OVERSIGHT HEARING ON THE AVAILABILITY AND ELIGIBILITY FOR PHARMACEUTICAL SERVICES PROVIDED BY THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHT CONGRESS

FIRST SESSION

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OVERSIGHT HEARING ON THE AVAILABILITY AND ELIGIBILITY FOR PHARMACEUTICAL SERVICES PROVIDED BY THE DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, MARCH 19, 2003

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

The subcommittee met, pursuant to notice, at 2 p.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Moran, Miller, Boozman, Bradley, Beauprez, Brown-Waite, Renzi, Rodriguez, Filner, Berkley, and Ryan.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. I want to welcome our members to the Subcommittee on Health for the 108th Congress. My name is Rob Simmons. I am a Vietnam veteran, and I am humbled to have been selected by my colleagues on both sides of the aisle to serve as chairman of this subcommittee.

I am especially pleased that my friend, Congressman Rodriguez of Texas, has been designated by his colleagues to be our new ranking member on health. And I look forward to working with him.

I hope, at some point, I may even get a chance to go down to Texas and see how you do veterans' health care. And I will do my best to get you up to the nutmeg State of Connecticut.

We have new Republican members of the subcommittee: Mr. Beauprez, Mr. Bradley, Ms. Brown-Waite, Mr. Murphy, Mr. Renzi. I see him over there looking good, standing tall.

And new Democratic members: Ms. Hooley, Mr. Ryan, and Mr. Strickland. I thank them for their service.

We also have some regulars, most of whom are not here today. So maybe they are not regulars, but let's say "prior service members of this subcommittee:" Mr. Moran, who was the chairman in the last session; Mr. Stearns, chairman in the 106th; Mr. Baker; Mr. Boozman; and Mr. Miller.

And our Democratic members, of course: Mr. Rodriguez; Mr. Filner, who has been ranking member in the previous cycle; Dr. Snyder; Ms. Berkley; Mr. Gutierrez; and Ms. Brown.

I look forward to working with all members of the subcommittee in a bipartisan fashion as we address the issues involving the health care of America's veterans.

The health care that we provide to our veterans is not provided through a mandatory system. It is provided through a discretionary system. This is one of the issues that we have wrestled with on this subcommittee, and what we have wrestled with at a full committee level.

This is one of the issues that we will be attempting to address in the coming months: To what extent should funding for veterans' health care be mandatory, and how can we do that in a fashion that is responsible from a fiscal standpoint?

I am committed to providing benefits to our veterans for their service. One of my heroes, Teddy Roosevelt, said years ago, "A man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards. Less than that, no man"—and I would say no woman—"who has served shall have."

I think there can be little debate on this, although considering this body, there may be some debate.

The subject at hand is very important. We are dealing today with VA's pharmaceutical services. We have millions of veterans demanding VA health care. We have medical centers across the country that are falling behind in the provision of health care.

The waiting lines are increasingly long, 6 or 7 months. What we are looking for is legislative initiatives; or from the Administration, administrative initiatives that can address the issue of the provision of pharmaceutical services or prescription drugs to our veterans.

We have a panel of Members, a thin panel right now. But we have a panel of Members who are going to testify on their legislative initiatives. I see that Congressman Wicker of Mississippi is here. But before we hear his testimony, I see that Steve Lynch of Massachusetts just came in.

Before we hear from them, I would ask if my friend, Mr. Rodriguez, has a comment that he would like to make.

[The prepared statement of Chairman Simmons appears on p. 60.]

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to personally thank you and your leadership. I want to thank you for opening our hearing session with such a critical and timely discussion.

I also want to say that I look forward to working with you and your staff, as we move forward on these issues. I have confidence that we would have a productive session, as we look and I look forward to both your leadership, and as we move forward.

I also want to personally commend you on your leadership that you have already demonstrated in standing up and speaking out against the cuts proposed in the veterans programs, in our budgets. I want to thank you for that.

And, as Americans, as we sit here today, Americans who cross our borders, both in Mexico and Canada, are going across and buying their prescriptions. Our seniors are often forced to choose between paying for prescription drugs and paying for other basic ne-

cessities such as rent, such as utilities, such as bills, such as groceries.

I still get constituents that tell me that "Mr. Rodriguez, you know, I only buy my husband's prescriptions. I don't buy certain others, because I don't have sufficient resources."

This situation should be intolerable for any of us. And as policymakers, we know we need to come up with some form of responses. And while the committee cannot address the needs of all American seniors, we can assure and make some efforts at meeting the needs of our veterans when it comes to prescription drug coverage.

I am an original co-sponsor of Mr. Evans' bill, H.R. 1309, the Veterans' Prescription Drug Act of 2003. And I believe this bill offers many of our veterans an opportunity to receive prescription drug coverage even if they are not able to use other VA services.

Certainly, it is clear that many veterans are already making the decisions to use the VA in order to receive inexpensive prescription drugs. The VA estimated almost 900,000 veterans are most likely using the system for the pharmaceutical drug benefits.

Many are attributing the rapid growth in veterans' demand for VA health care to veterans' needs for excess in coverage for medication. The Secretary has made clear his intentions to prohibit new Priority 8 veterans from enrolling for VA health care, at least through fiscal year 2004.

By the looks of the budget resolution proposed in the House, the VA will have to continue to make very hard decisions and discussions that need to be held, and will be shutting down off the veterans access to enrollment, and rising co-payments, and eliminating services into a indefinite future.

Mr. Secretary, while I don't agree with all of your decisions on this area, I certainly appreciate the hard work that you have done and forced to make—and I know that the Office of Management and Budget guidance.

And I would ask that you continue to push forward on that area for our veterans. And I know, knowing you personally, I know that you will work as hard as you can in those areas.

But in this time of budget shortfalls and hard choices, it is crystal clear we cannot provide any significant new benefits in veterans without guaranteeing the funding to provide the benefit.

That is why I support the ranking member's bill that would allow the VA to collect the Medicare funds for administering a prescription drug benefit to Medicare eligible veterans.

I share Mr. Evans' belief that this could have a dramatic effect on veterans' waiting times as some more than 200,000 veterans are awaiting care, up for prescription drug alternatives.

The Congress must get serious about providing meaningful prescription drug coverage to our veterans and to all Americans. On the subcommittee, we can start by approving the ranking member's bill.

Mr. Chairman, I look forward to listening to the other members. And I want to welcome the other members that are here. And I also want to welcome our Secretary, who is also here. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you, Mr. Rodriguez. I would like to go directly to the panel and request that members of the subcommittee

hold their opening statements, to the extent they have one, to their 5 minute question period, where they can make a statement and then question.

I know that our first panel is going to be in and out. So if there is no objection to that, I would like at this point to ask Mr. Wicker if he would begin his presentation.

STATEMENT OF HON. ROGER WICKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. WICKER. Thank you very much, Mr. Chairman, and Mr. Ranking Member. And I certainly appreciate the reference earlier to a thin panel of witnesses. It makes me feel good after that meal last night.

And to the members of the committee, who have already sponsored H.R. 709, I very much appreciate the support which we have received, and also the fine comments of support that we received during the last Congress, during testimony about this Act.

H.R. 709 would probably save tax dollars for the federal treasury, but it most certainly would enable the VA to be more responsive to the needs of veterans. Here is the problem, Mr. Chairman. And I have prepared testimony, which I ask to be submitted in full to the record, and I will simply summarize.

Here is the problem: For many veterans it is often difficult and expensive to drive to a VA facility for a prescription. Now think with me, members of the committee, about the typical veteran. He might have been out of the service for 20 years, 40 years, even.

No one knows that veteran better than his local family doctor. And, yet, oftentimes, when that veteran needs a prescription from the VA, he must travel 25 miles, sometimes even over a hundred miles to the nearest VA hospital, when the same prescription could be written right there in his hometown.

Veterans often see their local doctors and have prescriptions written, but then the medication cannot be filled by the VA until they are examined by a VA physician. H.R. 709 will provide veterans with the option of obtaining their prescriptions from a physician outside the VA system.

The Veterans Prescription Access Improvement Act will offer an alternative approach to thousands of veterans who would prefer to simply absorb the cost associated with a private physician visit, instead of visiting the VA facility.

Let me make two points about this concept, and then I will be happy to entertain questions. It happens that, as I was hearing from veterans and from physicians back in my local district, the Inspector General of the Department of Veterans Affairs was examining this very issue. And they recently issued a report, which I will quote from, which is exactly on point with this legislation.

The Inspector General's Report stated, and I quote, "We believe that the processes VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility and/or private insurance coverage, who choose to be treated by a private non-VA health care provider must frequently, as a result of these processes, submit to duplicate exams, tests, and procedures by VHA simply in order to receive their prescriptions. As a result, VA medical centers fre-

quently end up spending more on scarce clinical resources to rewrite prescriptions than prescriptions themselves cost."

The other point that I would make is that this is hardly a new concept. The VA already has a system in place to provide prescription drugs to veterans whose prescriptions are written by private physicians if they are "permanently house-bound, or in need of regular aid and attendance."

That is one exception to the current rule. And also, there is a model for implementation of this expanded service in the Department of Defense, which has for years allowed private physicians to write prescriptions which are filled by the military health services system.

As of the year 2001, Mr. Chairman, the Department of Defense filled approximately 30 million prescriptions a year, which were written by civilian physicians, about one-half of the total number of prescriptions which were handled.

Members of the committee, I say that if it can work in those instances, if it can work for the 30 million prescriptions in the DOD, we have a template to show how it can work in the VA system.

And I thank you for the opportunity to testify on behalf of H.R. 709. I encourage each and every one of you to look seriously at this legislation. It is in the very early stages of its introduction, so we are looking certainly for co-sponsors. And I thank you very much for your attention.

[The prepared statement of Congressman Wicker appears on p. 62.]

Mr. SIMMONS. Thank you very much, Mr. Wicker, for your presentation. And for the members who are not familiar with the report that you referenced, it is the Office of Inspector General, Department of Veterans Affairs. It is a report that is dated I believe December 20, in the year 2000. So it is not a new report.

I was intrigued, not only was the proposal that you have made one that is currently being used in the Department of Defense, but it is also being used in the State of Alaska, I gather, because of the geography of that state.

You made the comment your bill could save the Department of Veterans Affairs over a billion dollars a year.

Is that due to increased co-payments, or is that due to savings by reducing the numbers of doctor visits, tests, and related activities?

Could you comment on that?

Mr. WICKER. It would be because you would have fewer doctor visits. As I quoted from the report, oftentimes, the visit to rewrite the prescription costs more than the prescription itself. And so, I think the major savings would be as a result of not having to have that VA doctor see the patient after they have already been seen by the civilian doctor.

But I get back to the primary point, Mr. Chairman; and that is the service to the veteran is what is paramount. And whether that figure is an accurate predictor, I don't know. But there is no question that this legislation would allow us to be more responsive to the needs of the veterans who do not live right there in two with a VA center.

Mr. SIMMONS. I thank the gentleman.

Does the ranking member have any questions?

Mr. RODRIGUEZ. Let me ask you, I think—and I want to thank you for those recommendations that you have there. I am just concerned, in terms of how that will cut down.

Because, you know, how do you plan? How does it—you know, can you give me a little more, because I apologize, a little more specifics in terms of how it operates?

Mr. WICKER. Well, it would operate just as we do now in the Department of Defense.

Mr. RODRIGUEZ. And that is?

Mr. WICKER. It would give the veteran the option, if he or she so chooses, to see a private physician, oftentimes, the family doctor back in their hometown. And that prescription would suffice at the VA center for filling the——

Mr. RODRIGUEZ. In terms of you would not see the duplication?

Mr. WICKER. That is right. You would not have to go in and see a VA physician, in addition to seeing the doctor that knows you best, and has already written the prescription.

I might also mention, Mr. Rodriguez, that there certainly are safeguards in place of the DOD system, knowing that the doctor is indeed a competent doctor; and that is someone who is qualified to fill that prescription.

Mr. RODRIGUEZ. Okay. I only have one question I also wanted to ask. In fact, I probably would ask everyone that has a piece of legislation before us that is a member. And that is that the present budget right now is looking at cutting $844 million out of the VA discretionary programs for 2004, and I wanted to get your perspective.

Have you planned to vote on that, or how you planned for us to be able to handle that situation?

Mr. WICKER. Well, it is my understanding——

Mr. RODRIGUEZ. And if you don't, I would hope that you really kind of seriously look at it. But, go ahead, I'm sorry.

Mr. WICKER. It is my understanding that the budget that we will be voting on tomorrow does in fact not cut veterans programs. And I think that will be fully explained tomorrow in the budget debate.

But, you know, there are different ways in Washington, DC, that we call a particular figure, a cut, or an increase. Sometimes you use the baseline; sometimes you use the actual amount of money expended each year.

But, in terms of the amount of money that we plan to expend for veterans programs in fiscal year 2003, the budget that I will support calls for an increase in those expenditures in the future.

Mr. RODRIGUEZ. In the future?

Mr. WICKER. For 2004, and beyond.

