is next?

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Thank you. I just got off the telephone with your commissioner of veterans' affairs for the State of Connecticut who, at the ceremony the other day she attended with you, caught the flu, sir. So she is home recuperating, and will soon be back in action. But she sends you her very warmest greetings of great respect.

Mr. SIMMONS. Thank you.

Mr. WEIDMAN. I would like to thank you, Mr. Chairman, and ranking member Rodriguez, for your inviting us to share our views with you here today.

The first general statement is that the temporary pharmacy benefit, as intended by the Secretary in the regulations promulgated last year, appear to be working well. We sent out a message when we got word of his hearing to all of our state presidents, all of our national officers around the country, and to all of our service representatives.

And the feedback was universally positive, that where it was being employed—and I say "where it was being employed," because many of the waiting lists have dropped below 30 days—where it was being employed, it was working as the Secretary intended, and that the pharmacy service has done a great job.

Second thing I would just like to note about the pharmacy service in general is that if we could get the rest of VA to be as accountable and as efficient and effective as the pharmacy service has become over the course of the last two decades, we would be in much better shape today.

A lot of people talk about it at VA, a lot of people talk about the Baldwin Award, et cetera. Is is, in fact, the one part of VA that truly practices the Deming method of incremental improvements but on a constant basis, and no backsliding in making the service better and better, both more efficient and more effective.

The formulary versus non-formulary issue that was brought up earlier today is one that does need to be addressed, and that is patterns that—where people are frowned upon if they go non-formulary. You will notice the three percent figure, which certainly caught our eye, and I talked to Mr. Valentino briefly, and will be following up with him, sir, about all too often they go with what's cheapest because they're spoken to by their supervisors, various clinicians. They claim that's not the case, but the pattern is clearly there.

There should be no need for this temporary benefit, and that is VVA's position. We need proper funding for the entire system. You will notice I am wearing my button about health care budget reform specifically to emphasize this point, because if this is—as has been pointed out at this hearing numerous times—an earned right, that's just one part of it. We need the dough to make it go.

But secondly, we also need to make this truly a veterans health care system by beginning with every single veteran who comes to the VA who—currently there or in the future. You have taking of a complete military history and speeding up the process of putting that as part of the permanent patient treatment record, or the PTR, and used in the diagnosis and treatment.

There are many, many veterans who are currently category sevens and category eights that, if properly evaluated, it would turn out that they would become ones and twos. Why? Because they actually have diseases, maladies, injuries, et cetera, that are directly traceable to incidents, exposures, and to diseases and exposures to toxins that occurred in the military.

But we are not classifying them that way. And so, that needs to happen. We deserve a veterans health care system at VA, and citizens of America believe that's what they're buying with their tax dollars, and we need to enhance efforts greatly in that regard.

It is, as I said, a veterans health care system. And if it's not a veterans health care system, if it deteriorates only to be general

health care that happens to be for veterans delivered by the VA, we will lose this system. And we will also not do right by our veterans because they will not get well.

We have testified on this many times, and don't wish to prolong that, but do want to say that this card—and we attached a copy of the website as an attachment to this testimony—is something that still is not being utilized by VA, even while they wait for the new architecture of the new system in the Veterans Health Administration, there is no reason why the Secretary and the Under Secretary cannot move forward now to implement a training program in why is military history important and what are the certain signs based on when you served, what branch you served in, where you served, what was your military occupational speciality, and what actually happened to you my friend, and check with those diseases.

So, we agree with our colleagues from the DAV that the continuum of care that is both somewhat there now and can be much more there with existing resources even, and with the existing staff, simply by training, is something that should not be denied to any American veteran, to have them made as whole again as possible, as they would have been had they not put their life and limb on the line in defense of the Constitution.

Mr. Chairman, that concludes my remarks. I wish to thank you again for holding these hearings, and for allowing Vietnam Veterans of America to present our views to you here this morning, sir. Thank you.

[The prepared statement of Mr. Weidman, with attachment, appears on p. 74.]

Mr. SIMMONS. Thank you, Rick. And I will defer to the panel as to who goes next.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Simmons, Ranking Member Rodriguez, Paralyzed Veterans of America would like to thank you for the opportunity to testify today on a possible prescription-only health care benefit within the VA and on the transitional pharmacy benefit.

Lacking a detailed legislative proposal, we can only make general comments on a possible prescription-only health care benefit. We have expressed concerns in the past about the expansion of prescription drug benefits. We have previously testified that we have serious concerns about the costs associated with expanding the pharmacy benefits beyond our current scope.

Prescription drugs are an increasingly large component of medical care spending. Over the last 7 years, prescription drug expenditures have increased at double-digit rates, according to a fact sheet prepared last year by the Kaiser Family Foundation.

Likewise, the rising cost of pharmaceuticals have far outpaced the rate of inflation. This essentially translates into higher cost to the VA to obtain and provide these pharmaceuticals.

The VA does not operate in a health care vacuum. An expansion of the pharmacy benefit would increase demand on the system, and an increase in the demand would necessitate shifting scarce resources away from treating veterans. PVA believes that the VA would then be forced to treat fewer veterans, and might even be

tempted to once again increase prescription drug co-payments, thereby essentially shifting the higher costs on to the backs of more veterans.

Again, lacking a specific legislative proposal, we have no way of ascertaining the costs of expanding the pharmacy benefits or restructuring how pharmacy benefits are provided. PVA has also expressed concern that many recent prescription drug legislative proposals could change the basic mission of the VA, which is to provide health care to sick and disabled veterans. The VA does not need to take on the role of the veterans' drug store. Now is not the time to take chances with the lives and health of veterans by dramatically and fundamentally changing the nature of the VA health care system.

PVA fears that if we embark upon this path of only providing certain health benefits to certain categories of veterans, we could very well see the erosion of the VA's mission. The VA would essentially revert back to the way it provided care and services prior to eligibility reform, which health care was governed by the medical needs—or, rather arbitrarily budget-driven classification.

With regard to the transitional pharmacy benefit, public law 108-199, the omnibus appropriations bill from last year, provided Secretary Principi the authority to dispense prescription drugs from VHA facilities to enrolled veterans with prescriptions from private physicians.

Included in that public law, and further explained in the conference report that accompanied it, report 108-141, was a requirement that the VA would incur no additional cost in providing such a benefit. I say that again, that the VA would incur no additional cost in providing such a benefit.

PVA has expressed concern in the past with proposals similar to the transitional pharmacy benefit. The House report required the VA to collect and independently verify data on the costs and benefits of this new drug benefit, and submit a report to the committees on appropriations by March 2, 2004.

It was interesting to see some of the statistics that were mentioned in the Secretary's—or in the Under Secretary's testimony earlier, but I don't take that to be the report that's outlined in this omnibus bill. We look forward to seeing what—any details that may come out of that, and we're kind of interested to know if that actually has been put together yet, given that the date was set for March 2nd for that report to be provided.

PVA believes that allowing the VA to fill prescriptions written by private physicians will further exacerbate an already dangerous funding problem. I must emphasize that without adequate funding, to meet increased demand for prescription drugs created by such a program the VA will be forced to obtain funding through other means. The funding may be drawn from an already wholly inadequate health care budget that Mr. Weidman explained in detail, or it could come from increased costs to veterans, as I have already mentioned.

We appreciate the opportunity to testify today on this issue, and Mr. Chairman, I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 82.]

Mr. SIMMONS. I thank you for your testimony, and I believe Ms. Sullivan is available here. And if she could perhaps provide that information to us, the public law 108-199 report, that would be appreciated. Thank you. Who is next?

STATEMENT OF JOY J. ILEM

Ms. ILEM. Okay. Mr. Chairman, Ranking Member Rodriguez, thank you for the opportunity to present the views of the Disabled American Veterans on a prescription-only health care benefit.

The DAV has testified previously on several measures introduced in both the House and Senate that would authorize VA to fill prescriptions for veterans ordered by non-VA physicians. In general, we are opposed to this concept, and have expressed concern about the VA taking on the role of a pharmacy.

Specifically, we are concerned that the impact of such a benefit will cause a major shift in reliance on the VA health care system for other than a full continuum of care and utilization of the comprehensive health care benefit package, therefore, possibly jeopardizing the viability of the entire system.

However, we recognize that VA is struggling to provide timely health care to all veterans seeking care, and we appreciate the subcommittee providing this forum to further debate this issue and to re-examine the potential impact of introducing a prescription-only benefit option to certain veterans.

It has been reported that increasing numbers of veterans age 65 and older are turning to VA for low-cost prescription drugs. While we agree that in some cases a prescription-only benefit may eliminate the duplication of tests and procedures already conducted by a veteran's private physician, it would make available VA resources utilized in the current process. It is not clear whether this type of initiative would be wholly beneficial to the VA health care system or veterans themselves.

At the March 19, 2003 hearing on this issue, VA expressed concern that if an add-on pharmacy benefit was initiated without additional funding, it could erode the comprehensive medical care benefits that users of this system now enjoy.

VA expressed reservations about implementing such a program because of the potential for significantly increased demand, projected increases in current pharmacy workload, and the potential impact that a prescription-only benefit could have in its in-house and consolidated mail-out patient pharmacies. We believe the VA's concerns are valid and merit further consideration.

There is also the question of appropriate quality assurance if prescription-only benefit were instituted. Currently, VA prides itself on being a comprehensive health care provider offering coordinated interaction between VA clinicians and pharmacists to ensure veterans receive the highest quality health care possible.

VA has stated that the proper and effective use of medications by patients is the cornerstone of modern health care, and that drug therapy should be monitored, coordinated, and managed by a single primary care provider to ensure good patient care and avoid medication errors.

We do not believe there has been a sufficient study of the potential impact of implementing a prescription-only benefit on the VA

health care system, or on the quality of care veterans would receive with a limited pharmacy benefit.

Although VA's office of inspector general offered a potential savings for such a benefit, a potential cost analysis should be considered as well. importantly, the quality of care received by America's veterans should be the focus of assessing VA's pharmacy benefits.

Currently, we face challenges. Specifically, finding a comprehensive long-term solution to sufficient VA health care funding, maintaining access to timely, high-quality health care services, keeping open enrollment for all veterans who need VA services, and most importantly, protecting VA's specialized programs for veterans with spinal cord injury, blindness, amputations, and mental illness.

Therefore, we cannot afford to be short-sighted or satisfied with temporary solutions to resolve VA's backlog for care. Band-Aid approaches may help with few veterans in the short-term, but could ultimately short-change millions of veterans in the long run. The men and women serving in our armed forces today will need the VA for decades to come. We must ensure a stable and viable health care system for veterans now and in the future, and work together to develop long-term solutions to these complex problems.

Mr. Chairman, that concludes my statement, and I will happy to answer any questions this subcommittee may have.

[The prepared statement of Ms. Ilem appears on p. 89.]

Mr. SIMMONS. Thank you very much. And now, through the process of elimination, Mr. Jones?

STATEMENT OF RICHARD JONES

Mr. JONES. Thank you. Chairman Simmons, Ranking Member Rodriguez, on behalf of AMVETS' national commander John Sisler, and the nationwide membership of AMVETS, I am pleased to offer some comments on providing certain veterans with a prescription-only health care benefit.

Regarding prescription drugs, the current general policy makes veterans eligible to receive VA prescription medications only if a VA physician has prescribed the medication to today's certain limitations and certain exceptions.

According to the inspector general of the Department of Veterans Affairs, the VA pharmacy benefit is the primary reason that veterans without service-connected disabilities use VA health care services. The inspector general says that nearly 90 percent of these veterans have access to private health care and private physicians, yet they wait in lengthy lines at the VA in order to be re-examined and re-tested. This causes veterans with a prescription already in hand to wait weeks, even months, before it's filled, and creates a backlog of veterans waiting for doctors appointments.

It is little wonder priority eight veterans have availed themselves of this benefit after Congress allowed them access to the VA system. After all, figures from the National Association of Chain Drug Stores claimed that for 2001, VA's cost per prescription was almost half the cost found in the private sector.

Mr. Chairman, AMVETS is generally supportive of extending and enhancing the VA policy on prescriptions. For example, we would like to see all enrolled veterans allowed to renew their pre-

scriptions, as well as receive the first issuance of a non-VA-prescribed medication.

AMVETS would also support legislation that openly allows VA to fill a prescription for a veteran who has been diagnosed and prescribed medication by a non-VA physician. Many eligible veterans could see a substantial reduction in their medication expenses. They would also witness, in part, a promise of care fulfilled.

In addition, a benefit of this type would likely induce some priority eight veterans enrolled before the Secretary's cut-off date to return to their non-VA health care providers, and thereby reduce VA patient backlogs.

And in the past, we have voiced concerns about the potential for VA becoming a national drugstore, rather than a provider of care. We have said that we would not like to see further diminishment of veterans' access to care, because medical care dollars would be spent for prescriptions instead of primary or critical care of veterans.

