Testimony of Roger Landry, Former Maine State Representative, and Co-Chair of Maine's Task Force on Veterans' Health Services, Before the House Committee in Veterans Affairs Subcommittee on Health August 22, 2005

Congressman Michaud and distinguished members of the Committee. My name is Roger Landry; I am retired from the U.S. Air Force having served honorably for 22 years. I am also 100% disabled with the Veterans Administration with throat cancer derived from exposure to Agent Orange in Southeast Asia during the period of 1967 to 1968. I have spent the last 12 years working extensively with various veterans organizations in an effort to better the lives of our Veterans. Most recently, I served as a State Representative in the 121st Maine State Legislature for District 10 which is Sanford, Maine. During my short tenure in the State House I was able to bring numerous veterans' issues to the attention of our State government the most significant of which is veterans' health care as provided by the Veterans' Administration.

Let me begin by saying that I truly believe that the VA health care system in Maine and its staff are doing their level best to provide adequate health care to our veterans. However, recent developments in the economics, demographics, and ever changing geography of our Maine veterans' world have caused us all to re-examine that level of adequacy in our VA health care system. Namely, the aging of the American Veteran, the increased enrollment of uninsured into the VA, the increasing cost of providing healthcare, including prescription drugs, and a federal budget environment in which – without changes to the VA's funding mechanism – it appears increasingly likely that VA funding will not keep pace with costs faced by the VA, suggests that a 'Perfect Storm' scenario may be brewing for our nation's veterans just at the time when they need the system most.

Further, as has others have mentioned in their testimony, the CARES study found significant access gaps in Maine. The study came up with recommendations to close some – but not all – of the access gaps faced by Maine veterans, but, as you have heard, the CARES recommendations will not be implemented for a number of years.

In addition, Senator Collins of Maine has a bill in to allocate funding to provide better transportation for veterans to existing VA health care facilities. While this bill, if successful, will diminish the problem somewhat, it can by no means eliminate the problem.

For these reasons, it is critical that here in Maine, a state with the one of the nation's highest percentage of veterans (in the 2000 Census, veterans constituted 15.9% of Maine's population age 18 and over, while the average among the 50 states and District of Columbia was 13.5%)[1] and with a population older than the rest of the country,[2] we provide the leadership to a more efficient, more accessible, and more compassionate healthcare system for our national veterans.

In 2003, as part of the Dirigo Health Reform Act, Governor Baldacci and the Maine Legislature created a Task Force to review and assess the needs of the State's veterans for health care services and the availability, accessibility and quality of public and private health care services for veterans, and to make recommendations based on its review and assessment.

The Task Force, which I co-chaired, met almost monthly from December 2003 to January 2005, when it issued a report to the Legislature. This report, which was later forwarded to the Maine Congressional and Senatorial delegation, contained proposals that we are planning to provide to Secretary Nicholson soon. One proposal that we submitted was the decision of Governor Baldacci to join all four members of Maine's Congressional delegation in endorsing a Congressional measure to obtain mandatory funding for veterans health care as soon as possible, and that he encourage the National Governors' Association to endorse the measure. My testimony today alludes to that aspect of the overall problem with veterans' health care, affordability and accessibility being the key factors.

Because of the high cost of prescription drugs faced by many veterans, the Task Force also proposed that the VA conduct a pilot program in Maine to allow private physicians to write prescriptions that can be filled through the VA formulary, for a limited number of veterans living beyond a specified distance from a VA facility.

I will spend the remainder of my testimony giving the details of this proposal and explaining why it is in the best interest of both the VA and Maine's and the nation's veterans.

As we are all aware, because of a law allowing the VA to negotiate discounted prices on prescription drugs on behalf of the VA, the Department of Defense, the Public Health Service and the Coast Guard, the VA is able to offer some of the lowest prices on prescription drugs in the country. In order to access the drug benefit, veterans must enroll with the VA and receive prescriptions from a VA physician. Prescriptions that veterans receive from a private physician may not be filled through the VA.

The VA has stated that many veterans are enrolling in the VA system seeking only pharmacy benefits.[3] In other words, it appears that many veterans who might not otherwise have enrolled with the VA – veterans who have sufficient means to see a private physician but not necessarily to pay for prescription drugs – enroll to access the drug benefit.