Mr. RODRIGUEZ. Are you giving me the same fuzzy math the administration did with the $3 billion that we got increase?

The Secretary is sitting back there. He got that $3 billion of fuzzy math also in co-payments and stuff. I would ask you to really seriously go back and look at that.

And I am only taking advantage since you are coming before our committee and asking to consider that you really seriously look at that, and be careful with that fuzzy math, because it is an $844 million, you know, on those, you know. Okay? Thank you.

Mr. SIMMONS. Thank you. I see that we have now four of our five panel members: Congressman Evans, our ranking member wants to testify on his bill.

Would you prefer to go to the table for that purpose, or speak?

Mr. FILNER. A point of order, Mr. Chairman.

Mr. SIMMONS. Yes.

Mr. FILNER. Both the ranking member and the chairman gave opening statements. And both of you, I assume, questioned Mr. Wicker.

Are we also going to question him? Are you going to take your 5 minutes for each one? And then we will just be happy to sit here and listen to you.

Mr. SIMMONS. What I would recommend, unless there is objection, is that we now complete our panel, and then go into a question period.

Mr. FILNER. Well, that would be fine except that you each got time to question the first panel, and did not give your other members any chance to do that.

Mr. SIMMONS. When we started, we only had I believe one panelist. What I would recommend is we give each of them a shot to make their presentation, then go into the questions.

Mr. FILNER. But, I would appreciate fairness to all members. You started off by saying you each have opening statements, and now you each got another 5 minutes. Give us each 5 minutes at the same time.

Mr. SIMMONS. Absolutely. And what I recommend is that we allow our panelists to finish their presentations, and then we will go into the question period.

Mr. FILNER. So we are going to have 20 minutes of presentation, and you will each take another 5 minutes or not?

Mr. SIMMONS. Negative.

Mr. FILNER. I can do whatever you decide.

Mr. SIMMONS. Okay. That would be fine, and I thank you for your courtesy. Why don't we go now to Mr. Lynch?

STATEMENTS OF HON. STEPHEN F. LYNCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS; HON. JOHN L. MICA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; AND HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

STATEMENT OF HON. STEPHEN F. LYNCH

Mr. LYNCH. Thank you, Mr. Chairman. I also want to thank the members of the committee for the courtesy in hearing the panel. I want to thank you for the opportunity to testify on behalf of H.R. 372, which I have entitled, "The Veterans Pharmacy Access Bill," which I introduced earlier this year. I will submit written testimony in addition to my oral testimony today, but I briefly wanted to outline this bill.

Basically, now the problem has been described by Mr. Wicker. And that is that in very many cases in my district, as well as others, we have veterans who go to their private physicians and are diagnosed with a certain condition, and are given a prescription,

and then they proceed to the VA to fill that prescription, and therein find out that they must go through the same examination, and the have the same prescription rewritten by a VA doctor in order to get those drugs through the pharmacy at the VA.

The problem there is not only the duplicity of services, and the redundancy in the system, which is very expensive. But also, at least for the veterans in my district, they are waiting between 5 and 7 months for that appointment with the VA.

So that fact is creating a tremendous obstruction for veterans to whom we owe this service from accessing the services and the lower prescription drugs. At the same time, I would like to say that I think the VA has done a good job in providing low cost prescription drugs to those who can access the system.

The problem is one of access. The bill that I have drafted would create a pilot program. There is great question about the amount of savings, or the amount of increased cost that opening up the system to veterans who are now prohibited because of the lengthy waiting periods, or the obstructions that are put up in front of them from accessing the VA pharmacy program, there are some really outstanding questions there about what costs or cost reductions that might represent.

I think that it is important to consider that I am not suggesting that with the inception of their system that we somehow lay off the VA docs. And I think those who show enormous savings by opening up the system are assuming that the fixed costs of those appointments and those doctors goes away. It does not. The line goes away.

In other words, our veterans are no longer waiting 5 or 7 months for an appointment. But I would hope that those—that we understand that those doctors stay in place and continue to provide the wonderful service that they do to our veterans.

This programs, as I envision it, and have outlined in this bill would be a pilot program. But I do believe overall there would be greater efficiencies because of the reduction in those double appointments, and the two redundant systems.

I also think that, just as a moral issue, that this is a service that we provide to our veterans. And, as a former member of this committee, I know there are a lot of members up there, all of them agree with me that this is a service that is rendered to our veterans for their services rendered to our country.

So I think that this is a logical way to proceed. I think it can, by using a pilot program, show us in a small scale version what the costs might be if we extended the program nationally. And I ask the members to consider the legislation that I have offered.

Again, I am also looking for co-sponsors on this legislation. And, again, I appreciate the courtesy that the committee has shown me here today. Thank you.

[The prepared statement of Congressman Lynch appears on p. 66.]

Mr. SIMMONS. I thank the gentleman for his statement. We have Mr. Mica from Florida. I would ask him if he would like to make his statement now.

Mr. MICA. Thank you, Mr. Chairman. And I request that my statement be made part of the record.

Mr. SIMMONS. Without objection.
Mr. MICA. Thank you.

STATEMENT OF HON. JOHN L. MICA

Mr. MICA. Let me just describe the situation in Florida, and I have got a chart that shows the whole country here. But I have 7,811 new enrollees waiting to be scheduled. We have 22,000 people, current enrollees, waiting for a scheduled appointment, and a total of some 30,000 people in the State of Florida.

And I would estimate probably this shows 200,000 nationally. But, probably, a quarter of a million people waiting for their first primary appointment. And I met with my veterans and found what I think that the VA has found that about two-thirds of these people want prescription medication; that they are there because they want prescription medication.

I think it is kind of fitting that as we sit here today, and about to send our troops off into conflict, that thousands, tens of thousands of people who serve this country, who Congress passed the Millennium Health Care Act, and Access Act, and we are not providing them basic assistance.

Now I went to VA, and I sent a letter, and said, "Why don't we do this, a program to any veteran who has waiting more than 30 days on a list to access this," because I thought it would take down the number of veterans on an immediate basis. And they wrote me back very politely that the law did not allow that. And that is why I am here today is we need to change the law.

Quite frankly, a pilot program is nice, but I do not want a pilot program. I have got veterans who need care now. And a lot of these veterans will be dead because of our inaction, and we actually increase the cost of health care to these veterans.

If any of you are on medication, I want to suspend your medication for the next 6 or 8 months and see how you are doing medically. Okay? And you might have a prescription from a private doctor in hand, and you hold that while you get worse. And I will give you dozens of medical conditions in which people's physical condition deteriorates because they cannot get this. And that is wrong.

Now we might just as well throw out the Millennium Act, or any of our other veterans acts if we cannot—if we are saying that these people are going to get an appointment, and then they are not going to get access to prescription drugs. And I do not think we intended that. They are going to get it.

So why make them wait? We have shortages of physicians in some of my areas. The physicians should be treating people, not just giving a prescription, which has already been given in the private sector actually saving you money.

And I discovered in looking more into the issue that GAO and the VA Inspector General have already recommended, and it is an estimate of a billion dollars we would save. Literally, we are sending some of these people to their premature deaths because we are giving them this.

It is absolutely stupid. So I think a simple act by this body will save us a billion dollars, will save us veterans, will better utilize the health care resources that we have of physicians.

We have a limited number of physicians in Florida—I do not know about the other states—to treat people who are sick. So it makes sense to me. I prefer not a pilot program. I do not think veterans—and I am not prepared to take the crumbs from the table—we want something that is going to do the job for our veterans.

So it is very simple, and there are examples. We have got examples of others. CHAMPUS and others take these private sector prescriptions. We are not trying to circumvent the total care of a veteran.

We have got veterans who have waited month, after month, after month, indeed this. And we are not trying to put in place our own prescription program. I am sure we will have a national program. But these are veterans who need health care and access to affordable prescription drugs.

Even if you have some additional co-payment, even if we scale this so that we limit the number of individuals who are eligible for this, I think we can do a much better job. So that is my little pitch today, folks.

I do not care. You can take the Mica Bill and throw it on the floor. Our authorship is not important. It is important that we get some coverage for these veterans now. Thank you.

[The prepared statement of Congressman Mica appears on p. 70.]

Mr. SIMMONS. I thank the gentleman for his comment. And now I would ask the ranking member, Congressman Evans, if he would like to make his statement as a panelist.

Mr. EVANS. Yes, sir.

STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you very much, Mr. Chairman. I appreciate this opportunity to speak before the committee as a witness. I am pleased so many of our colleagues sponsored my legislation. H.R. 1309 is a bill that is supported by AMVETS, Blinded Veterans Association, Military Order of the Purple Heart, Paralyzed Veterans of America, and the Vietnam Veterans of America.

I request that their letters be included in the hearing record.

Mr. SIMMONS. Without objection.

(See pp. 53—59.)

Mr. EVANS. Before I begin, I want to acknowledge the contributions of my colleagues, and who will also be testifying today, who have made my understanding of this problem. I have tried to craft my bill in a manner that takes cognizance of some of the concerns each of these bills raise.

The critical difference between their bills and my own bill is the revenue stream through Medicare. Let me say from the outset that. I believe Tony Principi when he says that there would be a new demand for this benefit. A year-and-a-half ago, Secretary Principi told the subcommittee that while he would like to work to provide this benefit for veterans, he believed the cost would be too great between 9.2 billion and 15.9 billion in additional costs because of the new demand for such a benefit.

Well, this new demand means new costs. There are many who say that savings would be gained from relieving the system of duplicative health care examinations. I do not believe these savings would offset the costs of new demand. So this is why it is critical

to find some way to reimburse VA for the cost of this new benefit for veterans.

If we can agree that there will be new demands, we must find a way to pay for them. The VA is already overtaxed by this aging population's increasing health care needs and the funding levels proposed by the Republicans on the Budget Committee for veterans' programs for the next 10 years are bleak. In this environment, it would be irresponsible for us to support a bill that lacks a funding mechanism to support this benefit.

What evidence do I have to support the idea that allowing veterans to bring prescription drugs ordered by their private physicians to be filled by the VA and will draw new eligible veterans into the VA?

I look at the growth that has occurred in the VA for the past several years. Priority 7 and 8 veterans made up more than 75 percent of new enrollees for care in 2002. New lower priority VA users are not highly reliant on the VA for their health care.

This suggests that these veterans have other health care resources and are most likely using VA for services such as outpatient prescription drugs that many health insurers, including Medicare, do not cover. These veterans are cheaper to serve, and more likely to have insurance, but that does not mean that they are free.

Even with the current prohibition on the growing new Priority 8 veterans, I believe there would still be widespread interests in obtaining low cost drugs from the VA for veterans who remain eligible for care.

Eliminating the hassle factor veterans have to schedule an appointment that may be several months away, would remove one of the deterrents the veterans currently confront in seeking the cheap drug benefit from the VA. Our colleague, Mr. Wicker's, statement mentions that veterans in rural areas would be greatly attracted to such a benefit.

Are these veterans currently enrolled?

Some of them may be, but others face the current hassle factor because they live far away and do not want to wait for health care, have likely demurred.

When this impediment is removed, why wouldn't they want to obtain cheaper drugs from the VA? Many of these veterans, who would be Medicare eligible.

I believe it would be the some new cost from the new demand associated with the drug benefit for veterans. That is why, in this time of budgetary shortfalls, I consider it critical to find a way to pay for this new benefit.

The optional way that I found to cover the most veterans would be to use Medicare funds. If Congress is truly serious about enacting a Medicare prescription drug benefit for America's seniors, I see no reason why they should not start with our veterans.

As a member of this committee, it has been difficult for us to pass constructive Medicare subvention legislation. I believe we have an advantage with the legislation that I proposed, since the benefits would be for veterans who are using Medicare rather than the VA for using their health care. This is a new benefit, rather

than the VA attempting to receive funding for something it has been doing already.

Mr. Chairman, again, I appreciate the opportunity to be here today. I am happy to answer any questions of our colleagues and staff. I also want to thank the Secretary for joining us and staying here so long. Thank you, Mr. Chairman.

(The prepared statement of Congressman Evans follows:)

PREPARED STATEMENT OF HON. LANE EVANS

Thank you, Chairman Simmons.

I appreciate your invitation to testify on H.R. 1309, the "Veterans Prescription Drug Benefits Act" at this important hearing.

I am pleased that my bill is cosponsored by 11 of my colleagues on this Committee.

It has also won the support of AMVETS, Blinded Veterans Association, Military Order of the Purple Heart, Paralyzed Veterans of America, and Vietnam Veterans of America.

I request that their letters be included in hearing record.

Before I begin, I want to acknowledge the contributions my colleagues, who will also be testifying today, have made to my understanding of this problem.

I have tried to craft my bill in a manner that takes cognizance of some of the concerns each of their bills raise.

The critical difference between their bills and my own is the revenue stream through Medicare.

Let me say from the outset that, I believe Secretary Principi when he says there would be new demand for this benefit.

A year and half ago, Secretary Principi told the Subcommittee that, while he would like to provide this benefit for veterans, he believed the cost would be great—between $9.2 billion and $15.9 billion a year in additional costs because of new demand for such a benefit.