However, with the understanding that VA has rolled over more than $600 million unused fiscal year 2003 medical care dollars into fiscal year 2004, and projects increasing this amount to $800 million in fiscal year 2005, we no longer see the lack of available funding as a rationale for a barrier to veterans access prescription drugs. The money is there.

Indeed, in this understanding, AMVETS is doubly disappointed in the ban on priority eight veterans. We know that VA has instituted a 30-day appointment policy that allows veterans to be seen by doctors outside the VA system if they can't be scheduled within the time limit. Taking into account that the average cost of providing care to a priority eight veteran is $2,500 a year, there is ample funding available to give medical care to those veterans who earned and deserved it this year.

We recognize that the budget appropriations process for this year has only just begun. But the course set by the House last week raises concern. The approved budget may appear ample when viewed with green eyeshades to those who view them that way. But to the clear eye of those who served in the armed forces and many other Americans, this is a growing question about decision-making and national priorities.

Mr. Chairman, in closing, AMVETS thanks you for advancing the dialogue on the prescription drug needs of our nation's veterans. We look forward to working with you and others in Congress to resolve this matter.

As we find ourselves in times that threaten our very freedom, our nation must never forget those who ensure that our freedom endures. AMVETS thanks the panel for the opportunity to address this matter.

[The prepared statement of Mr. Jones appears on p. 93.]

Mr. SIMMONS. Very good statements, and I appreciate it very much. I appreciate very much the fact that we're all aware that last week there was some hurly-burly on the floor, and yet I'm so gratified, I guess I could say, that throughout the course of this morning we focused very clearly and intently on this issue, and there was no retrospective rhetoric, let's put it that way. And that

shows what a fine subcommittee we have here, made up of some very fine people.

I also personally wish to thank the representatives of the various veteran service organizations for their work, because it's got to be frustrating when we get through a week like last week, and you shake your head and you wonder what happened. But I commit to you that it ain't over until it's over, and it ain't over yet.

So, that being said, I have a couple of questions for the panel as a group, and perhaps I will start with a comment. You understand that we are not testifying on a specific bill today, but we are, if you will, examining a concept. And as I would frame the concept from the testimony of the first panel, the concept is that somehow we must be able to provide access to those veterans, priority sevens and eights primarily, who want access to a pharmacy benefit without the long delays, and without the cost of those delays, which is $1 billion, by the VA's own examination. And that's a substantial cost.

They appear to be more or less pleased with their private provider, they don't want to turn the VA into a drugstore, but as veterans they want to access that benefit.

And so, the question I posed to myself is is there a simply cost-neutral way to accomplish that task? Cost neutral, which means there may be a co-payment for them which is higher than what the average veteran is accustomed to, and yet would provide this priority eight or seven, who is currently out of the system, with access that would create savings. Is that not possible?

And I guess our actuaries can examine and see whether that's not the case. I think it would be possible. The VA has testified that they have encountered certain burdens and certain costs in implementing their temporary benefit, but by and large it seems to have been successful in meeting its limited goals.

The survey shows that they're up to 3,000,000 people out there who might be interested in this, which is a substantial number.

And speaking simply for myself, I have—I received a draft notice, I put in my time in Vietnam, I actually had 3½ years total service in that country on active duty and, in fact, in the Reserves. I did Reserve duty in Vietnam in Saigon, when I was assigned with the Central Intelligence Agency. So I did Reserve duty for 2 week in a war zone.

I retired last year with 37 years, 7 months, and 24 days of active in Reserve service. But because I am a priority eight, I cannot access the VA for my medical health care or for my pharmacy benefits. Now, that's because I didn't take advantage of the VA at a time when it was open to all priorities, but it's closed now.

And I guess the point that I'm trying to make with my own personal story is that it seems to me that priority eights who are seeking a pharmacy benefit should somehow be able to access that, particularly if it's cost neutral. Particularly if it's cost neutral and in fact, if it could be structured in such a way to capture some of the savings that are available there.

We all know that there is a struggle for resources. We all know that the funding is inadequate, or approaches adequacy. We all know that. We have been at this for a while. But we also know that

there are certain realities that we face in trying to capture those funds that are ugly realities.

And so, what I am trying to explore in this context is a way to accomplish a task in a way that's not going to add to the financial burden, but will add to the benefits of our comrades in arms, especially in this way.

The last thing I would be interested in doing is degrading the full benefits that our veterans receive, and degrading the capacity of the VA to meet its goals and objectives. But nonetheless, I felt that the issue of pharmacy is so important.

And just to conclude, veterans in Alaska have a pharmacy benefit, because the distances are so great, the facilities are so limited, that there is a full-service prescription drug benefit offered by the VA to veterans from Alaska. And I daresay certain other geographic areas of the United States could really benefit from that program, and that we have an obligation to explore that and not to let past history get in the way of where we are today and where we are going.

And for those who suggest that we don't want to degrade Veterans' Administration health care, I would argue that for many veterans, access to prescription drugs is that aspect of the health care that they really want and need, that they may not be seeking hospitalization or prosthetics, or certain other types of care and treatment, that in fact, with the modern model of health care delivery, prescription drugs are very much part of the health care.

But I see the red light, and I will cease and desist. I never got my question in, and I apologize. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you. Let me thank all of you for being here with us, and let me just say that what I gather, you know, is you're also saying that our budgets, have basically determined what we have provided. So your concern seems to be that if we move in this direction, that it will funnel away a lot of the resources that are being presently used for other things.

Now, if we begin to fund VA based on mandatory funding, I would presume that there would be an opportunity there to do the right thing and add resources based on where the needs are. Because of our current funding we are not sure that the money is automatically there and allocated based on the veteran.

Then I would presume that some of you would be supportive of a prescription benefit, in some formula basis, based on our veterans out there, We would be able to look, for example, to west Texas, where they might not have any access and give them at least something. And I know that you know the VA has a real gap in service that exists out there. We don't have that coverage uniformly across this country.

And somehow, we have got to keep working on that, see how we can do that, and distribute that money automatically so that we can—if we have 100 veterans come into a location, then we fund you for 100 veterans coming to that location for specific services.

Let me ask you—and I apologize, because I don't know—H.R. 1309 allows Medicare to reimburse VA. I wanted to get your perspective on that, and any other comments you want to make. Also, based on the need, tell me if you might be supportive of a program that would be uniformly supportive of a program that would pro-

vide the access to prescription drug coverage. And I guess we could start on either side.

Mr. JONES. Mr. Rodriguez, AMVETS has written a letter to Representative Lane Evans supporting the goal of H.R. 1309, saying that we may have some concerns about certain specifics.

I think the legislation would include all veterans, priority one through priority eight. That would mean that some priority one veterans might forego their comprehensive care to obtain the pharmacy benefit. There may be some need to tickle that part a little bit. But we have supported the goal of H.R. 1309, and we think that bill presents a nice adjustment and something that might well work.

We would like to—these people do pay Medicare dollars through their working lives following their military service, and this would be a good way to ensure that they get the benefits they paid for.

Mr. GAYTAN. The American Legion does support allowing Medicare-eligible veterans to receive health care through the VA. That entails pharmacy benefits, as well. The American Legion supports that.

I do want to go back to discuss a little bit about what the chairman mentioned earlier, about the fact that we know that priority group eight veterans have been shut out of the system. We know that VA is funded at an inadequate level, and that we're discussing or debating or considering a benefit that would be cost-neutral.

The American Legion doesn't feel that veterans have ever been asked to do anything cost-neutral. I'm sure you don't think your 37 years were cost-neutral. The American Legion doesn't feel that veterans should be one category of Americans that has to look at a benefit, an earned benefit, only if it doesn't cost the government anything.

The American Legion supports repealing the suspension of enrollment for priority group eights, allowing those priority group eights to go back to the VA. The American Legion supports mandatory funding that will provide a budget that will prevent us from sitting in this room today and discussing other options, other ways that we can get veterans out of a line that exists due to an inadequate budget.

The backlog that we have talked about all morning here is due to the fact that funding levels are too low. And when those facility directors of VA's hospitals actually receive their budget, it's 4 months late. They can't anticipate the need for full-time employees, they can't anticipate the needed resources. So, therefore, the backlog exists.

If they are waiting in line, if a veteran is waiting in line to receive pharmacy benefits, or if he or she is waiting in line to receive health care, the American Legion opposes that.

What the American Legion sees as a solution to all these problems, to prevent the debate on cost-neutral benefits that are earned by America's veterans, a quality budget needs to be provided and in a timely manner, so that the directors of these facilities are able to meet the needs of America's veterans. And the American Legion supports mandatory funding to address that problem.

Ms. ILEM. I would just respond also that we did a letter regarding that bill, and we did have some specific concerns about the bill but, you know, appreciated the overall intent.

However, I also would like to just mirror comments of Mr. Gaytan and my other colleagues, you know, that we believe there is an overall larger issue here, and we would like to have a hearing and further debate on that issue, as well, and the issue of mandatory funding.

We have been seeing lots of bills over the past year with regard to access issues, with regard to benefits, you know, these certain pharmacy benefits and all of these other things. And you know, when we boil those down, we keep coming back to the same issue.

And we want to—I think everybody has the same goal in mind, you know, we want to see what's right for veterans, what's best for the system to ensure its viability in the future for our veterans that are coming back today that, you know, are going to be needing that system, you know, for decades to come. So that has to be, you know, the priority. So we hope that you will consider that. Even though it's a controversial issue, we hope that you will. Thank you.

Mr. SIMMONS. I'm happy to extend my colleague all the time that he needs to have his questions answered.

Mr. BLAKE. Thank you very much, Mr. Chairman. I don't think I could really say anything any better than what Mr. Gaytan said, as far as the solution to the overarching problem we have here.

But in response to your question specifically about that bill, last year we did testify generally in support of the measure. We do have still some concerns that we have had all along with regards to any of these prescription drug legislative proposals, first and foremost being a possible fundamental change of admission of the VA.

We have to remember that the reason for the VA is to provide health care to the nation's sick and disabled veterans, and then every other thing that the VA does is in support of that mission. So we have to be careful not to erode that mission in providing a benefit.

We also have to be—also, as a secondary concern, we don't want to have a benefit where veterans may have to forego some part of their continuum of care just to receive a benefit.

A veteran should be able to receive all of their care. And as a part of that, prescription drugs are one of those benefits. But they shouldn't have to opt out of one to receive another. That's another major concern that we have had. But we were generally in support of Mr. Evans' bill last year.

Mr. WEIDMAN. VVA also has reservations about H.R. 1309, but has consistently been in favor of Medicare subvention at the VA. The—I want to associate VVA with the remarks made by my distinguished young colleague, Mr. Gaytan, as well as comments made by my other distinguished colleagues here at the table.

In regard to doing something about the funding base, we all are in agreement with that. That's number one. But from VVA's point of view, there are three things—three legs on this stool, otherwise this stool falls down.

One is we need the dough to make it go in a consistent fashion so people can plan, and therefore, use -- get bigger bank for the

buck, because they know how much they're going to have. That's number one.

Number two is that we need to make this truly a veterans' health care system. And everything that we do in terms of stopgaps, we believe, should be seen through that prism of does it detract from that fundamental core mission of assisting American veterans with their veteraness, if you will, that is, related to their military service.

And third, but by no means least, is significant action by the committee and by other committees in this Congress to increase accountability, not just on departments and not just on areas within departments, but on individual senior managers, and hold them accountable.

VA is—and particularly VHA—is notorious for never holding any senior managers truly accountable. The Kansas City hospital director that people say, "Well, he was fired." He wasn't fired. He retired with full benefits and a bonus and an award from VA and a retirement party paid for by VA. This is—I mean, throw us into that briar patch, any of us here at that table—is drawing a pension greater than most of us in this room earn.

So, it's—the question of accountability all has to enter into that, making it a VA health care system, and then making sure that we have adequate resources.

I do want to just offer one parenthetic, if I may, about the $1 billion that the IG says we could save by sending people straight to the pharmacy benefit. We would urge the chair and the ranking member and your distinguished colleagues to beware of reports bearing good news on financial savings.

[Laughter.]

Mr. WEIDMAN. The GAO report about saving $1 million a day drove this care system. It was bogus from the start, most of us knew it, and if, in fact, there was wastage in trying to heat buildings that were antiquated and dilapidated, why was that? Why was that? Because VA and the folks here on the Hill had not done proper stewardship for some time.

And turning around and selling some of those properties, as is now being discussed, is akin to selling your seed corn—and this is something you never do. You don't sell a seed corn, because then you don't have a crop the next year. Stewardship means the land does not belong to you. Stewardship means that the VA health care system does not belong to any of us here, it belongs to the American people, and to those veterans who will come after us so that that IG report we would look at very, very skeptically, and would urge you also to examine that Trojan horse very carefully as well, gentlemen. Thank you very much, sir.