There is considerable anecdotal evidence that many veterans receive care both from private community physicians as well as from the VA. This is especially true when veterans wish to avail themselves of the considerable discounts that the VA is able to offer on prescription drugs. To access this money saving benefit, they must see a VA provider at least yearly, either in Togus or one of the outlying clinics. This often involves a wait for an appointment, travel to a distant clinic, and duplicative health care with several primary care clinicians managing health care for the same patient. If the community physician wants to change a prescribed drug, the veteran must see a VA physician for approval. This often leads to duplicate lab tests, X-rays, and screening exams, increasing the cost to our health system, fragmenting care, delaying the veteran's obtaining medications, and inconveniencing the veteran, the VA, and the community physician.

Although many veterans put up with this cumbersome, costly, and fragmented system, a system that allows veterans to obtain primary care health services from their private physicians and prescription drugs through the VA pharmacy is what many veterans desire.

Accordingly, a number of bills have been introduced in Congress to allow the VA to fill prescriptions written by community physicians. The VA has opposed these bills for a number of reasons. Two primary reasons are:

- **Cost.** As you are aware, unlike the federal Medicare program, whose funding is mandatory and thus automatically additional increases when enrollment increases, the VA receives a fixed budget that is determined each year through the appropriations process. The VA has pointed out that if Congress expanded the drug benefit without providing additional funds to pay for the expansion, the expansion "would tend to erode the comprehensive medical care benefits that veteran users of the VA health care system now enjoy"[4] by crowding out spending on core services.

- **VA's Drug Benefit is Part of VA's Coordinated System of Care.** The VA has stated that it "strongly believes that drug therapy must be coordinated, monitored, and managed by a single primary care provider. VA has maintained control over the cost of its prescription benefit by using sophisticated formulary management techniques and by assuring that prescriptions written by VA staff are consistent with the formulary management process."[5]

Advocates for these bills have argued that the VA would realize savings from the passage of these bills as a result of a reduction in duplication of services, and that these savings would outweigh any additional costs to the VA. A December 2000 report by the VA Inspector General (IG) estimated the cost of the re-examinations at $1.3 billion in 2001.[6] However, the VA believes that there were significant flaws in the IG's methodology and has indicated that the IG is continuing to examine its methodology. The VA's position is that increase in enrollment would likely outweigh savings from reduction in duplication of services.[7]

Pilot Program Proposal. With these concerns in mind, the Task Force proposes that the VA conduct a three-year state-wide pilot program in Maine to test the feasibility of allowing a limited number of eligible veterans to obtain prescription drugs from the VA through their community physician. The pilot could include an evaluation to help assess whether the pilot might be worthwhile in other rural states.

Under the terms of the proposed pilot, veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to receive VA pharmacy benefits based on an initial visit with a VA physician. After the initial visit, a community physician would manage on-going care, including prescriptions. The veteran would enroll with the VA system and be required to see a VA physician every three years, rather than annually. Veterans enrolled in this program would pay a higher co-pay – to be established by the VA – and in return have the benefits of maintaining a relationship with their community physician, reducing unnecessary travel and duplication of services.

Specific elements of the proposal:

- **Increased co-payments to ensure cost neutrality to the VA, with all participants subject to co-payments, regardless of priority group.** The Task Force proposes that the VA establish a co-payment system that would enable the VA to fully recapture any additional cost to the VA of increased enrollment and prescription drug expenditures. This could include varying co-payments for specific drugs. The VA

could adjust the co-payment schedule annually to account for differences between projected and actual expenditures each year.