New demand means new costs.

Granted there are some savings that would be gained from relieving the system of duplicative health care examinations, lab costs, and other tests, but I do not believe these savings would offset the costs of new demand.

That is why it is critical for us to find some way to reimburse VA for the costs of this new benefit for veterans.

If we can agree there would be new demand we must find a way to pay for it.

VA is already overtaxed by this aging population's increasing health care needs and the funding levels proposed by Republicans on the Budget Committee for veterans programs for the next ten years are bleak.

In this environment, it would be irresponsible for us to support a bill that lacks a funding mechanism to support this benefit.

What evidence do I have to support the idea that allowing veterans to bring prescription drugs ordered by their private physicians to VA to be filled would draw new eligible veterans into VA?

I look at the growth that has occurred in VA within the last several years.

Priority 7 and 8 veterans made up more than 75 percent of the new enrollees for care in 2002.

New lower priority VA users are not highly reliant on VA for health care.

This suggests that these veterans have other health care resources and are most likely using VA for services such as outpatient prescription drugs that many health insurers, including Medicare, do not cover.

These veterans are cheaper to serve, and more likely to have insurance, but that doesn't mean they are free.

Even with the current prohibition on enrolling new Priority 8 veterans, I believe there would still be widespread interest in obtaining low cost drugs from VA from veterans who remain eligible for care.

Eliminating the "hassle factor" veterans have faced in having to schedule an appointment that may be several months away would remove one of the only deterrents veterans currently confront in seeking a cheap drug benefit from VA.

Even Mr. Wicker's statement mentions that veterans in rural areas would be greatly attracted to such a benefit.

Are these individuals currently enrolled?

Some of them may be, but others facing current "hassle factor" because they live far away or don't want to wait for care, have likely demurred.

When this impediment is removed why wouldn't they want to obtain cheaper drugs from VA?

Many of these veterans would be Medicare-eligible.

In closing, I believe there would be some new costs from new demand associated with a drug benefit for veterans.

That's why, in this time of budget shortfalls, I considered it critical to find a way to pay for this new benefit.

The optimal way I found to cover the most veterans would be to use Medicare funds.

If Congress is truly serious about enacting a Medicare prescription benefit for America's seniors, I see no reason why we should not start with our veterans.

As any Member of this Committee knows, it has been difficult to for us to pass constructive Medicare subvention legislation.

I believe we have an advantage with the legislation I have proposed since the benefits would be for veterans who are using Medicare rather than VA for their health care.

This is also a "new benefit" rather than VA attempting to receive funding for something it has already been doing like previous subvention bills.

Mr. Chairman, again, I appreciate the opportunity to be here today and I am happy to answer any questions you may have.

[The prepared testimony of Congressman Evans appears on p. 71.]

Mr. SIMMONS. I thank the gentleman for his statement. We have one final panelist, Ms. Johnson, who is not here. So I recommend we go into the question/answer period, which will be 5 minutes for each Member. Because I knew Mr. Wicker was leaving, I took advantage of my 5 minutes previously; and so I will pass at this point.

On the Republican side, we have got Mr. Renzi, Mr. Beauprez, and Ms. Brown-Waite. On the Democrat side, we have got Mr. Filner, Mr. Ryan, and Ms. Berkley. I ask the ranking member if he has a question he would like to ask?

Mr. RODRIGUEZ. I will pass.

Mr. SIMMONS. That being the case, we go to Mr. Renzi.

OPENING STATEMENT OF HON. RICK RENZI

Mr. RENZI. Thank you, Mr. Chairman. Mr. Mica, thank you for your testimony for concentrating particularly on the waiting time. And I know Mr. Wicker's testimony concentrated a little bit on travel distance.

Out in Arizona, we have got the Navajo Nation, a lot of good veterans up there. They drive 150 miles. In your testimony, in your research, I am asking you to kind of teach me here.

You see us being able to cut the waiting time by providing the benefit locally. And, yet, in order for the veteran to reach, or get a hold of the drug at a lower cost, he now has to go to where we buy it in bulk at the VA hospital, or at the VA clinic.

Does your bill—or can we address the ability to deliver the drug locally with the same kind of discount, the same kind of cost savings, or how would you see that worked out?

Mr. MICA. Well, we should be accommodating veterans just like Members of Congress. I have a prescription. And I can dial in an 800 number, or have it mailed to me. I think a veteran should be at least entitled to the convenience that is provided to a Member of Congress.

There is absolutely no reason in the world why we can't provide access. And what I propose, too, it doesn't eliminate the waiting time. They will still have to see a veterans' physician for full care.

What it does is it keeps people from getting sicker, and it helps us treat veterans, some of whom will probably be dead by the time they ever get to an appointment. It gives them some chance of medically being better. So you save money because you have a healthier veteran. They have access to this. We take the pressure off the waiting time.

And VA physicians, for example, in Florida, who should be spending their time treating sick, are not filling out prescriptions that have already been filled out and paid for by the veteran, or acquired by the veteran in a duplicate matter.

So it saves time, money, and on convenience I would advocate any convenience. And, again, we could increase maybe the co-payment for some of these folks if we had to. There are different ways to do it. You can limit the scope. But I tried to limit the scope by those that have been waiting 30 days or more.

Mr. SIMMONS. I thank the gentleman. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman, and I appreciate the hearing on this matter. Obviously, most of us, if not all of us, have been visited by veterans who think that the system is not working for them.

They have the prescription, as we have heard so eloquently by our panelists. And, yet, they can't get it filled. They may have to wait. Certainly, it is a waste of time and a waste of expense to go to the VA for a prescription that they have from their own doctor, who they may have been seeing for many years.

I think this is a vital issue. Because I want to see this issue addressed, I happen to be a co-sponsor of all of the bills that were presented here today, because I think we need to pursue each and every avenue that has been discussed to make sure that this gets on the table.

I am very partial to the bill that Mr. Evans has just introduced, the Veterans Prescription Drug Benefits Act of 2003, because Mr. Evans' bill, unlike the others, gives us a revenue stream through Medicare.

That means that we are fair to both, the VA and to Medicare, because Medicare-eligible veterans are currently using Medicare for their health services, and the VA then will not be absorbing the cost of their prescription drugs.

So I think it is an appropriate step, as Congress is also discussing the possibility of a prescription drug benefit within Medicare, for all Medicare users.

I thank all of the members who are here today. I thank the Secretary, even though he is wrong on this issue, but we thank you for being here. Let's see if we can move forward on this.

Mr. Mica, I was particularly struck by the savings that you estimate of a billion dollars.

Can you tell me how you got there?

Mr. MICA. Well, first of all, I was surprised at some of those documented already by studies of inspector general and GAO. Thank you.

Did you hear that, that we have some documentation?

But, again, it does not take a rocket scientist to figure this out. You have got sick veterans who have a prescription—or, well, are in line for a medical examination to get a prescription for some illness. You treat them and the treatment starts earlier, they are going to be healthier in the end. So you better utilize, again, your limited VA physician staff.

Mr. FILNER. I have a Ph.D. in rocket science, so I wish it would take a rocket scientist.

But who is paying for the prescription drugs?

Mr. MICA. Well, first of all, you have a co-payment. Now I was told that it cost on average about $20.

Is is 16 or 20 dollars?

Mr. LYNCH. Seven dollars, $7 co-payment.

Mr. MICA. No, that is a co-payment. But, actually, I said, "Well, what's the cost, the average cost?"

So if you took that, you could have some sliding scale to help pay for it. You can use Medicare reimbursement. I don't care.

Mr. FILNER. But your billion dollars—I mean the Secretary is going to testify that it is going to cost VA, I don't know, 7, 8, $10 billion, something like that.

Mr. MICA. For the prescription drugs?

Mr. FILNER. Yes.

Mr. MICA. Well, it is going to cost us, unless we are all part of some kind of charade, we are going to be providing this anyway, aren't we? Didn't we tell them we were going to give them that?

What they are waiting for is just the confirmation by a VA physician. Well, I have the confirmation by a certified—and you can set the certification of the kind of doctor that can certify it. So we are participating in some kind of charade.

Mr. FILNER. Mr. Mica, you are assuming that everybody who——

Mr. MICA. Bill me if it does not work out that way.

Mr. FILNER. You are the one who could afford it, so I would be happy to.

Mr. MICA. All right. I will pay.

Mr. FILNER. And, especially, after we vote for all of the tax cuts, I know you will be able to afford even more. But I think you are absolutely right, in terms of the concept.

The Secretary is going to testify. You probably won't be able to question him. So I am giving you a chance to lay out your arguments here.

And I think you are absolutely right. I think there is a cost that the Secretary will probably testify to.

As Mr. Rodriguez said earlier—you weren't here—to Mr. Wicker, that the budget resolutions that are on the table, that we may vote for this week, give a significant cut to the Veterans Administration.

I don't know how Mr. Wicker argued that we are going to have an increase. I was watching the facial expression of the Secretary, and I know he would not want for me to characterize it, but I will characterize as Mr. Rodriguez did, that there is fuzzy math that was proposed here earlier.

So there are going to be significant cuts, if you all vote for the budget on the table. By the way, if all the members of the Veterans Committee, all of us who profess to be supporters of veterans,

refuse to vote for that budget unless it had no cuts for the veterans, we could stop that.

So I hope you will join with us as we try to stop that resolution tomorrow.

Mr. SIMMONS. The gentleman's time has expired.

Mr. FILNER. So I hope that we do not vote for veterans' cuts, and we give the benefits such as you have outlined today.

Mr. SIMMONS. I thank the gentleman.

Mr. MICA. May I respond?

Mr. SIMMONS. Yes.

Mr. MICA. Just briefly, you know, it is not how much you spend always, it is how you spend it. And we have to look for some ways to save money. And this is a proposal that I believe will save you money.

And I know the Secretary is doing everything he can to shorten that list. And you will hear how that list has been diminished some, and we give him credit for that. But this is a solution because I don't think you are ever going to catch up with that, that has cost savings to the budget, and to this whole process, and better utilizes our limited resources. Thank you, Mr. Chairman.

Mr. SIMMONS. Ms. Brown-Waite, followed by Mr. Ryan.

Ms. BROWN-WAITE. Thank you very much. Mr. Lynch, the wait in the New England states is nothing compared to the wait in Florida. My veterans would gladly take a 6-month wait, and replace the 18-month wait that in many of the counties that I represent, they have to wait for an appointment. But what I wanted to ask was Mr. Mica.

Mr. Mica, do you have any estimate?

Mr. LYNCH. Can I respond to that, Mr. Chairman?

I think it is equally a disgrace that my veterans are waiting 5 to 7 months. It does not make it less of a disgrace because some other veterans are waiting longer. And it says here in Florida the average veteran is waiting 6 months. I mean, I don't understand the point of your remark.

Ms. BROWN-WAITE. Mr. Chairman, if I may respond?

Mr. SIMMONS. Absolutely.

Ms. BROWN-WAITE. The point of the remark is that 6 months would be a reasonable waiting period for the veterans in my district when they are having to wait 18 months. I have recently redocumented this, because I understand that the veterans department was saying that my figures were not accurate.

I do not think—you know, believe me, I think that the 6-month wait is a long time. My comment was that they would gladly exchange the 6 months for the wait that they are having to do. I do not believe that the 6 months wait is appropriate, either.

Mr. LYNCH. Well, I would not support something that would force your veterans to wait 6 months for prescription drugs. I think that defeats the whole purpose.

Mr. SIMMONS. If I could ask the panel and the Members, I think there is a lot of agreement in the room that, 6 months or 18 months, all of these are long waits. And what we are really trying to do is address the problem and solve it.

Ms. Brown-Waite, ask your question.

Ms. BROWN-WAITE. Yes, my question is for Mr. Mica.

Mr. Mica, do you have any estimate of, if that were—if your bill were implemented today, the number of people in Florida who would be able to take advantage of using a non-VA prescription?

Mr. LYNCH. Well, I mean, we have, I would imagine, close to 30,000. But, see, a lot of people have given up to even get on the list. A lot of folks do not even want to get on the list.

The other thing too that is interesting, if you are adopt this I do not have to have my limited physicians writing a prescription that has already been written in the private sector. And I would ask one of the members of the panel to give the number of veterans who are waiting for different procedures in Florida.

So they have already a doctor. They already have a prescription, but our doctors are tied up doing duplicative work, where I have sick patients who have months and months of waiting time to have certain procedures done because the physicians are not treating other sick people. They are doing another job and writing this prescription that has already been written.

Ms. BROWN-WAITE. It is a duplication of medical care in many instances. Thank you very much.

Mr. SIMMONS. I thank the lady.

Mr. Ryan. Mr. Ryan passes.

Mr. Moran, the former chairman of this subcommittee.

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Mr. Chairman, thank you. This is an awfully important topic, a path we started down more than a year ago, and I am delighted that you are continuing your interest in finding ways to more efficiently, and in a less costly manner, provide prescription drug service for our veterans.