Mr. SIMMONS. Thank you. I will just make a brief comment on the issue of cost-neutral. The way I see it is not -- the way I see it is cost-neutral to the VA, not to the veteran. And I guess I'm focusing on Mr. F that Dr. Hong was testifying about.

Mr. F is paying $642 a month for the same prescriptions that Mr. M is getting for $42 a month. That's a fundamental inequity. And what I'm trying to figure out is how I can get Mr. F to get his monthly cost down to at least $154.95, which, theoretically,

does not create a substantial burden for VA, but provides a substantial benefit for Mr. F, who is currently shut out.

Now, in a perfect world, I would want everybody in the system, and I would want them to get all the bells and whistles, the full enchilada. That's what I would like. But I don't live in a perfect world, and neither do you. Neither do any of us, as much as we would like to.

So the question I have in my mind is when we're looking at Medicare subvention, which I support, but I see the forces arrayed against it—we all know that, it's no surprise, we've tried, we know that they're out there—when we know that the dollars are inadequate—I know that as well as you do, but I'm not sure how much I can change that—then I look to see what part of the system I can tweak to get a few more people in the door to get a benefit that I think they have earned and a savings that, to them, will be substantial.

So, again, I think that we all have the same goal, we're perhaps trying to achieve it in different ways. And that really is the purpose of this hearing here today.

I will conclude by saying that years ago at Fort Devens, Massachusetts, which is now a prison and a community—talk about being a good steward of your resources, what a disgrace that is—but anyway, years ago at Fort Devens, Massachusetts, I met a retired colonel called Millett, Colonel Millett. I don't know whether anybody remembers that name, but he was a Korean War veteran who won the Medal of Honor. And he won the medal of honor as a young officer when he and his unit were surrounded. And they ran out of ammunition.

Now, of course, we always want our troops to have ammunition. I mean, we always want our veterans to have resources. But they ran out of ammunition. And the question was, "What do we do now?" Well, Colonel Millett—then Lieutenant Millett—said, "Fix bayonets." And they fixed bayonets, and they charged out of their position, and they broke out and lived to fight another day.

And in the process, a unit commander on another hillside, on observing this, wrote him up for the Medal of Honor, which he received. But there are times in all of this when we run out of ammunition, and so we have to fix bayonets. And I guess that's what this hearing is all about. Thank you all very much. The hearing is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT
HONORABLE ROB SIMMONS
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

HEARING ON A PRESCRIPTION-ONLY HEALTH CARE BENEFIT FOR VETERANS

March 30, 2004

The Subcommittee will come to order. I wish to thank everyone for coming this morning and welcome our witnesses and Members in attendance.

Sir William Osler (1849 - 1919), appointed in 1888 as the first physician-in-chief at the Johns Hopkins Hospital in Baltimore, is quoted in ***Aphorisms from His Bedside Teachings:*** "One of the first duties of the physician is to educate the masses ***not*** to take medicine." Another way of Sir William putting this would be: "Say no to drugs!"

However, today a century after we failed to take Dr. Osler's cure and stay off drugs, in today's health care system, prescription drugs play a vital role in healing and maintaining health. Not only are more Americans than ever before using prescription drugs, but the number of prescriptions per person has grown. Prescription drug costs rose 15.3 percent nationally in 2002—to $162 billion. VA's contribution to this is about $3 billion. These costs will invariably rise, as will utilization, because drugs are the miracle of modern medicine. The projected cost of prescription drugs in the United States in 2014 is predicted to be $414 billion and I am certain we will see a commensurate rise in VA's use of drugs as a part of delivering good health care to America's veterans.

In February 2004, a private task force on the future of health insurance reported that the growth in spending on drugs led all other health care services in both 2001 and 2002. The subject of today's hearing would build on an earlier hearing this Subcommittee conducted in the first session of the 108th Congress – a dialogue to gauge the viability of providing veterans a VA prescription-only benefit.

With millions of veterans demanding VA health care, VA medical centers across the country fell behind in providing veterans access to care. By all accounts, the waiting lines are improving, but we still hear about significant delays in providing veterans the care they need.

Today we will hear testimony on some ideas that might improve and extend prescription drug services to veterans in different ways. We will hear testimony on an idea of the Commander of the Veterans of Foreign Wars, Ed Banas, my friend and constituent of the Constitution State of Connecticut. Commander Banas is advancing a notion that many Members of Congress have heard much about from veterans – how to gain access to the important health service of prescription drugs, whether or not veterans actually use the full services available from VA. Also, Dr. Cornelio Hong, a practicing physician from Norwich, Connecticut, is graced us with his presence to give a private practitioner's perspective on why VA should be providing this service to a subset of our nation's veterans.

We will hear from the Department of Veterans Affairs on its efforts to provide "transition pharmacy benefits" to ease pressures on veterans while waiting for VA care, and VA also will provide a report on the results of VA's survey of veterans to determine the perceptions among veterans whether a prescription-only benefit would meet some of their needs. In addition, the survey collected

data to allow an actuary to produce meaningful projections on enrollment, utilization and the potential costs of a prescription-only benefit.

We have also invited representatives from national veterans service organizations to share their insights and perspective--adding to the dialogue today. I am looking forward to an interesting discussion today.

[After the first panel's testimony and while the second panel is approaching the witness table:]

While our second panel is being seated, I would like to take this opportunity on a related topic, to commend the VA for issuing Directive 2004-006, entitled "Audible Prescription Reading Devices," on March 10. One of the first letters I wrote to Secretary Principi as Chairman of this Subcommittee was to promote the use of script-talkers for visually impaired veterans. This innovation in the labeling of prescription drug containers provides audible instructions to help veterans understand and manage their own medications, so they can maintain a more independent life style. When science and technology come together to improve lives in a meaningful way, that's good science. I look forward to adding your roll-out plans for this innovative solution to an old problem.

Once again I thank all our witnesses, and our Subcommittee Members, for their participation and attendance today. As I said at the outset of this hearing, rest assured that we will continue to give this matter serious consideration, to see if extending prescription drug services to veterans as an adjunct or substitute for more direct VA health care, might help relieve some of the access pressure on VA today while satisfying at least part of the demand for that care.

This has been a very helpful and informative hearing. We thank you all for attending.

STATEMENT OF
CIRO RODRIGUEZ

Ranking Member
Subcommittee on Health
House Committee on Veterans' Affairs

Hearing on Prescription-Only Health Benefit within the Department of Veterans Affairs Medical Care System

March 30, 2004

Thank you, Mr. Chairman, for holding this timely hearing today. About this time last year we had an opportunity to discuss various proposals to improve the availability and eligibility for pharmaceutical services provided by the Department of Veterans Affairs (VA). I am a cosponsor of one of these measures -- Ranking Member Lane Evans' bill, H.R. 1309, a bill that would allow veterans, as Medicare beneficiaries, to purchase drugs prescribed by non-VA physicians from VA -- that was discussed that day. I continue to believe the bill has merit.

In testimony regarding Mr. Evans' bill, VA stated that it believed Mr. Evans efforts to provide a less expensive alternative for Medicare-eligible veterans to obtain pharmaceutical drugs were unnecessary because of the Medicare reforms that were being developed at the time. Since Congress approved the Medicare legislation, however, VA has completed an analysis of its impact on VA and veterans and determined that its effect will be **very minimal**. I am interested to hear if, in light of this finding, VA has reconsidered its position on H.R. 1309.

Mr. Chairman, those who support H.R. 1309 decided to allow it to lie while we worked out the details of a prescription drug benefit that would be widely available to our seniors under Medicare. Unfortunately, it must be pretty clear to everyone, even at this early date, that the bill Congress ultimately passed **fails** our seniors. That is why we are continuing to have this debate about how VA can help plug the holes in the dike.

Meanwhile, VA has been trying to plug its own holes with a transitional drug benefit offered to certain veterans whom it determined were likely to wait more than six months for a VA appointment. Once identified, these

individuals were allowed to send prescription drug orders from non-VA physicians to VA. VA will tell us that response to this benefit has not been overwhelming. When VA established eligibility for the transitional prescription drug benefit about 8,000 of the 41,000 individuals awaiting care opted for the benefit. While the per capita costs of this program have been higher than VA expected, overall it expected higher costs from the program than the $4.1 million it has expended. One must question how well VA has informed veterans about the availability of this benefit.

Given the high demand expected for a significant prescription drug benefit, it is also surprising that, in a recent phone survey, VA found only about 10-20% of veterans would be interested in a prescription drug-only benefit from VA. However, even this amount of interest would create enormous demand for VA pharmacy services which already will address an almost $4 billion workload in 2005.

In assessing any of the legislative proposals on the table, it is important to understand the demand for and costs of a new benefit. VA must have a way, outside of our normal appropriations process, to pay for a benefit that could conceivably double its pharmacy workload. In Mr. Evans bill, those funds come from Medicare. It is less clear where the funds would come from in other proposals. Commander Banas, I have not had a chance to review the VFW Prescription Drug Fairness Act to which your testimony refers, but I will certainly look forward to hearing more about it and ensuring that it creates access to a new benefit for veterans and identifies a reasonable funding stream for VA to provide this new benefit.

Thank you, Mr. Chairman. I will look forward to hearing from our witnesses.

Statement of Congresswoman Shelley Berkley
Subcommittee on Health
Hearing on the VA Providing Certain Veterans With Rx -Only Health Care Benefit
March 30, 2004

Thank you, Mr. Chairman. More and more veterans all over the country, and especially in Las Vegas, have been seeking health care from the VA in order to access affordable care and a prescription drug benefit. In southern Nevada, the VA Healthcare System has experienced a 21% increase in the number of prescription drugs filled in their facilities. In the first four months of this fiscal year, the VA pharmacy and clinics have filled over half-a-million prescriptions for southern Nevadan veterans.

Yet, as the demand for prescription drugs increases in Las Vegas and across the country, the VA has cut benefits for Priority 8 veterans, and the President has threatened enrollment fees and higher pharmaceutical co-pays for Priority 7 and 8 veterans. These veterans risked their lives, just like other veterans, to protect our freedom and should be eligible for these health care benefits.

We should do more for our veterans to ensure their health and well-being, including providing a prescription drug benefit for veterans. However, I find it very ironic that we are sitting here today discussing a prescription drug benefit for veterans when Congress, only four months ago, passed a bill that is supposed to alleviate the financial burden of prescription drugs for all seniors. What this says to me is that there is little confidence in the new Medicare prescription drug benefit among seniors, advocates, and government officials, even in the VA. In fact, the VA found that the new Medicare drug benefit would have "only minimal impact" on veterans care.

We all agree that veterans access to quality health care is a priority. However, in this new age of modern medicine, quality health care no longer means simply access to skilled physicians and nurses, but includes access to the prescription drugs recommended by their physicians.

We must ensure those veterans in need of quality health care are given the opportunity through the VA, including prescription drugs in some instances.

I look forward to hearing from the witnesses regarding the VA providing certain veterans with a prescription-only health care benefit. Thank you, Mr. Chairman.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

THE COMMANDER-IN-CHIEF

STATEMENT OF

EDWARD S. BANAS, SR.
COMMANDER-IN-CHIEF
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WASHINGTON, DC MARCH 30, 2004

DEAR MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

As Commander-in-Chief of the 2.6 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for this opportunity to testify today. It has indeed been an honor working with the members of this Subcommittee, but especially with the Chairman who I am proud to call my Congressman and my friend. I thank everyone on this Committee and their hard-working staffs for their dedication to these important issues.

The central issue of today's hearing and the draft bill under consideration, the *VFW Pharmacy Fairness Act,* is what can be done to improve veterans' access to pharmaceuticals.

The Department of Veterans Affairs (VA) offers an out-patient prescription drug benefit to enrolled veterans as part of its uniform health care package. Comparable to prescription drug plans offered by numerous health care insurers, this earned benefit is

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very important to many veterans, especially those without any other prescription drug coverage.

Currently, VA provides a 30-day supply of pharmaceuticals for a $7 co-payment to enrolled veterans. The co-payment is waived for prescriptions related to the treatment of service connected disabilities. Additionally, veterans with a 50% or higher disability rating or those who are indigent are not required to make co-payments.

Unfortunately present Department procedure drastically limits veterans' access to VA pharmaceuticals. Current law prohibits VA from filling prescriptions from duly licensed physicians who do not practice within the VA Health Care system.

Due to lengthy delays in scheduling appointments, many veterans have turned to their private physicians, outside the VA health care system. At its peak, there were nearly 300,000 veterans waiting six months or more for a medical appointment. We believe that many of these veterans became discouraged with the wait and were effectively forced to seek care outside VA. Even now, despite improvements, there are still thousands of veterans waiting six months or more for appointments. Many of them have established solid relationships and histories with their outside physicians.

A veteran who obtains care from his or her private physician--whether for convenience, out of familiarity or some other reason--is unable to have that prescription filled through VA. That veteran, despite already having a diagnosis, is forced to wait for an appointment with a VA physician who will provide the same battery of tests, the same exams and, eventually, the same diagnosis as the veteran's private physician. Only then, after waiting months for a duplicative exam, can the veteran have VA fill that prescription.