- **An enrollment cap set by the VA to limit the size of the pilot, and a program evaluation to assist the VA in monitoring impact of the pilot.** The VA could work with a local organization, such as from the University of Maine system or the University of New England, to design the pilot. This could include establishing an enrollment cap to balance the need to keep the pilot to a limited size while allowing statistically significant analysis, as well as to ensure enrollment of individuals from different parts of the state. The evaluation could answer such questions as:
  - What is the magnitude of savings to the VA from reduction in duplication of services? Does the pilot free up VA resources for veterans needing core services?
  - What is the demand for the program?
  - How do per-enrollee pharmacy expenditures in the pilot compare to per-enrollee outpatient pharmacy expenditures in the VA system?
  - What would the cost to the VA have been in the absence of the increased cost-sharing proposed by the pilot? Would those costs have been outweighed by savings from reduction in duplication of services?
  - How does enrollment break out between veterans who had already been driving to VA facilities for prescription drugs and those who are enrolling with the VA for the first time? Is there a reduction in the number of veterans who begin using VA services solely because they want access to the drug benefit?
- **Requiring Participating Veterans to Use a Single Primary Care Physician.** The enrollee must agree to use one primary-care physician, who would coordinate, monitor, and manage the veteran's care for the duration of their participation on the pilot. Any specialist wishing to write a prescription for the participating veteran would need to consult with the primary care physician before writing a prescription. The purpose of this provision would be to maximize the potential for the effective medication management to ensure cost effectiveness and safe, quality care.
- **The VA would determine which priority groups would be included in the pilot.** The VA might choose to include priority group 8 in the pilot, since there would be no additional cost to the VA.
- **Only veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to participate.**

Potential Benefits of the Pilot Program

- To Everyone:
  - Would free up essential Togus resources as Maine veterans return home from Iraq and Afghanistan and other areas of deployment.
- To Veterans:
  - Continuity of care; ability to maintain relationship with local doctor; easier for veterans to access the lower-priced prescription drugs to which they are entitled, with less travel and delay.
- To Togus and Togus Physicians:

  - Eliminates duplication; increases efficiency; allows Togus to target veterans with specific service-related health issues; reduces waiting lists. This would be good public relations for Togus and could help retention of Togus doctors.
  - Could increase funding for Togus by enrolling veterans who would not otherwise enroll.

- To private physicians:
  - Patients who are veterans can access lower-priced prescription drugs without redundancy of effort.
  - Less red-tape in providing prescriptions to patients who are veterans.
  - Continuity of care.

- To the VA, Congress, and the nation's veterans:
  - There has been interest nationwide in somehow expanding the VA's pharmacy benefit. Maine's serving as a pilot, with a strong evaluation component, could answer essential questions regarding the costs and benefits of such a program. The pilot and study could be used as a basis for estimating the impact of such a program nationwide, or at least in other rural states.

- Other benefits:
  - Fits VA " CARES Program" initiative to provide reasonable access to care
  - Fosters cooperation between State and Federal government.

In conclusion let me state for the record that we feel our proposals are solid, feasible and completely based on factual research. The Task Force -- which was comprised of members from all parts of Maine society to include veterans, doctors, business people, social workers and psychologists -- worked very hard to produce the most viable report of this type. Our ultimate goal is to have Secretary Nicholson review our proposals and give them due consideration. The opportunity to testify before this Committee gives us one more step closer to that goal. On behalf of the Task Force and especially the deserving veterans of Maine, I thank Congressman Michaud for his incredibly strong support in our efforts, and I thank the Committee for its time. I will now make myself available for any questions or comments the Committee may have.

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[1] www.va.gov/vetdata/census2000/index.htm
[2] US Census
[3] Statement of The Honorable Anthony J. Principi, Secretary of Veterans Affairs, Before The Subcommittee on Health of the Committee on Veterans' Affairs U.S. House of Representatives, March 19, 2003. Additionally, a recent Baltimore Sun article ("VA buys drugs cheaply, many veterans benefit," Cyril T. Zaneski, May 5, 2004) states that "about 20 percent of the veterans who use the VA each year do so solely because of its drug benefits, according to an agency survey, but that nearly 90 percent of the approximately 164,000 veterans who sought enrollment to the VA system last year wanted the drug benefit above all, according to the VA inspector general."
[4] Principi testimony, *op cit*.
[5] VA Responses to Questions for the Record from Honorable Rob Simmons, Chairman, Subcommittee on Health, Committee on veterans' Affairs, March 19, 2003.
[6] Department of Veterans Affairs, Office of Inspector General, "Audit Of Veterans Health Administration (VA) Pharmacy Co-Payment Levels And Restrictions On Filling Privately Written Prescriptions For Priority Group 7 Veterans," Report No.: 99-00057-4, Date: December 20, 2000.
[7] Principi testimony, *op cit*.