I have been interested in my colleagues' testimonies, and their proposals, and I look forward to working with them and you to see that we find a solution to this mounting problem associated with costs and waiting lists. But I have no questions, and I yield back my time.

Mr. SIMMONS. I thank the gentleman.

Ms. Berkley, followed by Mr. Boozman.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you, Mr. Chairman. I will also be very brief. It occurs to me that if 45 percent of the veterans enrolled in the VA health care are Medicare-eligible, if we provided a prescription medication benefit within the Medicare system, that would alleviate 45 percent of our problem.

Now there is a health care crisis in this nation, and you all have heard me talk about the crisis in southern Nevada with our veterans, and the needs that they have. I am anxious to hear Secretary Principi's concerns about this legislation.

Because, at first blush, it is something that I think we all agree is fundamentally important to provide the prescription medication to our veterans, and not have them have to go see a doctor, and then see a VA doctor, in order to fill their prescriptions.

I know that Secretary Principi's heart is in the right place, as—and he works tirelessly on behalf of the vets, I would like to hear

what he has to say about this proposal before I make any final decisions. And I thank the panel very much for their testimony.

Mr. SIMMONS. I thank the lady. Mr. Boozman.

Mr. BOOZMAN. I really don't have any questions, either. I just want to thank you all for working on this issue. This really is a very important issue. And I guess the only comment that I would have is that, you know, it just—it does seem like, however you argue this, that we just have a duplication of services.

And, in duplicating services that are limited to begin with, it does seem very inefficient, and, you know, costly. So, again, thank you all for spending your time and working on this.

Mr. SIMMONS. I thank you, Mr. Boozman. Mr. Bradley, followed by Mr. Miller.

Mr. BRADLEY. Thank you very much. I have nothing at this time.

Mr. SIMMONS. Mr. Miller.

Mr. MILLER. Pass.

Mr. SIMMONS. Pass. What a quiet group here we have today. Mr. Rodriguez, do you have any further questions?

Mr. RODRIGUEZ. No, thank you very much for being here.

Mr. SIMMONS. Thank you, gentlemen. The first panel is excused. And now we will be——

Mr. MICA. Thank you, Mr. Chairman. I will leave you this. It is a VA prescription bottle. It is empty, but you all have the chance to fill it for a lot of my veterans. Thank you.

Mr. SIMMONS. I appreciate it very much. And, actually, we would be interested, Mr. Mica, in getting a copy of your chart.

Mr. MICA. Well, I did send a copy for you.

Mr. SIMMONS. Oh, you did, okay. Thank you very much.

And if Mrs. Johnson is going to be submitting a statement, I ask unanimous consent that it be included in the record, Mrs. Johnson's statement.

Is there any objection?

Hearing no objection, so ordered.

[The statement of Hon. Nancy L. Johnson appears on p. 73.]

Mr. SIMMONS. Our second panel is made up of our Secretary of Veterans Affairs, Anthony J. Principi, somebody that I met many years ago as a Senate staffer. I don't know whether he still admits that, but we were both Senate staffers many years ago, he on the Armed Services Committee; I was on the Intelligence Committee, back in the early 1980s.

We were very young then, but not so young that we hadn't both served a tour in Vietnam; he with the Mobile Riverine Force in the Mekong Delta, and I was down in Can Tho in the Mekong Delta. I was there with military intelligence, so I can't tell you what I was doing. He probably can't tell us what he was doing, either, but it is a treat to have him here today.

He is accompanied by Dr. Roswell, and I welcome them both. I will ask for their testimony, and then we will go through questions in the same order that we followed previously.

Thank you, Mr. Secretary.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Secretary PRINCIPI. Thank you. Thank you, Chairman Simmons, Congressman Rodriguez, ranking member Mr. Evans, and members of the committee.

Thank you for inviting me to appear at this afternoon's hearing on legislative proposals concerning veterans' access to and eligibility for VA pharmaceutical services. Indeed, this is a very, very important hearing, on a very, very important issue. I ask that my written statement addressing these issues in more detail appear in the record.

Mr. SIMMONS. Without objection.

Secretary PRINCIPI. At this time, I would like to discuss the underlying foundation for my views.

VA's great strength as a comprehensive health care system is centered on our ability to provide our veteran patients with a complete and comprehensive continuum of care, in a coordinated and unified health care system. Prescription drugs are absolutely critical to that continuum of care, and play a very, very important role.

Unlike Medicare, private sector, we do not fractionalize health care in the VA, wherein physicians prescribe and then they send it down to a local CVS and have those prescriptions filled. Pharmacists play an integral role with our practitioners, our physicians, our nurse practitioners, and our physicians' assistants. And I think that is one of the great strengths of our VA health care system and how we can, through that continuum, measure outcomes and make important policy decisions regarding health care in this country.

I am concerned that very well-intentioned proposals with very noble goals can have unpredicted consequences and produce unexpected outcomes. That is my primary concern with the proposals. We struggle with this, and I personally struggle with this issue.

For example, the effects are still unfolding for the 1996 legislation mandating a uniformed health care benefits package for all 25 million veterans who enroll for VA care. I don't think we can compare the VA health care system with the military.

That is a very defined population, very limited in number compared to our 25 million. There is only 1.4 million in uniform, and military retirees certainly don't even approach the number of 25 million.

And, certainly, we can't compare it with 535 Members of Congress, keeping in mind that only less than 20 percent of the veteran population who are potentially eligible for VA health care come to the VA. Some four-and-a-half million are users.

There are 25 million, many of which are in need of prescription drugs. Proposals for prescription drug coverage outside of our health care benefit package have a similar potential for significant, but unpredictable outcomes. Let me tell you about a memo that crossed my desk not too long ago from one of America's largest Fortune 500 companies.

This memo, which was prepared by an official who handles this company's prescription drug program, and mentioned to his seniors at this company that amongst this employee population there were 50,000 veterans. And this corporation can save countless millions of dollars if we send a memo around to all 50,000 veteran employ-

ees, and tell them to go to the VA to get their care and their prescription drugs.

Is that what we intend?

I, frankly, cannot predict where that path would lead. But I believe that there is substantial risk that such a benefit expansion could impose significant stress on an already stressed VA health care system.

I believe that proposals for a pharmacy benefit, independent of our comprehensive health care benefit package, have both short-term and long-term implications. In the short-term, as we have heard here today, many of the approximately 200,000 veterans, who have applied for VA care, but who have not been promptly seen by a VA physician, are assumed to be motivated by a desire to obtain prescriptions at the VA co-payment rate.

I know that is true because I have been in many of these clinics and medical centers where many veterans are coming for prescription drugs only. This is primarily a waiting list issue rather than a pharmacy issue. We can best address this issue by addressing the underlying cause, the waiting list, rather than the symptom, prescription drugs.

At my direction, Dr. Roswell is implementing a plan to ensure that veterans now waiting for care be seen by a VA physician. And it is my hope and intent that the waiting list will be eliminated by the end of this year, thanks to the generosity of the president and the Congress with the 2003 appropriation.

A limited program, however, to fill non-VA prescriptions for veterans temporarily unable to see a VA physician on a timely basis could be useful in eliminating the backlog of veterans now waiting for care across the country. And I am willing to work with Congress to achieve this goal, so that we can fulfill these non-VA prescriptions.

Such a limited program could also provide useful information on the effects of a pharmacy benefit. In the long-term, I am, of course, concerned by the apparent redundant utilization of medical resources by veterans who are seen, both by the private sector, many of whom have their physicians fees reimbursed by Medicare, and then come and see VA physicians.

We can scarcely afford this redundancy in the consumption of scarce medical resources in this country. And this is an issue far beyond the VA. It involves the collaboration and the coordination of health care delivery in this country across federal health care lines.

I think it is in much part a Medicare problem, as it is a VA problem. But the fact that we do not have a Medicare prescription benefit in this country is causing a lot of people to come to the VA. But I must also consider the possibility of far-reaching consequences for VA, if the Congress were to create a new or expanded access to VA filled prescriptions.

Such a benefit would be attractive to millions of veterans, who do not now utilize the VA, as well as many who are now our patients. Proposals for a generalized or permanent pharmacy benefit should not be evaluated in a VA, or a veterans only stove pipe.

I urge the committee to consider this issue in the context of the President's, and various Members of Congress' Medicare mod-

ernization framework, which would provide for a pharmaceutical benefit to Medicare beneficiaries. The administration intends to ensure all Medicare beneficiaries have access to drugs throughout this benefit.

In summary, I believe that we can, and we should work together to address a short-term waiting list issue that has been highlighted today, raised by veterans for whom VA has been unable to schedule a timely appointment.

I agree with you, this is not good health care. We need to do better. We need to get him into see a physician, so that they can get their prescriptions filled. For the long-term, I believe we all need to be cautious and careful in approaching proposals with the potential to have very significant, but poorly understood, and difficult to predict consequences.

Whatever course Congress takes, I cannot overemphasize the importance of staying within VA's formulary, as well as our pharmacy management and distribution system. If there is one thing that we do well in the VA, it is our pharmacy benefit management program.

By having a national formulary, 65 percent of the drugs we prescribe are generic; 35 percent are brand name. The 35 percent that are brand name account for 92 percent of our costs. Our distribution system allows us to leverage our size and purchasing power, so that we can buy in bulk and distribute at less cost.

The average ingredient cost for our prescriptions over the past 48 months has remained constant at $13. There is no system in this country or the world that has been able to maintain pharmacy costs at a level of $13 for the past 48 months.

That is a tribute to the Veterans Health Administration and their Pharmacy Benefit Management Program. So I urge you to ensure that we are able to continue to use the VA formulary, and we continue to use our consolidated mail out pharmacy program, so that we can control our costs and provide more drugs to more veterans.

You know we have seen this enormous growth in workload. I am absolutely confident we would not have been able to see these veterans were it not for our reliance on good prescription drugs.

And, in the future, with miracle drugs coming down the pike, with the mapping of the human genome, we are going to see even more miracle drugs, which are going to consume even a greater percentage of our medical care appropriation. We are now at 14 percent of our medical care appropriation.

It is not unreasonable to believe that, at some point and time, we will be at 40 percent of our medical care appropriation. There is good news and bad news. The good news is we are treating more veterans more efficiently, not having to occupy a hospital bed, or a nursing home bed, or an institutional mental health bed.

They can be treated on a non-institutional basis. But we will be spending more for pharmaceuticals as the years go by, and as these new patented drugs come to market. I thank you so very much for your courtesy. And I am prepared to answer whatever questions you might have.

[The prepared statement of Secretary Principi appears on p. 75.]

Mr. SIMMONS. Thank you, Mr. Secretary. You are accompanied by Dr. Roswell.

Does he have a prepared statement?

No, he is there to keep you company. Okay.

Secretary PRINCIPI. He is here to answer questions.

Mr. SIMMONS. That being the case, what I would like to do is ask a few questions, and then defer to my colleague, and then go back through the same cycle.

And, again, I thank you for your testimony. I thank you for your patience.

You stated on page 8 of your prepared statement, Mr. Secretary—and I am not sure you mentioned verbally for the record—that you have "directed the VA staff to explore and provide recommendations for administrative approaches to initiate a time limited program during which we would fill prescriptions written by non-VA providers for enrolled veterans who are now waiting for VA care, and who only want prescription drugs."

Could you give us a time line on that? What do you have in mind, and when might that be implemented?

Secretary PRINCIPI. Well, it is, perhaps, a little bit of a difference of agreement whether we need legislation for such a program. My general counsel advises me we do need legislation.

But, and certainly I am prepared to work with the committee, the members, to come up with a program that would allow us to, again, fill prescriptions, a time limited program that would allow us to fill prescriptions written by non-VA physicians for veterans who are currently on the waiting list, so that we can, in a more expeditious manner, care for those who are on the waiting list, and those who just need prescriptions, who just want prescriptions, to have a mechanism for them to do so.

So any veteran on the waiting list, who cannot receive an appointment within 30 days of requesting such an appointment, and for the purpose of receiving prescriptions would be able to do so.

So that is basically the outline that we are prepared to work with the Congress on. And if it is determined that it requires legislation, and it is something that I cannot do administratively, then the time line would be up to the committee to decide on such a program.

Mr. SIMMONS. I appreciate that response.

Secretary PRINCIPI. I would think time is of the essence to get this program underway, so that we can get these veterans, places like Florida and New England, off the waiting list.

Mr. SIMMONS. I appreciate that response. And I would suggest that because of the presentation of our panels, that there are people willing to legislate this solution, and that it really is something that we need to get on right away.

Second question, the report of the Office of Inspector General has been referred to on a couple of occasions was referred to the National Leadership Board for review.

What became of that review? Did they endorse the report? Did they reject the report? Did they file the report? Where are they in examining this Inspector General's report?

Mr. ROSWELL. Mr. Chairman, the National Leadership Board is currently completing its review of the report, and we are compiling

their comments, which will be referred back to the Office of the Inspector General for inclusion in the final report.