I do not see the rationale for this. This duplication of services is a waste of time for the veteran and a mismanagement of resources for VA. In fact, in December 2000, the VA Inspector General had projected that this redundancy of services would waste over $1 billion a year. We expect that this number would be far higher today. When VA is currently unable to meet the demand for services and it forces veterans to wait months for appointments, it simply is irrational for VA to slide these veterans to the back of a growing queue. They already have had their diagnosis; they just simply need to utilize the benefit VA provides.

Additionally, it does not make sense to sever the important relationships many veterans have established with these outside doctors. The openness and trust that can come with familiarity can lead to optimal treatment and better health. VA should not impair these connections.

VFW strongly supports a pharmaceutical benefit that allows all veterans optimum access to the pharmaceuticals they need for their health and well-being. Given the current situation and the opportunity to potentially mitigate the impact of long waiting times and produce cost savings by streamlining an inefficient and overly bureaucratic process, VFW supports the creation of an out-patient prescription benefit that would free up VA health care appointments and potentially reduce the backlog. In addition, we support providing an outpatient medication benefit to Medicare-eligible Category 8 veterans who are currently precluded from enrolling in VA health care.

The VFW, however, does not support requiring veterans to forgo their earned VA health care in favor of Medicare. Veterans are unique in that they have an entitlement to Medicare by way of financial contribution and have also earned the right to VA health care through virtue of their service to this nation. They must not be forced to give up

their rights to either. The VFW will continue to fight for adequate appropriations to allow all veterans access to VA's medical benefits package.

Even with the recent passage of Medicare Prescription Drug Improvement Act (P.L. 108-173) it is as important as ever to improve the pharmaceutical benefit provided to veterans. Although many veterans will be eligible for these Medicare reforms, the complexity of the many types of coverage available under the plan, as well as the large gaps in coverage, make it an unattractive alternative for most veterans. Veterans cannot, and we should not expect them to, fall back on Medicare as a safety net. Past Congresses have seen fit to afford veterans special benefits because of our years of dedication on behalf of this country. This Congress must rise up and do the same.

Extending this benefit by allowing the department to fill non-VA prescriptions would greatly help all involved. For the veteran, he or she would have timely access to pharmaceuticals. For VA, significant financial resources would be freed up, as well as an increase in the number of appointments available to our sick and disabled veterans. Also, the American tax payer would benefit. VA's prescription drug formulary and its massive buying power ensures that it receives its pharmaceuticals at significantly lower prices than other outlets. Time after time, VA has demonstrated that it is able to provide more health care to more patients at a cheaper per patient cost than other health care systems. It is time that we use this leverage to the benefit of all parties.

Mr. Chairman, this concludes my testimony, I will be happy to respond to any questions you may have. Thank you.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

CORNELIO R. HONG, M.D., F.A.C.P.
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS PHARMACEUTICAL BENEFIT

WASHINGTON, D.C. MARCH 30, 2004

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to testify before you today on this important subject.

As part of the Department of Veterans Affairs' (VA) comprehensive medical care benefits package, veterans enrolled in the VA health care system are granted a pharmaceutical benefit. Veterans pay a $7 co-payment for each 30-day supply of medication. The co-payments are waived if the prescription is for a service connected condition, or if the veteran is severely disabled or indigent. With relatively few exceptions, such as for certain veterans living in Alaska, VA will only provide medication for prescriptions written by VA physicians, not outside physicians.

This policy, in effect, denies veterans their earned pharmaceutical benefit. It forces veterans to make medically unnecessary appointments for health care screenings

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through the department. However, when the veteran makes that appointment, he or she frequently finds that they must wait months for that appointment. In the face of these delays, many of these veterans are turning to their outside physicians for timely health care, as you or I would do. They then find themselves unable to have these prescriptions filled at VA, so they are either forced to completely abandon the VA health care system, or to take their place at the back of a long line for a VA appointment.

Although significant progress has been made in reducing this backlog of appointments, increasing demand for health care by veterans and funding levels that have not kept pace, access to the system is far from optimal. At one time, it was estimated that nearly 300,000 veterans were on a waiting list for at least six months for a basic health care appointment. While the number of veterans waiting that long is significantly lower, there are still many thousands of veterans who must still unacceptably wait month after month.

I continue to believe that a significant portion of that backlog is made up of veterans waiting solely for prescriptions from VA. Early indications from VA's temporary Transitional Pharmacy Benefit Program (TBP) support our conclusion. Despite a very narrow definition of who was eligible for the benefit, VA's statistics show that 8,200 of the 41,200 eligible veterans (20%) utilized the program. Extrapolating these numbers out to the entire VA population, it is clear that a substantial number of veterans are being denied part of their complete VA health care benefit.

The solution is simple. Veterans must be allowed to bring their private prescriptions to VA. It is a solution that benefits both parties involved: the veteran and VA.

For veterans, the benefits are obvious. They would be free from policies that inhibit their ability to receive a benefit they earned while defending this country. If that 20% figure holds up system-wide, the veterans' population would be getting the pharmaceuticals it needs to combat illness and disease, especially as it grows older. These would be the same pharmaceuticals and treatments they would receive if they had complete access to the VA health care system; it would not provide them any additional benefits, just access to a current one, which is severely limited.

Additionally, as a medical doctor, I can attest to the importance of patient/doctor relationships in maintaining optimum health. When access problems turned many veterans away from VA health care, they began establishing or reaffirming old relationships with their physicians. The communication, signals and history a doctor establishes with a regular patient enables us to better serve the patient's needs. It leads to better medicine.

For VA, it would free up health care resources, which are stretched to the breaking point, in part, because of this prohibition. The extra health assessments and screenings VA undertakes duplicate the same procedures the outside physician performs. The second screening is medically unnecessary; a physician has already determined the diagnosis. All it does is waste the veteran's time and wastes health care resources that could be better spent on sick and disabled veterans who truly need VA health care. In fact, a December 2000 VA Inspector General Report found that, "the costs of re-examining the veteran in order to fill the privately written prescriptions are significant and could be reduced with a more streamlined process." The report estimated that these re-examination costs totaled $1.3 billion in fiscal year 2001 alone.

Yes, we would probably expect the demand for prescriptions to increase, but this increased cost could be significantly offset by the reduced duplication of services and through co-payments and third party collections. Further, a December 2002 GAO study found that Priority 7 veterans, who at that time included the current Priority 8 veterans, utilized just 13% of VA's net pharmacy expenditures despite these veterans accounting for 22% of the patient population. They used less than their proportion of resources. Again, we would argue that, despite the increased demand, it would not be providing any additional benefits, just equitable access to that benefit.

To that end, the draft bill we are considering today would be a great benefit to those it covers. This bill would allow veterans receiving disability compensation or who are indigent to have outside prescriptions filled through VA. Additionally, it extends the same benefit to any Medicare-eligible veteran.

For those Medicare-eligible veterans to have their prescriptions filled through VA, they must, however, give up their right to VA health care services for one calendar year. This is an unacceptable choice. Veterans have earned the right to the full comprehensive benefits package. They should not be required to give up one portion of that package to secure access to another. Yes, these veterans would have Medicare to fall back on and it is entirely possible that some of these veterans would use Medicare anyway, but we cannot accept that as their sole health care option. VA is charged with providing the full continuum of health care to this nation's veterans. Forcing veterans out of the health care system turns VA into nothing but a pharmacy. Their other health care needs would be neglected. Veterans should be able to turn to VA, the health care system

set up just for their unique health care needs. This draft legislation would deny them that right.

Despite this, the bill is a solid step in the right direction. It provides a better benefit to more veterans at a cheaper cost than the complex Medicare prescription drug benefit. It would greatly benefit those veterans who could not otherwise afford prescription drugs.

In regard to the section of this bill that addresses immunizations, it appears that a more comprehensive immunization benefit must be addressed. Any veteran who is enrolled with VA should be able to receive immunizations free of cost as long as the immunization is recommended by the CDC in the National Immunization program. Preventive medicine is the most cost effective way of caring for any section of our population. For most of our veterans the complications of preventable diseases compound all other underlying health problems.

It is clear that the time for pharmaceutical reform is now. VA's current policies preclude veterans from accessing an earned benefit and the solution before us is an excellent step that would be beneficial to each stakeholder.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions that you or the members of this Committee may have.

STATEMENT OF
DR. JONATHAN PERLIN, DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

MARCH 30, 2004

*****

Mr. Chairman and Members of the Subcommittee: I am pleased to be here this morning to discuss the Department of Veterans Affairs' (VA's) Transitional Pharmacy Benefit Program (TPB) and the lessons learned from this program.

Background

Mr. Chairman, in recent years, VA has faced an extraordinary demand for medical care services. During FY 2002 and 2003, VA's ability to meet the demand for medical care services was challenged, especially in some geographic areas, and patients experienced delays in accessing VA services.

In response to these challenges, VHA has worked diligently and aggressively to reduce the list of patients waiting for their first clinic appointment and has demonstrated meaningful reductions in the wait lists. Many VA facilities extended clinics hours to nights and weekends, scheduled staff to work overtime, and/or hired additional staff to reduce appointment wait lists. I am happy to report that VHA's improvements in managing clinic wait times have been extraordinarily successful.

Nonetheless, as recently as this last summer, some geographic regions of the country continued to have wait lists for primary care and specialty care appointments. VHA was concerned that these eligible patients were shouldering the financial burden for their prescription requirements since VA's policy, in most

cases, did not authorize VHA to fill prescriptions written by private physicians. VHA's longstanding prescription policy had not contemplated the extraordinary demand and resulting access issues that VHA encountered during the periods of 2001-2003.

VHA recognized this problem and implemented a specific program in September 2003 to provide access to VA prescription drugs for veterans experiencing long waits for their initial primary care appointment. The implementation of this time-limited policy assured that these patients would not be financially burdened by the cost of their privately written prescriptions, which resulted from their wait for medical care.

This temporary program, known as the Transitional Pharmacy Benefit (TPB), was made available to veterans who were enrolled in the VA health care system prior to July 25, 2003 and had requested their initial Primary Care appointment prior to July 25, 2003, and had been waiting more than 30 days for the initial Primary Care appointment, as of September 22, 2003.

Description of the Transitional Pharmacy Benefit

The TPB program authorized VHA to fill prescriptions from non-VA (private) physicians until a VA physician could examine the veteran and determine an appropriate course of treatment. The TPB included most, but not all of the drugs listed on the VA National Formulary (VANF). Drugs specifically excluded from the TPB benefit include injectable drugs, drugs that must be administered by a health care professional, most over-the-counter drugs, extemporaneously compounded medications and controlled substances.

Letters of their eligibility for the program notified patients in early September 2003. Eligible veterans who wished to participate in the TPB program were asked to complete the VA TPB Information Sheet and then give that information as well as the Transitional Pharmacy Benefit Drug Formulary brochure to their private physician. The private physician was asked to complete their portion of the VA Information Sheet, provide written prescriptions for the veteran and mail the information to the VA medical care facility listed in the letter.

VA began to process prescriptions under the TPB program on September 22, 2003. All TPB paperwork was processed at local VA medical care facilities. Approximately 75% of all TPB prescriptions have been filled through VA's Consolidated Mail Outpatient Pharmacies (CMOPs) for home delivery to the veteran. The remainder has been filled at the local medical care facility.

Generally, we believe that veterans appreciated the benefit. However, the total number of TPB users grew at a much slower rate and, overall, total participation was lower than was anticipated. VHA believes that there were several reasons for the lower than expected participation in the program, including:

- The patient's apparent lack of awareness of the program (despite VHA's outreach efforts to notify veterans),
- Difficulty in obtaining prescriptions from private physicians,
- The patient's decision to wait to access the new benefit until on-hand drug supplies from private pharmacies were exhausted,
- The prescribing of non-formulary medications by private physicians, which may have discouraged some patients from accessing the benefit,
- Overestimation of veterans' desire/need to receive prescriptions from VA in the absence of comprehensive medical care.

Due to the rapid start up of the program and the lack of existing software support, there were additional challenges in accurately identifying TPB program participants and the associated workload. As data were collected and analyzed, it was discovered that TPB patients were not always initially identified correctly in the prescription record, and some TPB patients were not properly inactivated from the program after the first primary care appointment. It is estimated that these problems may have caused up to a 17% system-wide underestimate in prescription utilization data that was initially collected at the national level. Based on preliminary results, there were 8,298 TPB veterans (20 percent) of the 41,167

enrollees who chose to use the TPB. It is expected that the final analysis and reporting will be available the 3rd quarter of FY 2004.