Secretary PRINCIPI. Although I might just add, we have had a lot of discussions about this report. And I am a big fan of the IG. And I think their work has enabled us to make very, very meaningful and positive changes.

I think there are just some issues that—there is no question that filling a prescription eliminates the need for a physicians appointment, and, perhaps, some lab test. So there are some savings there.

But those savings don't outweigh the average cost of prescriptions for veterans, which, you know, five, six hundred dollars a year. The outpatient visit does not cost that much. But I think what is most important is we don't have a handle on how many new veterans would come to the VA, who may have other options, but choose to come to the VA.

So, whereas, there is without question a savings in some clinical costs, we also have to bear in mind that conceivably the demand for the prescriptions by many of the Medicare eligible veterans and others would be enormous, and there would be a cost associated with that.

And that is the cost I am so concerned about. I hate to duplicate the consumption of scarce medical resources. But, at the same time, I am just concerned that we might get swamped by many more veterans like those at that Fortune 500 company would come to us, and how are we going to pay for it? And I think that is the issue that concerns us.

Mr. SIMMONS. I thank you for that response. I will reserve the remainder of my questions for the record, and defer to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Secretary. Thank you for being here with us.

Let me ask you on Representative Evans' bill on Medicare reimbursement, I would think that that would even might—shouldn't cost anything. And it might even, in fact, if you are already providing that, it might even help you, you know, with additional resources there, not necessarily directly, but indirectly where you don't have to be provided. It will be provided by Medicare.

Do you want to comment on that?

Secretary PRINCIPI. Well, I think there are many, many positive aspects of Mr. Evans' bill. I also believe, and I would like to see it considered in the context of Medicare prescription reform. I think these two are inextricably linked.

And so I think there are aspects of it that are very positive. I have studied the bill. I would hope that this would be part and parcel, as we consider Medicare reform, and prescription drugs, in particular.

Mr. ROSWELL. I would also like to commend, Mr. Evans, on the competent nature of his bill. He clearly demonstrates a keen insight into the health care problems in this nation, in the way he has drafted his bill's language.

In the simplest of terms, quality health care must be an integrated package of clinical services including prescription drug benefits. That really was not true in 1960, when Medicare was being envisioned.

But today, quality health care is a balance of clinical services, prescription drug benefits. VA is a system that provides both of those to its beneficiaries. There are, unfortunately, many veterans who don't use VA for their health care needs who are Medicare beneficiaries.

And, sadly, Medicare provides clinical services without the prescription drug benefits. The idea that we would provide the prescription drug benefits to compliment a Medicare set of clinical services to create a holistic package of health care is laudable, but it is a very different role than what VA has filled before.

We have been a provider of services, not a purchaser of drugs, or an insurer. And that causes me some concerns. Ultimately, if you are asking us to make whole a Medicare benefit for veterans, and do that out of an already finite, limited medical care appropriation, I have grave concerns.

But, to the extent we can do that in a way that doesn't impact our budget, then certainly we have some interest. Although I think, as the Secretary said, you know, I really believe that the real answer here is in Medicare reform.

Mr. RODRIGUEZ. Okay, and I agree. And I think the whole discussions about the concerns about that you might open a little window there to allow—and it is because of the need that exists out there, and because of the fact that, as politicians and elected officials, we have been unwilling to come forward and meet that responsibility. And it is unfortunate, and I agree.

But I think that, as veterans, we have an opportunity to try to provide, at least, for our veterans out there, some access to good quality prescription drug coverage.

And let me ask you, in your statements, you addressed the prescription drug benefit as one component of a continuum of care. And, however, the VA budget proposal on Priority 8 veterans, they are no longer eligible to enroll, you know, in this health care.

So in the case of Priority 8 veterans, who are no longer eligible for care, is it your view that no benefits is better than some kind of carved-out benefit?

Secretary PRINCIPI. So no benefit is better than a carved-out benefit?

Well, I think the question is carved-out benefit for millions, or, you know, there are a lot of Priority 8 veterans in the country.

Mr. RODRIGUEZ. I know it. And what are we doing to them?

Secretary PRINCIPI. But, again, I think that is a policy issue. Many Priority 8 veterans, presumably, are at a higher income, have some other options for health care. And that is why I have tried to focus on those who have few other options by virtue of their income, or their service connected disability.

Mr. RODRIGUEZ. And I understand your position. But I am hoping that the members here understand that we are still not fulfilling our responsibility to our veterans the way we should.

And I am hoping that, as we look at this budget, that was just passed, the budget resolution by the Republican Committee. And it is 844 million cut. And you can't get away, no matter how you explain that. And I know we are putting you in a bind.

Secretary PRINCIPI. No, you are not putting me in a bind. I am very proud. I am very proud of the VA, and I am very proud of the

VA budget. I mean, I don't know about the budget resolution, but I—there is no nation on earth that cares more deeply about their veterans than the United States. You know I wish we could do more, obviously.

Mr. RODRIGUEZ. When you look at relative, it is kind of like comparing me here in the United States and somebody in Mexico. I am a lot better off. But we have got to make sure we treat our—and I know we treat our veterans better than what they do in Russia, anywhere else.

But I think that we have—you know, we have got to be doing more. And I think you understand that, and because I know—and I know you. And I did not mean to put you on the spot. But I think we all, you know, in this committee have a responsibility, and I hope do the right thing.

Secretary PRINCIPI. Mr. Rodriguez, I agree. But I think you can be very proud, every member can be very proud of what they do for our nation's veterans. And, sure, we could do more, and we should do more, but—and we are doing more. We are treating more veterans than we have ever treated in our history. We are up from 2.9 million users to over four-and-a-half million users. I mean, that is the good news, and we sometimes see the glass as half-full.

But let me tell you, we are doing a lot. And we are doing it better. And this predates me, but the whole system has improved dramatically over the past decade.

Mr. SIMMONS. I thank the gentleman. Next would be Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for your testimony.

I want to thank you for even having the prescription drug benefit as a part of your health care. And it is interesting that it has not by now been provided to Medicare, and hopefully this session it will be.

I also sense your heart on this, and can see your passion, you know, that you do care deeply. I am one of the freshmen who is holding out on the budget, and will not vote in favor of it because I won't—will not cut veterans' benefits.

Now, that said, it was interesting to hear the testimony from Mr. Mica, and in the idea that he feels we should provide a benefit that is equal to Members of Congress. And that is nice, but we are talking about millions of veterans, and we are talking about being able to provide them with a prescription drug benefit at a cost that this government can afford.

And so I go to the idea of your buying power, the ability for you to reach out and really purchase—as you pointed out, 65 percent of your drugs are generic drugs. And I look at the idea that you have this buying power that we need to protect for you.

Otherwise, if we allow a benefit to be given to a vet in his local town, filled by a local doctor, and he goes and gets it filled, you are going to be reimbursing, I imagine, at a rate at who knows what. And that takes away that protection from your formula. Am I correct?

Secretary PRINCIPI. Correct.

Mr. RENZI. If you have got the buying power, and if we are hearing that the waiting lines, and the travel distances is the issue, and we focus on the distribution of your inventory of generic drugs, is

it possible that a local veteran could go to a local doctor, get a prescription drug, and mail it into you; and then you would mail him the generic drug that you have purchased at a reasonable price?

I know we probably have some fraud, because, you know, with what was mailed in. But we would also have some cost, as it relates to him not traveling, or going to see, or taking the time from a VA doc—if you don't mind, sir. I appreciate it.

Secretary PRINCIPI. And I recognize that in some parts of the country you do have to drive long distances. You know, it is a heck of a lot better today than it was in 1994, 1995, when we had virtually no outpatient clinics. Today we have 850 outpatient clinics, and our goal has always been that—to try to have outpatient clinics within 30 minutes, 45 minutes of a veteran's home. Now, of course, you can't do that in some parts of this country.

So I believe that access is much better today. And, of course, a veteran just—you know, once they have that first primary care appointment, and the doctor prescribed the drugs, from that point on, everything is mailed to the veteran's home. They don't have to keep coming back. They don't have to drive 4 or 5 hours, in some cases, in rural parts of the country. And I think that's the beauty of the consolidated mail-out pharmacy.

But I think, you know, if we ever moved in the direction that you have mentioned, clearly, I think two things are critical: That if you had a private physician prescribe medication to be filled by the VA—and I am not saying I subscribe to that. But if you did, then I think that doctors prescriptions are going to be based on the VA formulary.

And there are exceptions to the formulary, Dr. Roswell could go into some detail. But, basically, we control costs by, again, using generic drugs where therapeutically equivalent.

And by using the consolidated mail out pharmacy like you indicated, where we mail the prescriptions, because then we buy in huge quantities, and we have magnificent robotic equipment that packages the prescriptions and ships them out. That is where our real cost savings have come in.

But, again, to get back to the point that Dr. Roswell made very eloquently, I think the success of the VA health care system is that it is a integrated, comprehensive health care system, in that, we link the physicians, the nurse practitioners, and some of those outpatient clinics in rural America with the pharmacists.

And that is how we get good quality care. But I think the two key components are formulary and the consolidated mail-out pharmacy.

Mr. RENZI. Thank you, sir.

Mr. SIMMONS. I thank the gentleman. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Secretary. I come from an area of the country that has one of the highest concentrations of veterans, in northeast Ohio. And we have many people who were retirees from the steel industry, and from the rubber industry, that are now I think part of the demand.

Have you accounted for—I know you said that the—read that the prescription drug benefit that they receive from the veterans' facilities are part of a demand. Do you have any numbers that suggest

how many of these steel workers are part of the demand situation you are dealing with?

Secretary PRINCIPI. I would think that given the dramatic economic downturn in the steel industry, and the closing of a lot of the steel mills, that they account probably for a significant percentage of our veteran population, who are coming to us, both for medical care and prescription drugs.

And so, I don't know precisely what their percentage would be, but, perhaps, Dr. Roswell.

Mr. ROSWELL. I can tell you this, that this fiscal year, our greatest growth, both in Priority 1 through 6, and in Priority 7, of any of the 21 VISNs has been in both categories in VISN 10, which is predominantly the State of Ohio.

So it clearly has had an impact. We attribute that remarkable increase in growth rate in your state to the economic situation in the steel industry.

Mr. RYAN. Is that consistent with the industrial midwest, or is it just Ohio specifically?

Mr. ROSWELL. It is actually most pronounced in the State of Ohio, VISN 10.

Mr. RYAN. Great. Well, I would just like to thank you for what you are doing, and also maybe make a little bit of a comment regarding some of the decisions that I think we have to make here in this Congress.

And I think we are choosing, with the actions that are coming up with a war—and I don't dare mean to demagogue the issue, but there are some real hard choices that I think Mr. Renzi articulated, that, you know, we have a tax cut here, and we have a war impending with not exactly knowing how much that is ultimately going to cost.

So I thank you for what you are doing under some difficult circumstances.

Secretary PRINCIPI. Thank you, Mr. Ryan.

Mr. SIMMONS. I thank the gentleman. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. There it is.

Actually, though, my question was different; the Secretary answered my question when he spoke to Mr. Renzi. I would just say that I am really glad I was able to make it back for at least part of your testimony, because it enlightened me considerably on the issue.

If, in fact, we do, as a committee, if we can apply any assistance, provide any assistance to resolving this problem in short order, I would certainly stand ready to do that, Mr. Chairman.

Mr. SIMMONS. I thank you for that comment. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman.

First of all, Mr. Secretary, I want to commend you. I know you have got a tough job, and I know you are doing the very, very best. You know, Florida is like Arizona. It is kind of like the perfect storm of no income tax and great weather.

So many veterans, many citizens, want to move there. If we did go to a proposition similar to the one that Mr. Renzi was proposing, wouldn't that require you to share with the private sector physicians your formulary?

And is that—I mean, can I go online and get your formulary? Is that readily available?

Secretary PRINCIPI. Yes, I will let Dr. Roswell really expound on this. But, yes, we would share our formulary with the private sector physicians, and we have the electronic capability to get that information to their offices, I would imagine, through the internet, the web, different ways that they would know what our formulary is.

Ms. BROWN-WAITE. Good, because absent that, I think we would have a false promise out there of doctors prescribing drugs other than those on the formulary. So that is a very key component.

The other thing that I wanted to ask—and this does relate to the prescription drug issue—and the backlog of veterans.

Do you all track when the clinics cancel the appointments for veterans?

In other words, on paper it may appear as if a clinic is meeting a 30-day deadline, or coming close to it, when they set an appointment. But then I am hearing from veterans, well, yes, they set the appointment, but then 3 days before, they called me and cancelled it.

Are you all tracking? Is there any way to track that?

Mr. ROSWELL. Yes, we are tracking that. It makes it more difficult, obviously, to do that calculation. But we have heard of situations. Of course, sometimes that is unavailable because of provider unavailability. But the points were all taken. And we are aware of that.

We are trying to improve the scheduling system, along with a new software package that looks at our waiting list to track that more definitively. We hope to have that within the next couple of weeks.

Ms. BROWN-WAITE. Good, because I am hearing it more and more.