The types of medications prescribed by the non-VA physicians for patients in the TPB were also tracked. The preliminary results through the first 20 weeks of the program (through February 8, 2004) have proven helpful in evaluating the costs associated with the prescribing patterns of non-VA physicians. Forty two percent of the prescriptions written by non-VA physicians were for non-formulary (non VA National Formulary) medications. In collaboration with the private physician, VHA attempted to convert non-formulary prescriptions to formulary prescriptions. However, conversions were not as successful as compared to conversion attempts with VA physicians. Actual non-TPB Formulary dispensing was shown to average 27% through Week 20 of the program. This compares very unfavorably with the less than 3% overall non-formulary dispensing rate within VA.

Because the TPB non-formulary prescriptions necessitated that VA pharmacists contact the private physician to suggest TPB formulary alternatives, there was a significant increase in the labor and time required to process these prescriptions. This was reflected in the overall costs to the TPB program. The additional labor associated with the TPB program through the first 20 weeks has been calculated to cost $915,126. TPB drug costs totaled $3,268,041 as of the end of January 2004.

VHA Prescription-Only Benefit Survey

Due to Congressional and veteran interest in a VA prescription-only benefit, Secretary Principi requested that VHA conduct a survey to explore veterans' attitudes toward a potential prescription-only benefit. In addition, the survey was to provide data to support the development of sound actuarial projections for enrollment, utilization, and expenditures for a prescription-only benefit.

VHA surveyed 1,800 veterans (600 each enrollee users, enrollee non-users, and non-enrolled veterans) by phone in January and February of this year.

Veterans were asked whether they would choose to enroll in a prescription-only benefit if one was offered and queried to explore the impact of different co-payment levels of their choice. We also collected data to enable us to identify those characteristics of veterans that influenced their choice, such as the number of chronic medications taken regularly, out-of-pocket prescription drug expenses, prescription drug coverage, health status, age, and income. A copy of the survey questionnaire is included for the record.

Some preliminary results of the initial analysis of the survey data are presented below. Please be advised that additional, more in-depth analysis is needed to fully understand and quantify the implications of the survey data with regard to potential enrollment and costs for a prescription-only benefit.

- 89% of enrollees would choose comprehensive VA health care over a prescription-only benefit.
- More non-enrolled veterans would choose comprehensive VA health care (42%) than would choose the prescription-only benefit (19%).
    - 29% of non-enrolled veterans say they are likely to enroll in VA health care but not the prescription-only benefit.
    - 13% express interest in both VA health care and the prescription-only benefit, and 7% express interest in the prescription-only benefit but not VA health care.
- Interest in the prescription-only benefit drops when specific co-payments are mentioned. When offered at a co-payment of $10 or less, only 6% (226,000) of enrollee users, 14% (342,000) of enrollee non-users, and 15% (2.6 million) of non-enrolled veterans are likely to enroll.
- The prescription-only benefit would primarily serve a new group of veterans since 91% of veterans who say they would choose the prescription-only benefit are not currently enrolled or are enrollee non-users.
- Enrollee interest in the prescription-only benefit, as indicated in this survey, is similar to enrollees' responses when asked *how do you intend to use VA in the future* in the FY 2003 VHA Enrollee Survey.

  - 70% of enrollees said they intended to use VA as a primary source of care or backup to non-VA care.
  - 16% of enrollees said they intended to use VA for prescriptions only.
- Prescription drug coverage and high out-of-pocket costs are key factors determining interest in the prescription-only benefit.

Furthermore, based on our experience with the TPB, per-enrollee drug costs and administrative costs could be expected to be high due to adverse selection and the higher drug utilization and significant number of off-formulary scripts expected when VA fills prescriptions written by private providers.

VHA staff, with assistance from the private-sector actuary who develops the enrollment and expenditure projections for VA health care, is currently analyzing the results of the survey. We are reviewing the survey data, along with data from the FY 2003 VHA Enrollee Survey and enrollees' actual VA health care utilization data, in order to fully understand its implications for enrollment and expenditure projections for a prescription-only benefit. When this analysis is completed, VHA will brief the Secretary on the results of the survey and publish a final survey report.

Conclusions

The Transitional Pharmacy Benefit program met the original goals of the program by reducing the financial burden of prescription medications for patients waiting longer than 30 days for an initial primary care appointment. The temporary TPB program also provided valuable information about the increased labor requirements and non-formulary drug costs associated with filling prescriptions from non-VA physicians, the information technology infrastructure necessary to effectively administer such a program, and insight into how the overall program design can impact its costs.

Mr. Chairman, in closing, I believe VA is one of the leading health care providers in the United States in integrating the provision of pharmaceuticals in its comprehensive patient treatment programs.

From a financial and clinical perspective, the important lessons learned from VA's experiences with the comprehensive care model are that clinically appropriate and cost-effective drug therapy can best be achieved when providers who treat patients are actively involved in formulary decisions, when best clinical practices are employed; and when clinical pharmacists are fully integrated into the medication use process.

This completes my statement. I will be happy to respond to questions from the committee.

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CAC0303

User Cell	CIRCLE
Enrollee user	1
Enrollee non-user	2
Potential enrollee	3

OMB # 2900-0609

VETERAN ENROLLEE AND POTENTIAL ENROLLEE
INTEREST IN A VA PRESCRIPTION-ONLY BENEFIT
(FINAL 1/21/04)

INTENDED AUDIENCE: Priority 1-3,5 and 7-8 veterans who are currently enrolled for VA healthcare services or who are eligible for VA healthcare services.

RESPONDENT NAME: _____
TELEPHONE: _____ INTERVIEWER: _____
START TIME: _____ END TIME: _____
LENGTH: _____ DATE: _____
ZIP CODE: _____ DATE OF BIRTH: _____
PRIORITY LEVEL: _____

Hello, my name is (YOUR NAME) and I'm calling on behalf of the Department of Veteran Affairs.

(IF VA LIST SOURCE) May I speak to (INSERT NAME FROM LIST)?

(IF RDD LIST) Is there a veteran in your household? By veteran, I mean anyone who has served on active duty in the U.S. military and who is not now on active duty. (READ ONLY IF RESPONDENT NOT SURE: This includes anyone who has served in the Army, Navy, Marine Corps, Air Force, Coast Guard, Nursing Corps, Women's Army Corps (WAC), Women Accepted for Volunteer Emergency Services (WAVES) or was called into active duty, not including initial basic training or yearly summer camp, from the Military Reserves or National Guard.) (IF NO, RECORD AND TALLY. IF YES, ASK TO SPEAK WITH VETERAN)

[CAN CONTINUE WITH CARETAKER PROXY ONLY IF VETERAN IS PHYSICALLY OR MENTALLY INCAPABLE OF PARTICIPATING IN PHONE INTERVIEW, BUT STILL RESIDES IN THE HOME; RE-PHRASE AS NECESSARY SO THAT ALL INFORMATION IS ABOUT THE LISTED VETERAN.]

The Department of Veterans Affairs is investigating the possibility of offering a choice of health benefits plans to veterans, and we are conducting a survey to learn about veterans' interest in these potential health care benefits. Your participation is important to the success of this study. This survey will take about 8 minutes of your time. Your responses and the information you provide will remain confidential

because we do not release your name. Do you have a few minutes available now to participate in our health survey?

(NOTE: READ ONLY IF RESPONDENT QUESTIONS LEGITAMACY OF THE STUDY:) This survey has been reviewed and approved by the Office of Management and Budget or OMB. If you have any questions about why VA is conducting this survey, you may call Ruth Hoffman with the Department of Veterans Affairs at 202-273-8934.

	CIRCLE ONE	
Yes	1	→(CONTINUE)
No	2	→(THANK AND TERMINATE)
Not available now	3	→(ARRANGE CALLBACK AT A MORE CONVENIENT TIME)
Refused to engage in interview	4	→(TERMINATE AND TALLY)

1. INTERVIEWER RECORD. DO NOT ASK. Was the respondent the veteran or a proxy?

	CIRCLE ONE
Respondent	1
Proxy	2

2. (ASK ONLY IF FROM RDD LIST) Do you currently receive any service-connected disability compensation or non-service-connected disability pension payments from the VA?

		CIRCLE ONE	
	Yes	1	→(THANK AND TERMINATE)
	No	2	
OR	Don't know	3	
(DO NOT READ)	Refused to answer	4	

3. (ASK ONLY IF FROM RDD LIST) What is your age?
_____ Years (RECORD)
(999=DK; 998=Refused)

4. I'd like you to think about your current healthcare coverage. Which of the following types of healthcare coverage do you have? (READ LIST. RECORD NUMBER FOR EACH)

	CIRCLE ONE PER ROW			
	Yes		No	Not Sure
Private individual or group health plan paid for by you, your employer or someone else such as a family member	1	→(ASK Q.5b)	2	3
Medicare Part A which primarily covers hospitalization costs	1		2	3
Medicare Part B which covers doctor's office visits and medical expenses for a monthly fee you pay to Medicare	1	→(ASK Q.5a)	2	3
Private Medi-Gap or Medicare Supplemental insurance plan	1	→(ASK Q.5b)	2	3
VA enrollee health care benefits	1	→(THANK & TERMINATE IF FROM RDD OR C&P LIST)	2	3 (READ EXPLANATION OF VA CARE. CIRCLE ONLY IF STILL DK)
Department of Defense TRICARE or TRICARE for Life (TFL)	1		2	3
Medicaid (provided by your state's social service department)	1		2	3

5a. (ASK ONLY IF CODE 1/YES IS CIRCLED FOR MEDICARE PART B IN Q.4. OTHERWISE, SKIP TO Q.5b) Do you participate in a Medicare managed care plan such as an HMO?

	CIRCLE ONE
Yes	1
No	2
Don't know	3

5b. (ASK ONLY IF CODE 1/YES CIRCLED FOR PRIVATE MEDI-GAP OR PRIVATE INSURANCE IN Q. 4, OTHERWISE SKIP TO Q.7) Does your private (Medi-Gap or Medicare Supplemental) health plan include a prescription drug benefit?

		CIRCLE ONE	
	Yes	1	
	No	2	
OR	Don't know	3	→(SKIP TO Q.7)
(DO NOT READ)	Refused to answer	4	

6. I am now going to ask you a series of questions about the amount you are required to pay, also known as a co-payment, for generic and brand name drugs each time you have a prescription filled at either a retail pharmacy or by mail. What is your co-payment for: (READ LIST ONE AT A TIME)

A. A generic drug filled using a mail order pharmacy? $_ (RECORD AMOUNT) (DK=99)

B. A generic drug filled at a participating retail pharmacy? $ _____ (RECORD AMOUNT) (DK=99)

C. A brand name drug filled using a mail order pharmacy? $_____ (RECORD AMOUNT) (DK=99)

D. A brand name drug filled at a participating retail pharmacy? $_____ (RECORD AMOUNT) (DK=99)

7. Now, I'd like to ask a few questions about your health. Compared to people your age, would you say your health is: (READ LIST)

		CIRCLE ONE
	Excellent	5
	Good	4
	Fair	3
	Poor	2
OR	Very Poor	1
(DO NOT READ)	Don't know/can't say	6

8. How many different medications do you currently take on a regular or ongoing basis? _____ ____ (RECORD) (DK=99)

9. How much on average do you currently spend out of pocket per month on prescription drugs? $_____ (ROUND TO NEAREST FULL DOLLAR AMOUNT) (DK=9999)

10. (ASK POTENTIAL ENROLLEES ONLY. CURRENT ENROLLEES SKIP TO Q.11) Currently, the VA offers a full range of health care services to eligible veterans, including hospital care, doctor's visits, medical tests and prescription coverage at any VA medical facility with cost sharing for some veterans. Assuming you are eligible, how likely would you be to enroll to receive VA health care? (READ LIST) (NOTE: IF QUESTION ABOUT VA HEALTH BENEFITS, REFER VETERAN TO VA HEALTH BENEFITS INFORMATION CENTER AT 877-222-8387)

		CIRCLE ONE	
	Very likely	5	
	Somewhat likely	4	
	Undecided	3	
	Somewhat unlikely	2	
OR	Very unlikely	1	
(DO NOT READ)	Don't know	6	
(DO NOT READ)	Already enrolled	7	(THANK AND TERMINATE)

11. VA is considering offering a prescription-only benefit. Under this benefit, prescriptions written by your private doctor would be filled by VA's mail order pharmacy with a co-payment. This would only cover the drugs you use regularly and can order through the mail, not drugs you need immediately for a brief illness. If you choose this prescription-only benefit, you would not be eligible to receive any other health care provided VA. Also, you would not be able to switch back and forth between benefit options at your leisure. Would you have an interest in enrolling in this type of prescription-only benefit option?

		CIRCLE ONE	
	Yes	1	
	No	2	
OR	Don't know	3	→(SKIP TO Q.13)
(DO NOT READ)	Refused to answer	4	

12a. How likely would you be to enroll in this prescription drug benefit option if the co-payment was $35 for each 30-day prescription? Would you be: (READ LIST)

		CIRCLE ONE	
	Very likely	5	→(SKIP TO Q.13)
	Somewhat likely	4	
	Undecided	3	
	Somewhat unlikely	2	
OR	Very unlikely	1	
(DO NOT READ)	Don't know	6	

12b. How likely would you be to enroll in this prescription drug benefit option if the co-payment was $20 for each 30-day prescription? Would you be: (READ LIST)

		CIRCLE ONE	
	Very likely	5	→(SKIP TO Q.13)
	Somewhat likely	4	
	Undecided	3	
	Somewhat unlikely	2	
OR	Very unlikely	1	
(DO NOT READ)	Don't know	6	

12c. How likely would you be to enroll in this prescription drug benefit option if the co-payment was $10 or less for each 30-day prescription? Would you be: (READ LIST)

		CIRCLE ONE
	Very likely	5
	Somewhat likely	4
	Undecided	3
	Somewhat unlikely	2
OR	Very unlikely	1
(DO NOT READ)	Don't know	6

13. These last few questions are for classification purposes only. Not including yourself, how many dependents such as a spouse or dependent children do you currently have?

_____ (RECORD)

(DK=999)

14. What is the zip code of your primary residence?

_____ (RECORD)

(DK=99999)

15. And, lastly, is your total annual household income from all sources: (READ LIST. ASK COLUMN A THEN CLARIFY WITH COLUMN B)

COLUMN A			**COLUMN B**	
	CIRCLE ONE			CIRCLE ONE
Less than $16,000	1		Under $11,000 OR	1
			$11,000 – $15,999?	2
$16,000 - $24,999	2		$16,000 - $20,999 OR	3
			$21,000 - $24,999?	4
$25,000 - $31,999	3		$25,000 - $29,999 OR	5
			$30,000 - $31,999?	6
$32,000 - $36,999	4		$32,000 - $34,999 OR	7
			$35,000 - $36,999?	8
$37,000 - $49,999	5		$37,000 - $46,999 OR	9
			$47,000 -$49,999?	10
$50,000 or over	6		$50,000 -$59,999 OR	11
			$60,000 OR OVER?	12
Don't know	7	→(RECORD)	Don't know	13
Refused	8	→(RECORD)	Refused	14

That's all I have. Thank you for your participation. The information you have provided will help VA to better serve all veterans in the future.

RECORD INFORMATION ON PAGE 1

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS'
PRESCRIPTION-ONLY HEALTH BENEFIT
AND
TRANSITIONAL PHARMACY BENEFIT

MARCH 30, 2004

Mr. Chairman and Members of the Subcommittee:

I appreciate this opportunity to express the views of the 2.7 million members of The American Legion on the Department of Veterans Affairs' (VA) prescription-only health benefit. We commend the Subcommittee for holding a hearing on this important and timely subject.

In fiscal year 2003, the VA's total pharmaceutical expenditures increased by approximately 11 percent from $2.9 billion in fiscal year 2002 to $3.2 billion. Under current law, to use VA pharmacy veterans must be: 1) enrolled and either receiving care or; 2) be waiting in excess of 30 days for an initial appointment with a VA provider. As VA's enrolled patient population continues to reach record-high levels and the rate of veterans actually using VA health care benefits grows, increased demands for VA pharmaceutical services system-wide have heightened demands for timely access to health care. In fiscal year 2003, over 200 million 30-day equivalent prescriptions were filled.

Many factors are attracting veterans to enroll in VA to meet their health care needs:

- Collapse of many health maintenance organizations and preferred provider organizations;
- Dramatic increases in private health care premiums;
- No affordable Medicare prescription plan;
- Dependence on costly maintenance medications;
- VA's reputation for high quality primary and specialty care and patient safety.

Prescription-Only Health Benefit

The American Legion believes VA's pharmacies are very much a part of its integrated, holistic approach to medical care. VA's pharmacies were established to support the nation's largest health care delivery system and was never intended to become a mail-order prescription house or

the corner drugstore. The American Legion is concerned about the overall cost of VA filling a larger number of prescriptions. With the increase in enrollment since the implementation of P.L. 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, and a projected actual increase in utilization by a traditionally older, sicker population, additional funding and pharmacy personnel will be required to meet the demands of any such benefit.

The success of a permanent prescription-only benefit is dependent on adequate funding levels. VA's pharmacies are already overtaxed, given that over 4 million veterans currently receive their prescription medications through VA. Even without enactment of a permanent prescription-only benefit, VA expended $2.8 billion in outpatient pharmacy, or 88 percent of its total pharmacy budget. This share is due to many factors including increased enrollment, medical inflation and new drug therapies

Should such a benefit be enacted, it must not be simply another unfunded mandate, but must include adequate appropriations to pay for it. VA should not be required to absorb what will be certainly an astronomical cost, further stretching its already seriously under-funded programs and causing cuts in other service areas.

Without details of the proposed prescription-only benefit, it must be assumed that VA would fill non-VA prescriptions without examination or testing of the veteran by VA. Questions must be answered while evaluating changes to current pharmacy policies and practices:

- What impact would any suggested changes have on patient safety?
- What safeguards are in place to incorporate a comprehensive inspection of drug interactions and duplicate drug class orders?
- What impact, positive or negative, will there be on the medical care budget?
- What is the role of VA pharmacy?
- What safeguards are in place to deter potential fraud, waste and abuse?
- What requirements will be placed on participating private practitioners?

Mr. Chairman, while The American Legion agrees with the need to ensure veterans receive prescriptions in a timely manner, we fear the possible detrimental effects a prescription-only benefit may have on the overall delivery of health care by VA. Veterans must be able to have their prescriptions filled through VA without having to join the line of more than 30,000 veterans currently waiting for appointments. It is our hope that the information presented on the status of the "transitional pharmacy benefit" presented here today will provide some insight into the effectiveness of such a plan.

The American Legion stands ready to assist this Subcommittee and VA in developing a pharmacy benefit that will improve the current VA pharmacy plan without creating new liabilities for the VA health care system. Thank you again for this opportunity to provide testimony on behalf of the members of The American Legion.

Statement

VIETNAM VETERANS OF AMERICA

Presented By

Rick Weidman
Director of Government Relations

Before the

Subcommittee on Health

Of the

House Committee on Veteran's Affairs

Regarding

The Department of Veterans Affairs providing certain veterans with prescription-only health care benefits

March 30, 2004

Vietnam Veterans of America

House Veterans Affairs
Subcommittee on Health
March 30, 2004

Good morning, Chairman Simmons, Ranking Member Rodriguez, and other distinguished members of the House Subcommittee on Health of the Committee on Veterans Affairs. On behalf of National President Thomas H. Corey, we thank you for the opportunity for Vietnam Veterans of America (VVA) to appear here today to share our views on the issue of "Transitional Pharmacy Benefits" at the Veterans Health Administration facilities of the U.S. Department of Veterans Affairs (VA). I ask that you enter our full statement in the record, and I will briefly summarize the most important points of our statement.

The "Transitional Pharmacy Benefit" would never have been necessary if the veterans health care system were fully and properly funded to take care of the veterans who are statutorily eligible to use the VHA system. If there were anything approaching adequate funding, there would have been no need to promulgate the regulation issued to accomplish the filling of prescriptions written by non-VA physicians as there would never have been waiting periods of longer than thirty days. This would have rendered the premise of VHA Directive 2003-047 (issued August 14, 2003, and affecting veterans enrolled in VA health care by July 25, 2003) and other various legislative proposals moot. This is but one more good reason why we need mandatory funding for health care for America's veterans.

When VVA received notice of this hearing late last week, we sent out messages soliciting thoughts and data from our Service Representatives and from the VVA National and State leadership who are geographically dispersed across the nation. The reports were that it was not utilized because there was no waiting list longer than 30 days at the local VA Medical Center, or that the "Transitional Pharmacy Benefit" was working well, and in the manner intended by the Secretary of Veterans Affairs. The reports are consistently favorable. The VA pharmacy service is doing a very good to excellent job with this program, and that veterans and veteran's advocates at the local level are pleased with this benefit, if not the reasons that made it necessary.

It is worth noting that the pharmacy operation has so improved in the last two decades that it is now one of the best-run VA programs. It is generally effective, efficient, and is constantly improving based on clinician and veteran reactions and suggestions. Of all the VA operations, it is the one that appears to be truly operating on the "Demming" method, devised by the late W. Edwards Demming, of constant improvements, with many of these modifications being small but some large, that result in an increasingly more effective operation at the least possible cost. It is indeed ironic that the pharmacy operation should apparently be one of the areas targeted for eventual outsourcing by the Office of Management & Budget (OMB). One could say that this is yet another case of "if it's working, let's break it" by the OMB bureaucracy.

There has been discussion of making the concept of VA filling prescriptions written by non-VA physicians a more far-reaching and permanent program. VVA in the past has not favored such efforts, for a variety of reasons, and not just cost to the medical operations fund at the current inadequate level under discretionary spending.

The most important function of the VA medical system is "to care for he who hath borne the battle" In other words, it should deal with the "veteran-ness" of an eligible person by properly testing and diagnosing all of the maladies, injuries, and illnesses that a veteran may have that are in some way related to his military service. Currently the VA largely has no idea of "who hath borne the battle" among the users of the VA system, even if they are service-connected disabled veterans. For example, VA can only tell at a glance if an individual is a Vietnam-era veteran, and not whether or not they served in the Vietnam theater of operations.

In the five years since the announcement of the "Veterans Health Initiative," the VA has yet to implement a training program for all employees, or even just the new employees and clinicians that defines these special people whom we serve, and what makes veterans different from the general population that one might see in a general hospital. The taking of a complete military history (what branch, when, what duty stations, what military job – M.O.S., and what actually happened to them) and utilizing this vital information in the diagnosis and treatment process, is central to the raison-detre of the VA, i.e., that it be a Veterans Health Care System, and not just general health care that happens to be for veterans.

While we are assured that the new Information Technology is being designed to find out complete military histories, and correlate this information with diseases, exposures, and the like which may have affected the veteran, this architecture is not due for realization until FY 2008 at the earliest. VVA commends Undersecretary Robert Roswell for including this in the ""20/20 Vision Statement" for the VHA. VVA believes that much more can be done today even without all processes being automated. VVA also commends Secretary Principi for including the taking and using of military history for each veteran in the above-described manner, for the very first time in the "2003-2008 Strategic Plan for VA."

If the VA were taking a complete military history and using it in the diagnosis and treatment processes, then it would become doubly important for those who potentially served at a time and place where they were exposed to toxic substances or diseases that should be evaluated by VA physicians who (at some time in the future) would be trained to spot and to test as appropriate for these potential service related conditions. Attached please find a copy of the web site for the "Pocket Card" that is supposed to be used to train interns, residents, and other new VA professionals. These cards are also supposed to be available to, and used by, all VA clinicians, although that is rarely the case.

If the VHA were working as a true Veterans Health Care system, and when it is again adequately funded to properly care for all veterans who are statutorily eligible, VVA would not favor any program that moves case management outside of the VA.

Since we are where we are with funding and overcrowding today, VVA again congratulates Secretary Anthony J. Principi for moving ahead with this program to provide a short-term fix for those who needed medications but had to endure long waits to secure these already privately prescribed medicines, and to reduce the backlog of veterans waiting to be seen at many facilities, especially in VISN 8 and other areas where particularly long waiting times had become a really sever problem.

Mr. Chairman, that concludes our brief remarks on this issue. I would be pleased to answer any questions you or your distinguished colleagues may have.

Again, thank you for allowing VVA the opportunity to offer our views here today.

VIETNAM VETERANS OF AMERICA
Funding Statement

March 30, 2004

A national organization, Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true for the previous two fiscal years.

For further information, contact:

Director of Government Relations
Vietnam Veterans of America
(301) 585-4000 ext 127

RICHARD WEIDMAN

Richard F. "Rick" Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam war, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as statewide director of veterans employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readadjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on veterans' entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veteran affairs.

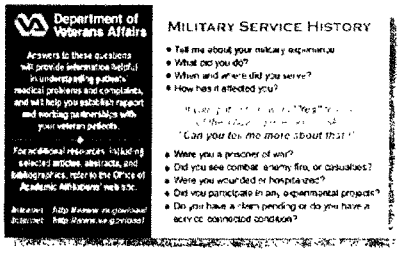
Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

VA Trainee Pocket Card

FACT SHEET

What is the VA Trainee Pocket Card?



The VA Trainee Pocket card is a pocket-sized resource tc all VA health professions trainees a guide to under-standir issues that are unique to veterans.

VA's students and trainees generally are **young** while **our ve patients are older** and have had experiences in a different ti place. This card is intended to **bridge that gap.** Moreover, th a gateway to selected literature references on a specially dev Internet web site. The card suggests questions to **invite** the v to tell his/her own story while the web site provides informatic will offer greater **insight** into the veteran's story.

This initiative is rooted in the premise that it is important to m patient aware that his/her unique experiences as a veteran a **concern to VA clinicians.**

Who should receive the VA Trainee Pocket Card?

All health professions trainees should receive the VA Trainee Pocket Card during orientation to the VA.