And the last question is, if you do such a great job where you bring your average cost of prescription drugs down to $13, I certainly hope that if we go to a prescription drug plan that you will share it with Medicare, so that they, too, are able to take great advantage of that.

And just one other quick comment. And that is, that although I voted for the budget in the Budget Committee, two things that I have been negotiating with leadership on: One is Medicare; and the other is veterans, to make sure that we have some answers and some fixes.

Medicare is being fixed. It is being held harmless. They are not taking the cut on Medicare, and we are still waiting for some language that will help with the veterans. So it is not over yet.

I just want to assure the members of this committee that those of us who are passionate about veterans, certainly, Representative Renzi. And I know so many of you all here are. I will use up all of my time if I mention all of your names. But for those of us who are passionate about caring about veterans, we are working on it.

Secretary PRINCIPI. Thank you very much.

Mr. ROSWELL. Ms. Brown-Waite, if I could respond, I just want to make a point, because I don't want to mislead the committee.

Our remarkable progress in containing the cost of drugs is, as the Secretary said quite correctly, a result of our use of generics, strict adherence to a VA formulary, the use of combined collective purchasing power, the use of a highly efficient consolidated mail-out prescription refill system. But it is also a result of the way we manage the pharmacy benefit, and monitor compliance, and educate our provider staff.

Any patient who receives a medication may have drug interactions, or side effects, which, in turn, could necessitate another medication. So part of our cost avoidance is looking for drug-drug interactions, looking at contraindications, making sure that a condition vernacularly known as polypharmacy, when drugs are overprescribed, is not something that is taking place in the VA health care system. We are able to do that because of the way we work with our provider staff to monitor that through an automated computerized patient record system, which is state=of-the-art.

And I have some reservations, if the committee believes we could transport our drug benefit to a population of patients not managed through VA's computerized patient record system with a pharmacy benefits management, and still sustain those costs. I don't believe we would be able to keep it.

Ms. BROWN-WAITE. If I may respond.

Mr. ROSWELL. Good.

Ms. BROWN-WAITE. Very quickly. I would suggest——

Mr. SIMMONS. Quickly.

Ms. BROWN-WAITE. I would suggest that you take a look at an HMO model that does exactly that. I mean, HMOs manage that care now, and they do track the prescription drugs. So take a look at how they do it. I am not saying go to an HMO. I am saying take a look at how some of the major HMOs do it.

Mr. ROSWELL. The VA, in essence, is a very large HMO, because we have our own staff. My point is if we allowed any physician to write prescriptions off of formulary that would not be an HMO-like process, we would not be able to regulate it. And that is where the concern comes in.

Mr. SIMMONS. I thank the lady for her questions.

Now, Mr. Boozman, followed by Mr. Bradley.

Mr. BOOZMAN. Yes, first of all, I really do appreciate you all. I know that you worked awful hard to try and do us best.

You mentioned, Mr. Secretary, in your testimony, that duplication of services, you know, that this was an underlying—kind of a Medicare/VA problem. For both of you all, what is the solution to that problem, and do you have any ideas that you can just throw out in general?

I guess the other problem I see is that with—I see that as the underlying problem, too. I mean, we have got people that are using Medicare facilities. They are using VA facilities. And, really, the way, you know, I understand your arguments about the prescription drug. And, yet, the system now is kind of encouraging that behavior because of the way it is set up. So that's encouraging behavior we don't want. That's taxing on both systems.

Again, I think you have made good arguments about the industry, you know, may be over-utilizing, making it so easy that we, you know, instead of 5 million, or whatever it is, we got 20 million.

But, again, what are your ideas on the underlying problem?

Secretary PRINCIPI. Well, I will lead off and turn it over to Dr. Roswell.

Again, I think we are trying to devise a solution within VA to a critical problem that where the underlying cause is Medicare, and the lack of prescriptions drugs. As Dr. Roswell indicated, Medicare provides a range of services, but the one thing they don't have is probably the most important in the 21st Century is drug therapy. The benefit is not there.

And, like you said, then the veterans are coming to us, and they are seeing a physician, getting lab tests, and we are duplicating the consumption of resources. So I think, first and foremost, is a Medicare prescription plan that tends to address this overriding health care issue in the country.

Of course, I think there needs to be collaboration and coordination between VA and HHS. And I think Mr. Evans' bill certainly goes in that direction in trying to recognizing the role of each other.

I think we need to be part of the solution with the Medicare prescription drug plan. There are 25 million veterans in this country. We are way out in front in the aging of the veteran population where drugs become more important.

So I think it is a great deal of coordination and collaboration. And I think the VA Plus Choice program that we are trying to put together for the Priority 8 veterans that, basically, says, "If you are a Priority 8 veteran, and you wish to enroll in a VA Plus Choice program, the equivalent of a Medicare Plus Choice program, with the exception that we will provide you with drugs. But the VA becomes your provider of choice, and you can't go back to Medicare. But we will take of you, and we will give you your prescription drugs."

I think that demonstrates real coordination and collaboration amongst all of the agencies of the government in a cost-effective manner. Now it does restrict choice a little bit, but we are providing a full continuum of services, a comprehensive plan, at a very cost-effective price because we control, as Dr. Roswell said, for the myriad of reasons, we control our prescription costs.

And so I think those are the kind of choices that need to be made. Those are the tough decisions that need to be made. And I think veterans who are Medicare-eligible would benefit by coming to the VA and making—letting the VA be your provider.

Mr. ROSWELL. I just might add that the Secretary carried out his statutory obligation in making the enrollment decision in January of this year. He did that because he didn't see that the resources were sufficient to continue to allow open enrollment to Priority 8 veterans.

I have some real reservations about the ethical integrity of having made that decision, turning around and saying, "But even though you can't get care, we can provide prescription drugs." I mean somehow it just doesn't sit right with me.

To more directly answer your question, though, Dr. Boozman, to me, the tail should not wag the dog. I don't think VA should try to solve the problem for the small percentage of Medicare beneficiaries who happen to be veterans.

Rather, I think, VA has to work with Health and Human Services, and with you, the Congress, to help determine what the best answer to provide a Medicare drug benefit is, and then index our Medicare drug benefit, so that we don't create this incentive because of a more robust, greater benefit.

And that, I believe, is the answer. And that is why the VA Plus Choice program that the Secretary spoke of is so important, because that is a Medicare drug benefit. And one of the things we are trying to do in working with Health and Human Services is show that within the capitated risk adjusted payments under a Medicare Plus Choice plan, you can provide a modest prescription drug benefit. And we hope to be able to do that.

Mr. BOOZMAN. We are in the process now, as we did last year, and will be debating pretty heavily the, you know, the Medicare inclusion of a prescription drug plan. Do you all have any estimates, or could you come up with an estimate, on how much it would save the VA if Medicare tomorrow had a plan? I think that would help us in our discussion, as to the other, because these things do go together. They aren't linked, and they are becoming more and more linked daily. But I think that would be valuable information.

Secretary PRINCIPI. As you know, we have the most generous prescription plan in the country. Even if the co-payment goes up a few dollars, at $7 or $10, it is still a wonderful, wonderful benefit. I am not sure what the Medicare co-payment would be, whether we would approach the VA, so that it would serve as an option for many people.

So I think a lot depends—I think it is directly proportional to the benefit itself, and what the co-payment level is, and what the cap on the out-of-pocket costs would be. And those are variables that we simply don't know.

Mr. SIMMONS. I thank the gentleman. Mr. Bradley.

Mr. BRADLEY. No, thank you.

Mr. SIMMONS. Pass. Mr. Rodriguez, do you have any final comments you would like to make?

Or, excuse me, ranking member Evans is here. He is not a member of the subcommittee, but he is a distinguished member of the committee.

Would you like to avail yourself of this opportunity, or submit questions for the record?

Submit questions for record, okay.

Mr. Rodriguez, final comments?

Mr. RODRIGUEZ. Just thank you, Mr. Chairman; and thank you, Mr. Secretary. Thank you very much.

Mr. SIMMONS. I believe we have written statements from VFW, American Legion, DAV, and PVA.

Without objection, I would ask that they be made a part of the written record.

(The provided material appear on pp. 83—96.)

Mr. SIMMONS. I want to thank our freshman Members of Congress, who are here in great numbers, and participated in a substantive fashion. Thank you for your participation.

I would like to announce that next week, March 27, at 10 a.m., we will be discussing bioterrorism.

[Whereupon, the subcommittee was adjourned.]

APPENDIX

I

108TH CONGRESS
1ST SESSION

H. R. 709

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 11, 2003

Mr. WICKER (for himself, Mr. WEXLER, Mr. TAYLOR of Mississippi, Mr. WHITFIELD, Mr. PAUL, Mr. NORWOOD, Ms. WOOLSEY, Mr. HOLDEN, Mr. FILNER, Mr. SANDLIN, Mr. COMBEST, Mr. PICKERING, Mr. FROST, Mr. DUNCAN, Mr. SHERMAN, Mr. BOUCHER, Mr. RUSH, Mr. HALL, Mr. MEEKS of New York, Mr. DAVIS of Illinois, Mr. PLATTS, Mr. UDALL of Colorado, Mr. GORDON, Mr. FALEOMAVAEGA, and Mr. CALVERT) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Prescription Access Improvement Act".

SEC. 2. AUTHORITY OF DEPARTMENT OF VETERANS AFFAIRS PHARMACIES TO DISPENSE MEDICATIONS TO VETERANS ON PRESCRIPTIONS WRITTEN BY PRIVATE PRACTITIONERS.

(a) AUTHORITY.—Section 1712(d) of title 38, United States Code, is amended to read as follows:

"(d) Subject to section 1722A of this title, the Secretary shall furnish to a veteran such drugs and medicines as may be ordered on prescription of a duly licensed physician in the treatment of any illness or injury of the veteran.".

(b) CLERICAL AMENDMENTS.—(1) The heading of section 1712 of such title is amended by striking the sixth through ninth words.

(2) The item relating to section 1712 in the table of sections at the beginning of chapter 17 of such title is amended by striking the sixth through ninth words.

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108TH CONGRESS
1ST SESSION

H. R. 372

To provide for a pilot program to be conducted by the Department of Veterans Affairs to assess the benefits of providing for pharmacies of the Department of Veterans Affairs to fill prescriptions for drugs and medicines written by private physicians.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 2003

Mr. LYNCH introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To provide for a pilot program to be conducted by the Department of Veterans Affairs to assess the benefits of providing for pharmacies of the Department of Veterans Affairs to fill prescriptions for drugs and medicines written by private physicians.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PILOT PROGRAM FOR DEPARTMENT OF VETERANS AFFAIRS PHARMACIES TO DISPENSE MEDICATIONS TO VETERANS ON PRESCRIPTIONS WRITTEN BY PRIVATE PRACTITIONERS.

(a) PILOT PROGRAM.—The Secretary of Veterans Affairs shall conduct a pilot program to assess the advantages and disadvantages of furnishing to veterans through Department of Veterans Affairs pharmacies drugs and medicines ordered on prescription of any duly licensed physician in the treatment of any illness or injury of a veteran.

(b) LOCATION OF PILOT PROGRAM.—The pilot program shall be conducted through health-care facilities of the Department of Veterans Affairs located in the service region of the Veterans Health Administration designated as Veterans Integrated Service Network 1 ("VISN 1").

(c) DURATION OF PROGRAM.—The pilot program shall be conducted during the two-year period beginning on the date of the enactment of this Act.

(d) CONDUCT OF PROGRAM.—Under the pilot program, the Secretary shall provide for health-care facilities of the Department of Veterans Affairs in the area specified in subsection (b) to furnish to a veteran such drugs and medicines as may be ordered on prescription of a duly

licensed physician in the treatment of any illness or injury of the veteran.

(e) REQUIRED COPAYMENT.—The furnishing of drugs and medicines under the pilot program shall be subject to the copayment requirement in section 1722A of title 38, United States Code.

(f) REPORT.—Not later than 180 days after the end of the pilot program under this section, the Secretary shall submit to Congress a report on the pilot program. The Secretary shall include in the report the following:

(1) The Secretary's assessment of the benefits to veterans of the pilot program.

(2) The Secretary's assessment of the effect of the pilot program on the Department of Veterans Affairs, including the effect on delivery of health care to veterans.

(3) Any other findings and conclusions of the Secretary with respect to the pilot program.

(4) Any recommendations of the Secretary for continuation of the pilot program or for extension of the pilot program to other service regions or to all service regions.

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108TH CONGRESS
1ST SESSION

H. R. 240

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private health-care practitioners in the case of veterans who, after having made an appointment to see a Department of Veterans Affairs physician to obtain such a prescription, have been waiting for longer than 30 days, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 8, 2003

Mr. MICA introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private health-care practitioners in the case of veterans who, after having made an appointment to see a Department of Veterans Affairs physician to obtain such a prescription, have been waiting for longer than 30 days, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Prescription Drug Equity Act".

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS PHARMACIES TO DISPENSE MEDICATIONS TO VETERANS ON PRESCRIPTIONS WRITTEN BY PRIVATE PRACTITIONERS.