How is the Trainee Card Website used?

When the **VA Trainee Card Web Site** is accessed, a replica of the card is found. The Web site contains topic **summaries of veterans' health issues** as well as relevant **articles** and **abstracts**. In addition, **links** to other web sites are provided. If VA was unable to obtain the complete reference for Internet access, they are available in local VA Medical Center libraries.

http://vaww.va.gov/oaa/ or http://www.va.gov/oaa/

How can you use the VA Trainee Pocket Card to improve veterans' care?

Orientation:

- Summarize the issues presented on the card.
- Demonstrate the web site and how it can be accessed.
- Encourage trainees to become familiar with the resources on the card and web site.

The Card can be used to capitalize on many learning opportunities:

- Give trainees better understanding of the veteran's perspective.
- Encourage trainees and staff to take more careful, veteran-centered histories.
- Stimulate case discussions augmented by information found on the web site.
- Consider discussing issues presented on the card during daily work rounds or informal
  case-based conferences.

STATEMENT OF CARL BLAKE,

ASSOCIATE LEGISLATIVE DIRECTOR,

PARALYZED VETERANS OF AMERICA

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE ON HEALTH

CONCERNING PRESCRIPTION-ONLY DRUG BENEFITS

FOR CERTAIN VETERANS

MARCH 30, 2004

Chairman Simmons, Ranking Member Rodriquez, members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on a possible "prescription-only health care benefit" in the Department of Veterans Affairs (VA) and the "transitional pharmacy benefit." Lacking a detailed legislative proposal, we can only make general comments regarding a "prescription-only health care benefit."

PVA has expressed concerns in the past about the expansion of prescription drug benefits. We previously testified that we have serious concerns about the costs associated with expanding pharmacy benefits beyond their current scope.

Prescription drugs are an increasingly large component of medical care spending. Over the last seven years, prescription drug expenditures have increased at double-digit rates, according to a fact sheet prepared last year by the Kaiser Family Foundation (KFF). Likewise, the rising costs of pharmaceuticals have far outpaced the rate of inflation. This translates into higher costs to the VA to obtain and provide pharmaceuticals to veterans.

The VA does not operate in a health care vacuum. An expansion of pharmaceutical benefits would increase demand on the system. An increase in demand would necessitate shifting scarce resources away from treating veterans. PVA believes that the VA would then be forced to treat fewer veterans and might be tempted to once again increase prescription drug co-payments, thereby, shifting these higher costs onto the backs of veterans. Now is not the time, when the VA is not being given the resources it needs to meet the needs of veterans and the servicemembers who are currently returning from Iraq and Afghanistan, to force the VA to treat fewer veterans or charge them more for services. Opening the VA up as a pharmacy would only further burden the system with additional demands on scarce resources.

Again, lacking a specific legislative proposal, we have no way of ascertaining the costs of expanding pharmacy benefits or of restructuring how pharmaceutical benefits are

provided. We believe that the VA will be unable to meet the demand of such an expansion in light of the critical budget situation it is facing for yet another year. The President's Budget Request for FY 2005, released in February, provided for only a $300 million increase in the veterans' health care appropriation, a mere 1.2 percent increase over the FY 2004 appropriation. This amount does not even cover mandated salary increases and the rising cost of inflation for the coming year. This recommended increase falls far short of the amounts recommended by *The Independent Budget* for FY 2005, and the "Views and Estimates" of the full Committee.

PVA has also expressed concern that many recent prescription drug legislative proposals could change the basic mission of the VA which is to provide health care to sick and disabled veterans. The VA does not need to take on the role of the veterans' drug store. With the VA having taken steps to drastically reduce access by denying enrollment to Category 8 veterans last year and a budget situation that can only be described as critical, now is not the time to take chances with the lives and health of veterans by dramatically, and fundamentally, changing the nature of the VA health care system.

PVA fears that if we embark upon this path of only providing certain health benefits to certain categories of veterans, we could very well see the erosion of the VA's mission. The VA would essentially revert back to the way it provided care and services prior to eligibility reform, when health care was not governed by medical needs but rather by arbitrary budget-driven classifications.

With regards to the "transitional pharmacy benefit," P.L. 108-199, the "Consolidated Appropriations Act of 2004" provided the Secretary of VA the authority to dispense prescription drugs from Veterans Health Administration (VHA) facilities to enrolled veterans with prescriptions written by private physicians. Included in the public law, and further explained in the Conference Report H. Rpt. 108-401, was the requirement that the VA would incur no additional cost in providing such a benefit.

PVA has expressed concern in the past with proposals similar to the "transitional pharmacy benefit." H. Rpt. 108-401 requires the VA to "collect and independently verify data on the costs and benefits of this new drug benefit and submit a report to the Committees on Appropriations by March 2, 2004." We are not aware of any report providing detailed information on the implementation of this benefit and the cost to the VA that has been released at this time. As I mentioned, PVA has testified that the costs associated with such a prescription drug benefit could prove to be detrimental to the VA. We look forward to any findings that the VA provides.

VA physicians, by being the sole source of care, have been fully able to monitor patients for potentially contra-indicative prescriptions. PVA is concerned that if VA is to accept non-VA physician written prescriptions, veteran patients may be put at risk with this loss of monitoring should the patient seek treatment both inside and outside the VA health care system.

PVA believes that allowing the VA to fill prescriptions written by private physicians will further exacerbate an already dangerous funding problem. I must emphasize that without adequate funding to meet increased demand for prescription drugs created by such a program, the VA will be forced to obtain funding through other means. The funding may be drawn from an already wholly inadequate health care budget or from increased costs to veterans.

PVA appreciates the opportunity to testify today on this issue. We look forward to working with this committee to find a workable solution to provide a reasonable pharmacy benefit to all veterans seeking prescription drugs. I would be happy to answer any questions that you might have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000 (estimated).

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,803.

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,413.

William Carl Blake
Associate Legislative Director
Paralyzed Veterans of America
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Carl Blake is an Associate Legislative Director with Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management. In addition, he represents PVA on issues such as homeless veterans and disabled veterans' employment as well as coordinates issues with other Veterans Service Organizations.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998. He received the National Organization of the Ladies Auxiliary to the Veterans of Foreign Wars of the United States Award for Excellence in the Environmental Engineering Sequence.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the United States Army. He was assigned to the 1st Brigade of the 82nd Airborne Division at Fort Bragg, North Carolina. Carl was retired from the military in October 2000 due to a service-connected disability.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus and son Jonathan.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 30, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on providing certain veterans with a prescription-only health care benefit. As an organization made up of wartime service-connected disabled veterans, the DAV is concerned about enhancing benefits and medical services for sick and disabled veterans, but most importantly about maintaining a stable and viable health care system to meet the unique medical needs of our nation's veterans now and in the future.

The DAV has testified previously on several measures introduced in both the House and Senate that would authorize the Department of Veterans Affairs (VA) to fill prescriptions for veterans ordered by non-VA physicians at VA medical care facilities. In general, we are opposed to this concept and have expressed concern about VA taking on the role of a pharmacy. Specifically, we are concerned that the impact of such a benefit could cause a major shift in reliance on the VA health care system for other than a full continuum of care and utilization of the comprehensive health care benefit package; therefore, possibly jeopardizing the viability of the entire system.

Though we agree that such a benefit may be advantageous to a large segment of the veteran population, this type of initiative would also prevent VA from providing this group a full continuum of treatment for which the comprehensive health care benefit package was created. The possibility that this benefit may fundamentally change the very nature of the VA health care system is a great concern.

We recognize that VA is struggling to provide timely health care to all veterans seeking care. We appreciate the Subcommittee providing this forum to further debate this issue and to reexamine the potential impact of introducing a prescription-only benefit option to certain veterans. Extensive research and development over the past 10 years has led to new prescription drug therapies and improvements over existing therapies that, in some instances, have replaced other health care interventions. Today, prescription drugs are an integral component of health care delivery. However, increased reliance on new drug therapies has also contributed to a significant increase in drug spending as an overall component of health care costs. This is an issue that affects not only VA but the general population and private health care systems as well.

It has been reported that increasing numbers of veterans age 65 and older are turning to VA for low cost prescription drugs. It has also been noted that these veterans are not seeking access to VA health care services but inexpensive prescription medication only. However, because VA physicians are required to examine patients before dispensing medications there is a "duplication" of health care services being rendered unnecessarily. The December 2000 report by VA's Office of Inspector General estimated over a $1 billion savings by eliminating the duplication of completing medical examinations and tests performed by VA. While we agree that in some cases a prescription only benefit would eliminate the duplication of tests and procedures already conducted by a veteran's private physician and would make available VA resources utilized in the current process, it is not clear whether this type of initiative would be wholly beneficial to the VA health care system or veterans themselves.

At the March 19, 2003, House Veterans' Affairs Committee Subcommittee on Health hearing on this issue, VA expressed concern that if an "add-on" pharmacy benefit was initiated without additional funding, it could erode the comprehensive medical care benefits that users of the system now enjoy. VA stated it must take care to ensure such actions would have no unintended consequences that could adversely affect VA's ability to provide timely, quality health care to all enrolled veterans. VA expressed reservations about implementing such a program because of the potential for significantly increased demand. In questions for the record VA commented that it was possible that nearly twice the current number of enrolled veterans could turn to VA if a prescription-only benefit were offered. VA also expressed concern about projected increases in current pharmacy workload and the potential impact of a prescription-only benefit could have on its Consolidated Mail Outpatient Pharmacies (CMOPs). Specifically in terms of increased cost, and how quickly they could ramp up to meet increased demand with changes to infrastructure and hiring of new personnel. VA also noted it would be unreasonable to expect VA could quickly expand capacity in local medical center pharmacies with limited space availability.

We concur with VA that providing a pharmacy only benefit may act as an incentive for a significant number of veterans, both current users and potential enrollees not currently using the system, to choose this option thereby significantly increasing overall pharmaceutical costs. We are also concerned about additional funding, staffing, and other resources that would likely be necessary to establish such a benefit and the additional burden it may place on an already severely strained health care system. As veterans' demand for pharmaceuticals has increased, VA expenditures on prescription drugs has increased dramatically as well. Because the budget for veterans' health care has not been sufficiently increased to meet demand for services, more of a burden has been placed on certain veterans in the form of increased copayments for medical care and prescription drugs. DAV Resolution No. 175 supports the repeal of copayments for medical care and prescription medications provided by VA. Copayments were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. Unfortunately, copayments are now a permanent feature of some veterans' health care services. We will continue to voice our objection to copayments on the basis that they fundamentally contradict the spirit and principle of veterans' benefits. No requirement that veterans be burdened with copayments is justified. Providing our nation's veterans with high quality health care is a continuing cost of national defense and should be our first priority.

There is also the question of appropriate quality assurance if a prescription only benefit were instituted. Would VA have access to the veteran's complete health information? Such access is needed to aid in making appropriate medication decisions and to conduct a complete check for possible drug allergies. Currently, VA prides itself on being a comprehensive health care provider offering coordinated interaction between VA clinicians and pharmacists to ensure veterans receive the highest quality health care possible. VA commented that the proper and effective use of medications by patients is the cornerstone of modern health care and that drug therapy should be monitored, coordinated, and managed by a single primary care provider to appropriately avoid medication errors. VA sited its pharmacy practice models to demonstrate improved patient outcomes. Finally, in the follow-up questions for the record of the March 2003 hearing VA reported briefly on its analysis of a survey on the utilization of new enrollees and stated that although pharmacy access was their primary reason for enrollment their use of services was not limited to primary care and pharmacy services.

Even with collaborative efforts between VA and Department of Defense (DoD) at joint venture sites and implementation of certain measures for protection, increased risk of medication errors remain. The United States General Accounting Office submitted a report on September 27, 2002, VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients. According to the report, veterans who present prescriptions written by DoD physicians to the VA pharmacy face an increased risk of medication errors. The report cites gaps in utilization of a pharmacy formulary, uncoordinated information and formulary systems, and incomplete automatic checks for drug allergies and drug interaction. Clearly, there is greater risk for patients who may be receiving prescriptions from more than one physician and having prescriptions filled by more than one pharmacist.

We do not believe there has been a sufficient study of the potential impact of implementing a prescription only benefit on veterans or the VA health care system. Although VA's Office of Inspector General offered potential savings of such a benefit, a potential cost analysis should be considered as well. Likewise, the impact on the quality of health care for veterans should also be assessed. We look forward to VA's survey results on a potential prescription-only health benefit and the status report on the implementation of its "transitional pharmacy benefit" to gain more insight into this complex issue.

As we search for solutions to best serve our nation's sick and disabled veterans, we must consider all the factors involved in providing high quality health care services. Ultimately, the quality of care received by America's veterans should be the focus of assessing VA's pharmacy benefits. We face significant challenges of finding a comprehensive long-term solution to VA health care funding, maintaining access to timely high quality health care services, keeping open enrollment for all veterans who need VA health care, and most importantly protecting VA's specialized programs for veterans with spinal cord injury, blindness, amputations, and mental illness. We cannot afford to be shortsighted or satisfied with temporary solutions to resolve VA's back-log for care. Band-aid approaches may help a few veterans in the short term but will ultimately shortchange veterans in the long run. The men and women serving in our Armed Forces today will need the VA for decades to come. We must ensure a stable and viable health care system, and work together to develop long-term solutions to these complex problems.

In closing, DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on this important issue.

SERVING
WITH
PRIDE

Testimony

of

Richard "Rick" Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

on

VA's Prescription Drugs Benefit

Tuesday, March 30, 2004
10:00 a.m., Room 334
Cannon House Office Building

AMVETS

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Chairman Simmons, Ranking Member Rodriguez, and Members of the Subcommittee:

On behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views to the Health Subcommittee on providing certain veterans with a Department of Veterans' Affairs prescription-only health care benefit.

As the Subcommittee is all too aware, Secretary Principi took action on January 17, 2003, that banned healthcare access to an estimated 164,000 veterans who could have enrolled in 2003, citing a lack of resources. During budget briefings earlier this year, VA indicated that as many as 320,000 veterans would be denied access to VA under current policy by the close of fiscal year 2005.

Mr. Chairman, Congress authorized enrollment eligibility for these so-called high-income veterans or "Priority 8s" into the VA system since 1996, but the funding to provide for them has never been adequately appropriated. In addition, VA has not, repeat not, done its job of collecting on the insurance coverage these patriots carry for the care they have been provided. The result is high-stress within the VA system and a blame-game outside the system, pointing a finger at non-service connected veterans for making a "run" on VA.

Regarding prescription drugs, current policy makes veterans eligible to receive prescription medications from the VA only if a VA physician prescribes the medication. While it may not seem like too great an imposition to require a VA doctor to see the patient, many of the veterans waiting over six months for a VA doctor's appointment are

waiting solely to have a prescription written and filled.

According to the Inspector General of the Department of Veterans Affairs, the VA pharmacy benefit is the primary reason that veterans without service-connected disabilities use VA healthcare services.

Nearly 90 percent of these veterans have access to private health care and private physicians, yet they wait in lengthy lines at the VA in order to be re-examined and re-tested so they can receive their prescription drugs through the VA. This causes veterans with a prescription already in hand to wait weeks, even months before it is filled and creates a backlog of veterans waiting for doctor appointments.

Once these veterans are under the care of a VA physician, they can see dramatically reduced prescription drug costs versus the private sector. Clearly with VA dispensing over 100 million prescriptions yearly to its 4.5 million patients, VA can negotiate very favorable drug prices. They have done an excellent job in this regard.

Figures from the National Association of Chain Drug Stores claim that for 2001, VA cost per prescription was almost half the cost found in the private sector. It is little wonder Priority 8 veterans have availed themselves of this benefit after Congress allowed them access to the VA system.

Mr. Chairman, AMVETS is generally supportive of extending and enhancing the current VA policy on prescriptions. We would, for example, like to see veterans able to renew their prescriptions as well as receive the first issuance of the non-VA prescribed medication.

In addition, AMVETS supports legislation to remedy the situation faced by older "banned" Priority 8s. While we would like to see VA lift its ban on Priority 8s, beginning with those veterans who currently have health insurance that pays VA for the care they may provide.

We also would support legislation, which, at the least, would permit Medicare-eligible veterans access to the VA system through an outpatient medication benefit.

AMVETS would also support legislation that openly allows VA to fill a prescription for a veteran who has been diagnosed and prescribed medication by a non-VA physician. The current VA prescription cost for enrolled patients is $7.00 for a 30-day supply. At this cost, many eligible veterans could see a substantial reduction in their medication expenses. They would also witness, in part, a promise of care fulfilled.

In addition, a benefit of this type would likely induce some Priority 8 veterans, enrolled before the Secretary's cut-off date, to return to their non-VA healthcare providers and thereby reduce VA's patient backlogs.

In the past, we have voiced concerns about the potential for VA becoming a national "drug store" rather than a provider of care in the event of a change in the way VA dispenses prescriptions.

We have said that we would not like to see further diminishment of veterans access to care because medical care dollars are being spent for prescriptions instead of primary and critical care of veterans.

However, with the understanding that VA rolled over more than 600 million unused fiscal year 2003 medical care dollars into fiscal year 2004, and projects increasing this amount to $800 million in fiscal year 2005, we no longer see the lack of available funding as a rational for a barrier to veterans access to prescription drugs.

Indeed, in this understanding AMVETS is doubly disappointed in the ban of Priority 8 veterans. We know that VA has instituted a 30-day appointment policy that allows veterans to be seen by doctors outside of the VA system if they cannot be scheduled in VA within that time period. Taking into account that the average cost of providing care to a Priority 8 veteran is $2,500 a year, there is ample funding available to give medical care to these veterans who earned and deserve it this year.

We must never forget who Priority 8 veterans are. They are those brave Americans who answered our nation's call and with God's grace returned from service whole and able to continue their lives without disabling injury or illness. They are the soldiers, sailors, airmen or marines who stand a post or walk a patrol somewhere in Iraq or elsewhere across the globe defending America, her interests and her freedoms. As we speak, these defenders may be replacing a buddy who yesterday gave the ultimate sacrifice. Today these patriots are ready voluntarily to take the place of those who have fallen. In doing so, we recognize victory in defense of freedom and our way of life.

The members of AMVETS believe these men and women, these $25,000-a-year "high-income" veterans, should be able to seek care at

VA if they have the need following their military service. Current statute makes them eligible, as long as appropriations are available. And it is the least our nation can do for those on whom America depended to defend her liberty.

It is almost beyond belief to members of AMVETS that our elected Congress -- at this time when we have young Americans engaged in the war on terrorism, risking their lives -- would pass a budget that fails to fully fund veterans health care and veterans benefits.

We recognize that the budget-appropriations process for this year has only just begun, but the course set by the House last week raises concern. The approved budget may appear ample when viewed with green-eye shades, but to the clear eye of those who served in the Armed Forces and many other Americans, there is a growing question about decision-making and national priorities.

Mr. Chairman, in closing, AMVETS thanks you for advancing the dialogue on the prescription drug needs of our nation's veterans.

We look forward to working with you and others in Congress to resolve this matter. As we find ourselves in times that threaten our very freedom, our nation must never forget those who ensure that our freedom endures.

AMVETS thanks the panel for the opportunity to address this matter.

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WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Chairman Simmons to Carl Blake, Associate Legislative Director, Paralyzed Veterans of America

Question 1 – You stated in your testimony that establishing a pharmacy-only benefit without guaranteeing additional new funding, could erode the comprehensive medical care benefits provided to current veteran users of the VA health care system. However, the VA currently spends a significant amount of funds re-examining, re-testing, and countersigning prescriptions that veterans obtain originally from private providers, many if not most who are approved by Medicare. Would it be reasonable to believe that the resources saved by eliminating duplication of diagnostic services could actually free up additional VA resources to be used for other enrolled veterans?

Answer: Although reasonable, PVA believes that any cost savings realized by eliminating duplication of services could be more than offset by the costs of implementing a new prescription drug program. The VA would face significant increases in the costs of the pharmaceuticals because it would need to purchase many more prescription drugs to handle the influx of prescriptions to its system.

Question 2 – The Department of Defense (DoD) military health system routinely processes prescriptions from non-DoD providers under the TRICARE program. Are you aware of any concerns about patient care issues associated with that benefit? Please describe any such concerns.

Answer: PVA is not familiar with the DoD health care system and how it processes prescriptions for military retirees under the TRICARE program. As such, we are not aware of what patient care concerns may exist as a result of the TRICARE benefit that is available. However, TRICARE, unlike VA, is an insurer of care, not a provider. As such, it is more accustomed to billing and accounts receivable processes associated with a prescription drug plan than is the VA.

Question 3 – How would you view a cost-neutral approach to providing a prescription-only VA health care benefit that would average the cost of all prescriptions to cover the marginal additional costs of providing this new benefit through cost sharing by veterans receiving it?

Answer: PVA does not believe there is enough information available to determine what would represent a cost-neutral approach to providing such a benefit. As we previously stated, we believe that the cost of implementing a new prescription drug program could more than offset any cost savings. PVA also remains concerned about what the cost of this program would be to a veteran as part of the cost sharing.

Question 4 – How would you respond to Dr. Hong's suggestion (made during the first panel of our hearing) to provide this prescription-only benefit at VA cost?

Answer: Once again, we have no data to support how the prescription-only benefit could effectively be maintained at VA cost. Without real data, we can only assume that the VA would not be able to provide this benefit in the suggested manner.

Question 5 – For many veterans, such as a veteran with a nonservice-connected spinal cord injury or one in a remote area, it is physically difficult and expensive to travel to a VA facility. In your opinion, would a prescription-only benefit extended to a disabled veteran in such circumstances provide a worthwhile VA service?

Answer: This could perhaps be a worthwhile service; however, non-service connected spinal cord injured veterans are already able to receive pharmaceuticals and supplies by mail order once they are enrolled due to their classification in Category 4. Non-service connected PVA members would recognize no additional benefit that they do not already have.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE ROB SIMMONS, CHAIRMAN
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
March 30, 2004 HEARING

Question One: You expressed the view that establishing a pharmacy-only benefit without guaranteeing additional new funding could erode the comprehensive medical care benefits provided to current veteran users of the VA health care system However, the VA currently spends a significant amount of funds on re-examining, re-testing, and re-writing prescriptions that veterans obtain from their private health care providers, many if not most who are approved Medicare providers. Is it not reasonable to assume that the resources saved by eliminating this duplication of health care services could help the VA to do a better job at maximizing the quality of care for other enrolled veterans?

Answer: It is reasonable to assume that there may be savings from eliminating duplication of health care services that could be used to treat other veterans seeking care if VA were to offer a prescription-only benefit; however, our main concern is the potential for fundamental change in the very nature of VA health care if such a benefit was offered. Though we agree that such a benefit may be advantageous to a large segment of the veteran population, this type of initiative would also prevent VA from providing this group a full continuum of treatment for which the comprehensive health care benefit package was created. For DAV, this proposal represents a significant divergence from the current standard of VA health care; specifically, VA acting as a comprehensive health care provider. Starting down this road could lead to a fragmented health care benefits delivery system similar to the one in effect prior to Health Care Eligibility Reform. There is also the potential for a significantly increased demand as a result of such a benefit. It is unclear if the potential savings would outweigh potential increased cost.

Question Two: The Department of Defense (DoD) military health care system routinely processes prescriptions from non-DoD providers under the TRICARE program. Are you aware of any concerns about patient care issues associated with that benefit? Please describe any such concerns.

Answer: I am not aware of any specific concerns related to patient care issues and prescription processing under the TRICARE program; however, as cited in my testimony, even with collaborative efforts between VA and DoD at joint venture sites, and implementation of certain measures for protection, increased risk of medication errors remain. The United States General Accounting Office submitted a report on September 27, 2002, "VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients." According to the report, veterans who present prescriptions written by DoD physicians to the VA pharmacy face an increased risk of medication errors. The report cites gaps in utilization of a pharmacy formulary, uncoordinated information and formulary systems, and incomplete automatic checks for drug allergies and drug

interaction. Clearly, there is greater risk for patients who may be receiving prescriptions from more than one physician and having prescriptions filled by more than one pharmacist.

Question Three: How would you view a cost-neutral approach to providing a prescription-only VA health care benefit that would average the cost of all prescriptions to cover the marginal additional costs of providing this new benefit through cost sharing by veterans receiving it?

Answer: We do not believe there has been a sufficient study of the potential impact of implementing a prescription-only benefit on veterans or the VA health care system. Therefore, DAV is opposed to a prescription-only benefit for veterans using the VA health care system, even using a cost-neutral approach.

Question Four: How would you respond to Dr. Hong's suggestion (made during the first panel of our hearing) to provide this prescription-only benefit at VA cost?

Answer: DAV is opposed to a prescription-only benefit in any form without a comprehensive study of the impact of such a benefit on veterans and the VA health care system.

Question Five: For many veterans, such as a veteran with a nonservice-connected spinal cord injury or one in a remote area, it is physically difficult and expensive to travel to a VA facility. In your opinion, would a prescription-only benefit extended to a disabled veteran in such circumstances provide a worthwhile service?

Answer: The challenge of providing health care to veterans in geographically remote areas remains a complex issue. Veterans under these circumstances may feel a prescription-only benefit would be beneficial; however, larger issues are at stake. We face significant challenges of finding a comprehensive long-term solution to VA health care funding, maintaining access to timely, high quality health care services, keeping open enrollment for all veterans who need VA health care, and most importantly, protecting VA's specialized programs. We believe that band-aid approaches may help a few veterans in the short term but will ultimately shortchange veterans who need the system most in the long run.

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