(a) AUTHORITY.—Section 1712(d) of title 38, United States Code, is amended—

(1) by inserting "(1)" after "(d)"; and

(2) by adding at the end the following:

"(2)(A) In addition to drugs and medicines furnished under paragraph (1), the Secretary shall furnish to a qualifying veteran such drugs and medicines as may be ordered on prescription of a duly licensed physician or other health-care professional in the treatment of any illness or injury of the veteran.

"(B) A veteran is a qualifying veteran for purposes of this paragraph if—

"(i) the veteran has made an appointment to see a Department physician for the sole purpose of obtaining a prescription for drugs or medicines in the treatment of any illness or injury of the veteran; and

"(ii) a period of not less than 30 days has elapsed since the appointment was made without the veteran obtaining such a prescription.

"(C) Any prescription furnished under this paragraph is subject to section 1722A of this title.".

(b) CLERICAL AMENDMENTS.—(1) The heading of section 1712 of such title is amended by striking the sixth through ninth words.

(2) The item relating to section 1712 in the table of sections at the beginning of chapter 17 of such title is amended by striking the sixth through ninth words.

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[DISCUSSION DRAFT]

108TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. EVANS introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 38, United States Code, to provide improved prescription drug benefits for veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Prescription Drug Benefit[s] Act of 2003".

SEC. 2. PRESCRIPTION DRUG BENEFIT FOR VETERANS.

(a) IN GENERAL.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1722A the following new section:

"§ 1722B. Prescription drug benefit program for medicare-eligible veterans and Priority 1 veterans

"(a) BENEFIT.—The Secretary shall establish a prescription drug benefit program in accordance with this section. Under the program, the Secretary shall furnish to veterans who are participants in the program drugs and medicines ordered on prescription of a duly licensed physician or other authorized health care professional who is not an employee of the Department, subject to the payment of any applicable premium and copayment under this section.

"(b) VETERANS ELIGIBLE FOR THE PRESCRIPTION DRUG BENEFIT.—The following veterans are eligible to participate in the prescription drug benefit program under this section:

"(1) Priority 1 veterans.

"(2) Medicare-eligible veterans (other than Priority 1 veterans) who enroll in the program.

"(c) ENROLLMENT.—(1) In order for a medicare-eligible veteran who is not a Priority 1 veteran to participate in the prescription drug benefit program, the veteran must

enroll in the program. Such enrollment shall be carried out in such manner as may be prescribed by the Secretary by regulation. The status of a veteran as a medicare-eligible veteran shall be verified by the Secretary of Health and Human Services upon request of the Secretary.

"(2) A medicare-eligible veteran who enrolls in the prescription drug benefit program is not eligible for enrollment in the patient enrollment system under section 1705 of this title. The Secretary shall inform any veteran applying for enrollment under this section that the veteran, while enrolled in the prescription drug benefit program, will not be eligible for health care provided by the Secretary.

"(3) Any medicare-eligible veteran who enrolls in the prescription drug benefit program under this section and who at the time of such enrollment is enrolled in the patient enrollment system under section 1705 of this title shall, upon such enrollment under this section, be automatically disenrolled from that patient enrollment system.

"(4) The Secretary shall conduct an annual open enrollment period during the last two months of each fiscal year. During that period—

"(A) a medicare-eligible veteran who is not a Priority 1 veteran may enroll in the program under this section; and

"(B) such a veteran previously enrolled under this section may disenroll.

"(5) During the first five fiscal years during which the prescription drug benefit program under this section is in effect, the Secretary may limit enrollment as determined necessary by the Secretary for administrative and fiscal reasons. All medicare-eligible veterans who apply for enrollment under this section during the first year that the program under this section is in effect shall be enrolled by the end of the fifth such year.

"(d) ANNUAL PREMIUM AND COPAYMENTS.—(1) The Secretary shall by regulation establish an annual premium amount that must be paid to the United States by a veteran for drugs and medicines furnished under this section each year before such drugs and medicines are furnished to that veteran at the expense of the United States that year.

"(2) The Secretary shall by regulation establish an amount (known as a 'copayment') that must be paid to the United States by a veteran for each 30-day supply of drugs and medicines furnished under this section. If the quantity of such drugs and medicines furnished is less than a 30-day supply, the amount of the copayment charge may not be reduced.

"(3) The Secretary may establish different copayment amounts for prescriptions depending on—

"(A) whether they are filled under a generic drug name or by brand name;

"(B) whether or not they are available by mail; and

"(C) whether or not they are on the Department's National Prescription Drug Formulary.

"(4) The amount of the copayment charged for any particular prescription—

"(A) may not be less than the amount in effect under section 1722A of this title for the copayment for medications furnished by the Department on prescription of Department health-care professionals; and

"(B) subject to subparagraph (A), may not exceed the cost to the Secretary of furnishing the drugs or medicine.

"(e) DISPOSITION OF RECEIPTS.—(1) Any amount received under subsection (d) from a Priority 1 veteran shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund.

"(2) Any amount received under subsection (d) from a medicare-eligible veteran enrolled in the prescription drug benefit program under subsection (c) shall be trans-

ferred by the Secretary to the Federal Supplementary Medical Insurance Trust Fund established in section 1841 of the Social Security Act (42 U.S.C. 1395t).

"(f) INTERGOVERNMENTAL REIMBURSEMENT OF COSTS.—(1) The Secretary of Health and Human Services shall transfer to the Secretary, from the fund referred to in subsection (e)(2), amounts to reimburse the costs to the Department of furnishing drugs and medicine under the prescription drug benefit program under this section to medicare-eligible veterans enrolled under subsection (c). Amounts to be included in such costs are the following:

"(A) The cost of such drugs and medicines to the Department.

"(B) A reasonable charge for processing, filling, and dispensing the prescription, including overhead costs such as labor, equipment, space, and utilities.

"(C) Costs of postage, if furnished by mail.

"(2) To the extent the Secretary hires new personnel, purchases new equipment, or obtains additional facilities to carry out the prescription drug benefit program under this section, the Secretary shall document those expenses in charges to the Secretary of Health and Human Services that incorporate those expenses.

"(3) The Secretary of Health and Human Services shall make transfers of funds under this subsection peri-

odically, as agreed upon by the two Secretaries, but not less often than weekly. Such payments shall be made upon receipt of a certification from the Secretary of Veterans Affairs of costs incurred by the Secretary under this section for the period with respect to which the certification is made.

"(4) Any amount received under this subsection shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund.

"(5) The Secretary and the Secretary of Health and Human Services shall enter into an agreement for the methodology to be used for determining costs of the Department for purposes of this subsection.

"(g) NONLIABILITY.—A health care professional may not be considered to be an agent or employee of the United States by reason of a prescription of that health care professional being furnished by the Secretary under this section.

"(h) INFORMATION RESOURCES.—(1) The Secretary shall develop and maintain a database of veterans enrolled under subsection (c) and of persons who have applied for such enrollment.

"(2) The Secretary shall maintain records of the costs of the program under this section, including separate

costs for Priority 1 veterans and for veterans enrolled under subsection (c).

"(3) Not later than six years after the date of the enactment of this section, the Secretary shall implement a computerized patient profile system for participants in the prescription drug benefit plan under this section. The patient profile system shall have the capability, for each participant in the program, of identifying—

"(A) known drug interactions;

"(B) contraindicated drugs;

"(C) available 'best value' treatment alternatives for prescribed medications; and

"(D) patient safety issues.

"(i) ANNUAL REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the operation of this section for each of the first five years this section is in effect. Each such report shall include the following:

"(1) The number of participants in the program during the year covered by the report and, of that number, the number who are enrolled under subsection (c), including the number who were new enrollees during such year.

"(2) The number of veterans who have applied for such enrollment and, as of the end of the year

covered by the report, are waiting for such enrollment.

"(3) The number of veterans who during the year covered by the report were disenrolled from the patient enrollment system under section 1705 of this title in order to enroll under subsection (c).

"(4) The cost to the Department of the program under this section during the year covered by the report.

"(5) The amount of funds transferred to the Secretary during the year covered by the report under subsection (f).

"(6) The amount of resources added during the year covered by the report to accommodate increased workloads by reason of this section.

"(j) REGULATIONS.—The Secretary shall prescribe regulations to carry out this section. Such regulations shall be prescribed in consultation with the Secretary of Health and Human Services.

"(k) DEFINITIONS.—For purposes of this section:

"(A) The term 'medicare-eligible veteran' means a veteran who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and who is enrolled under part B of that title (42 U.S.C. 1395j et seq.).

"(B) The term 'Priority 1 veteran' means a veteran covered by section 1705(a)(1) of this title.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1722A the following new item:

"1722B. Prescription drug benefit program for medicare-eligible veterans and Priority 1 veterans.".

(b) EFFECTIVE DATE.—Section 1722B of title 38, United States Code, as added by subsection (a), shall take effect on October 1, 2003. The initial enrollment period under subsection (c)(4) of such section shall be the period beginning on Augustt 1, 2004, and ending on September 30, 20034.

.....
(Original Signature of Member)

107TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mrs. JOHNSON of Connecticut introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans enrolled in the health care system of that Department for prescriptions written by private practitioners, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Prescription Drugs Access Act of 2002".

SEC. 2. AUTHORITY OF DEPARTMENT OF VETERANS AFFAIRS PHARMACIES TO DISPENSE MEDICATIONS TO VETERANS ON PRESCRIPTIONS WRITTEN BY PRIVATE PRACTITIONERS.

(a) AUTHORITY.—Section 1712(d) of title 38, United States Code, is amended—

(1) by inserting "(1)" after "(d)"; and

(2) by adding at the end the following:

"(2) In addition to drugs and medicines furnished pursuant to paragraph (1), the Secretary shall furnish to a veteran enrolled under section 1705 of this title such drugs and medicines on the formulary of the Department as may be ordered on prescription of a duly licensed physician in the treatment of any illness or injury of the veteran. Any such prescription is subject to section 1722A of this title.".

(b) CLERICAL AMENDMENTS.—(1) The heading of section 1712 of such title is amended by striking the sixth through ninth words.

(2) The item relating to section 1712 in the table of sections at the beginning of chapter 17 of such title is amended by striking the sixth through ninth words.

SERVING
WITH
PRIDE

AMVETS

NATIONAL
HEADQUARTERS
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Lanham, Maryland
20706-4380
TELEPHONE: 301-459-9600
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March 17, 2003

The Honorable Lane Evans
Ranking Member
House Veterans' Affairs Committee
Washington, D.C. 20515

Dear Rep. Evans:

On behalf of the members of AMVETS, I write to express our gratitude and support for your leadership in proposing legislation to permit veterans to obtain prescriptions from veterans' hospitals using prescriptions written by hometown doctors.

Currently, veterans are eligible to receive prescription medications from the VA only if a VA physician prescribes the medication. While insisting that a VA doctor see the patient may not seem like too great an imposition, many of the more than 200,000 veterans waiting over six months for a doctor's appointment are waiting to have a prescription written and filled.

Your legislation would allow VA to fill veterans' prescriptions written by hometown doctors under special circumstances. First, the veteran would accept VA solely for the purpose of filling prescriptions. Second, the veteran would be required to make a copay based on the type of drug treatment requested. And, third, the cost of the prescription would be partially offset through Medicare reimbursement.

This change would provide an avenue for many veterans to receive timely access to prescription drugs and reduce the number of veterans waiting to see a VA physician as well.

Again, we appreciate your creative approach to solving an issue facing many veterans and thank you for taking a very big step toward helping veterans receive access to prescription medications.

Sincerely,

Richard A. Jones
National Legislative Director

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001-2694 • (202) 371-8880

March 14, 2003

The Honorable Lane Evans
Ranking Democratic Member
House Veterans Affairs Committee
333 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans,

On behalf of the Blinded Veterans Association (BVA), the only Congressionally chartered veterans service organization exclusively dedicated to serving the needs of our Nation's blinded veterans, thank you for your initiative to create a prescription drug benefit for veterans. BVA supports your proposed legislation. Offering Medicare-eligible veterans an opportunity to fill their non-VA prescriptions at a VA facility in lieu of enrollment into the VA health care system is the right approach to take. Over 900,000 veterans indicate they use the VA system primarily for prescription drugs. BVA believes this bill, as written, will alleviate some of the unnecessary waiting time backlog created by veterans scheduling appointments exclusively to receive a prescription from a VA doctor. In many cases, a non-VA physician has previously prescribed the prescription they are seeking. Provision of a funding mechanism that will not further erode the already insufficient funding levels for VA Health Care is the most attractive aspect to this proposal.

BVA supports inclusion of Priority 1 veterans in this benefit. Offering a prescription drug benefit to veterans who choose not to fully use the VA health care system because of distance or personal preference, is the right action to take. We caution you to be very clear in your explanation of prescription coverage as an ADDITIONAL benefit that does not take away a Priority 1 veterans access to any other VA service.

Sincerely,

Thomas H. Miller
Executive Director

MILITARY ORDER OF THE PURPLE HEART
CHARTERED BY CONGRESS

NATIONAL HEADQUARTERS
5413-B BACKLICK ROAD
SPRINGFIELD, VA 22151-3960
(703) 642-5360 FAX (703) 642-2054

OFFICE OF: National Commander

March 14, 2003

The Honorable Lane Evans
Ranking Minority Member
House Committee on Veterans Affairs
333 Cannon Building
Washington, DC 20515-6335

Dear Congressman Evans:

First, on behalf of the members of the Military Order of the Purple Heart (MOPH) I want to thank you for your unwavering support for combat wounded veterans, indeed your support for all veterans.

Second, we are aware that you are going to introduce legislation that would create a prescription drug benefit for veterans. MOPH supports you efforts in this endeavor and looks forward to passage of the legislation.

Respectfully,

William A. Wroolie
National Commander

March 18, 2003

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
333 Cannon House Office Building
Washington, DC 20515

Dear Representative Evans:

On behalf of the Paralyzed Veterans of America (PVA), I am writing to offer our support for the "Veterans Prescription Drug Benefits Act of 2003." By providing a new Medicare drug benefit to veterans, your measure would begin to address a vital need and concern of our elderly citizens – the need for affordable pharmaceuticals.

The increasing use of prescription drugs for medical treatment options has revolutionized the provision of medical care. Every year pharmaceuticals represent an ever-growing percentage of health-care expenditures. Medicare has not kept up with this revolution. By providing veterans with this benefit, facilitated through the Department of Veterans Affairs (VA) and ensuring that VA does not spend scarce and inadequate resources, we can begin the process of reflecting the manner in which health care is delivered in this Nation.

This measure, unlike others, would not force the VA alone to bear the burden of addressing this national policy failure. The VA would merely be acting to facilitate a benefit offered to veterans, a benefit that would provide substantial pharmaceutical savings to the federal government because of VA's statutorily mandated discounts. In addition, this measure would reimburse the VA for expenses relating to the implementation of this benefit as well as costs incurred in administering it.

Although veterans seeking treatment for a service-connected condition, and veterans with service-connected disabilities rated at 50 percent or more are expressly exempted from the requirement of enrolling in order to receive care by Medicare benefit, and foregoing their VA health care options are always able to seek treatment for service-connected conditions at VA facilities. Additionally we request that other veterans needing specialized services be afforded access to care.

Again, thank you for introducing the "Veterans Prescription Drug Benefits Act of 2003." We look forward to working with you closely in order to pass, and ultimately enact, this important measure.

Sincerely,

Delatorro L. McNeal
Executive Director

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

March 18, 2003

The Honorable Lane Evans
Ranking Democrat
Committee on Veterans Affairs
U.S. House of Representatives
333 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Evans:

Vietnam Veterans of America (VVA) strongly supports the "Veterans Prescription Drug Benefit Act of 2003" that you plan to soon introduce to the House of Representatives.

As you know, VVA reluctantly supported Secretary Principi's decision to temporarily suspend new enrollments of Category 8 veterans only because the Veterans Health Administration (VHA) medical facilities were in such a dire under-funded state. While the approach that you have taken in moving to relieve this pressure might not be what VVA would choose in a perfect world, in the real world of a veterans health care system that is so grossly under funded this is a similarly sensible, responsible, and effective approach to provide relief to the system.

While VVA has not favored such plans to allow VA to so provide pharmaceuticals in the past because they included no way to fully fund VA honoring prescriptions written by non-VA physicians, your proposal does allow for payment of such from both Part A and Part B of Medicare in addition as well as and annual enrollment fee and co-payments that are reasonable. As long as such prescriptions are provided at a net negligible additional cost to the system, VVA does favor this proposal for Medicare eligible veterans who are not service connected disabled.

In regard to the provision that would accord priority group 1 (70% or greater service connected disabled) veterans the opportunity to have non-VA prescription drug orders filled by VA via mail fulfillment, VVA favors such mail fulfillment as a convenience for veterans who sometimes have to travel great distances to reach a VHA each time they renew their prescription, imposing a hardship

As the primary purpose of the Veterans Health Administration is to be a "veterans health care system" and not just a general health care system that happens to be for veterans, VVA urges that you amend this bill at mark up to require that there is a complete physical, including blood draw tests annually performed on at least the Priority 1 veterans covered under this proposal. While VHA continues (inexplicably to VVA) to fail to ensure that a complete military history be taken on every single veteran seeking health care services from VHA, and that VHA clinicians use this key data to do a proper assessment of overall health of the veteran, including conditions or illnesses that may be due to exposures or other factors during his/her military service, there is still a need for VHA to fulfill their responsibilities for medical oversight of significantly and or profoundly disabled veterans.

If this proposed legislation reduces the utilization of VHA services primarily or only to secure pharmaceuticals by only a proportion of the 900,000 veterans reported seeking services for this reason, then it will help relieve the pressure that is crushing the VHA system without leaving any veteran without alternative services.

Again, VVA thanks you for your strong leadership on behalf of America's veterans.

Sincerely,

Richard F. Weidman
Director of Government Relations

Statement of Chairman Rob Simmons (CT-2)
Subcommittee on Health

Oversight Hearing to Examine Proposed Changes to
VA's Prescription Drug Benefit for Veterans

March 19, 2003

As a veteran, I am honored and humbled to have been selected as Chairman of the Health Subcommittee by Chairman Smith and my colleagues. I look forward to a very active Congress and to addressing the complex issues that face our nation's veterans, their health care needs and the country's largest health care system.

I am especially pleased that my friend, the Honorable Ciro Rodriguez of Texas, was designated by his colleagues to be our new Ranking Member on the Health Subcommittee. I welcome his contributions and look forward to a continuing dialogue with Ranking Member Rodriguez to serve our nation's 25 million veterans.

Before addressing prescription drugs for veterans, I want to make a few points on a different but related topic: guaranteed funding for VA health care.

There are two ways to fund any federal program:

One is through mandatory spending through some kind of standard formula. Mandatory programs, such as Social Security, railroad retirement payments and veterans' disability compensation, are not annually subject to anyone's "red pen," or the whims of the moment, or the political winds. Rather, each year the federal government must accommodate for current real needs in these populations and make automatic adjustments. There is no debate anywhere about these needs or the money appropriated to fund them.

The other way to fund programs is through discretionary appropriations. Veterans' compensation and education benefits are considered mandatory accounts, but amazingly, veterans' health care is not. VA health spending is considered discretionary. This means that each year the veterans hospitals and clinics and community health care providers that care for our veterans hold their collective breaths while the amount of money they will have becomes the grist for the political process.

One hundred years ago, on July 4, 1903, Teddy Roosevelt recognized the importance of the nation's commitment to veterans. *"A man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards... Less than that, no man shall*

have." Yet a hundred years after Roosevelt said this, we are engaging in a debate over whether to give veterans dependable and reliable health care. ***There should be no debate.*** We ought to get this done, and I consider it an honor to fight this battle on behalf of my fellow veterans. Let me repeat: there should be no debate about caring for the nation's veterans.

The focus of our hearing today is on prescription drugs; they are an integral yet distinctive component in the delivery of health care. The policies and practices surrounding the provision of this benefit are the worthy topics of this oversight hearing. The Subcommittee is particularly interested in examining the effects of introducing innovative approaches to dispensing a pharmaceutical benefit to veterans.

The Subcommittee will consider a variety of approaches that have been proposed to address the availability and eligibility for pharmaceutical services provided by VA. A number of bills related to this subject will be discussed during this hearing. This will be important testimony to build a record to validate that America's veterans—particularly those who are in their elder years—need and deserve a comprehensive drug benefit.

The latest Medicare debates on prescription drugs, while a separate issue, serve to further highlight the need to find solutions to a growing national dilemma. Medicare provides no outpatient prescription drug benefit, leaving millions of elderly Americans, including millions of veterans, without coverage—at a time in their lives when their incomes are fixed, often inadequate, and their need for medications much greater. Of the 6.8 million veterans enrolled in VA health care, nearly 45 percent are Medicare-eligible. Many veterans—although the actual number is unclear—have been attracted to VA because of its prescription drug benefit. Few health care plans in the country offer a comparable prescription drug benefit at a cost to plan participants as low as VA's prescription drug benefit to veterans.

Notwithstanding a future universal Medicare outpatient prescription drug benefit—there remain challenges within VA's health care system that compound the imperative for the Health Subcommittee to examine and continue to re-examine VA's prescription drug benefit. The budget shortfall, the recent enrollment cutoff, and a quarter million veterans still waiting to see VA physicians, are among the challenges that will shape our oversight discussions.

As this Committee continues seeking long term solutions to VA health care funding, to promote open enrollment and high-quality care, it must do so without jeopardizing VA's historic rehabilitation and restoration programs, such as those for amputees, the blind, spinal cord injured, and the mentally ill. With these objectives in mind, we should ask ourselves how changes to the provision of prescription drug benefits might impact the VA's health care system as a whole. This is a question that should drive our discussions as we lock to make VA health stronger.

The Subcommittee will hear testimony on legislative proposals that would improve and extend prescription drug services to veterans in several different ways. This testimony comes from the Honorable Lane Evans of Illinois, who is also the Ranking Member of the Full Committee on Veterans' Affairs; the Honorable Nancy Johnson of my home state of Connecticut; the Honorable Stephen Lynch of Massachusetts; the Honorable John Mica of Florida; and the Honorable Roger Wicker of Mississippi.

Secretary Principi has also agreed to address this topic in his testimony, and I appreciate his commitment to do so. The Subcommittee welcomes our distinguished witnesses, and we look forward to hearing their testimonies.

Testimony by Representative Roger Wicker
House Veterans Affairs Health Subcommittee
March 19, 2003

I appreciate the opportunity to testify on behalf of H.R. 709. This legislation has bipartisan support and is cosponsored by 33 of our colleagues, including the former Ranking Member of this Subcommittee Mr. Filner, and also Mr. Gibbons. I am pleased this panel is considering this change in law because it should save tax dollars and enable the VA to be more responsive to our nation's veterans.

For veterans in Mississippi and other states, it is often difficult and expensive to drive to a VA facility for a prescription. I have discussed this issue with veterans across my state, and they share similar experiences. The comments of one North Mississippi man are typical. He makes the point that no one knows his medical history better than his family doctor, whom he has seen for more than 40 years. He questions the need to travel 25 miles to a VA clinic or sometimes 100 miles to the VA hospital in Memphis when the same service could be provided closer to home. Veterans often see their local doctors and have prescriptions written, but the medication cannot be filled by the VA until they are examined by a VA physician.

H.R. 709 will provide veterans the option of obtaining their prescriptions from a physician outside the VA system. The Veterans Prescription Access Improvement Act will offer an alternative approach to thousands of veterans who would prefer to absorb the costs associated with a visit to a private physician instead of utilizing VA facilities.

Although this problem may be felt most acutely in rural areas, this bill will improve access to health care for all veterans. Our nation's veterans face unreasonable delays when they seek care. If a veteran in the first district of Mississippi called today to the Memphis, Tennessee, VA hospital to get an appointment with a doctor, they would be lucky to get on the schedule by June.

There are several possible solutions to this problem. As a member of the Appropriations Committee, and a former member of the VA/HUD Subcommittee, I have supported increased funding for veterans medical care. Congress has increased funding for veterans health care by approximately 26% in the past three years, including the $2.5 billion increase in the FY 03 VA/HUD bill. But in addition to this increased funding, we

should also consider new approaches to improve access and quality of care for our veterans at a reduced cost.

In a December 2000 report, the Inspector General of the Department of Veterans Affairs stated that many veterans use the VA solely for the purpose of filling prescriptions originally written by private physicians. In order to acquire the less expensive drugs provided by the VA, a veteran will undergo exams by both a VA doctor and a private physician.

> The Inspector General's report stated:
> "We believe that the processes VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility and/or private insurance coverage who choose to be treated by private non-VA health care providers must frequently, as a result of these processes, submit to duplicate exams, tests, and procedures by VHA simply in order to receive their prescriptions. As a result, VA medical centers frequently end up spending more on scarce clinical resources to "re-write" prescriptions than the prescriptions themselves cost."

The Inspector General determined that the Department of Veterans Affairs could save over $1 billion a year by allowing the VA to fill prescriptions written by private physicians -- money which could be spent on needed care for our veterans.

The President's Fiscal Year 2004 Budget evaluates the effectiveness of some of VA's most important programs. This evaluation indicates that while all veterans are currently offered medical care, waiting lists are growing and the VA can not efficiently focus on poor and disabled veterans. It recommends that services and resources should be re-focused on veterans with service-connected disabilities, those with low income, and those with special needs. This legislation will directly address the need to reduce backlogs at crowded VA facilities. Also, it will support the President's recommendations by allowing some patients to choose an alternative method of care, closer to home, while freeing up VA medical staff so that they can attend to those more needy veterans.

Critics of this proposal have said that this legislation could result in added demand for prescriptions which the Treasury could not afford. However, easier access to medication should be a goal for which we strive. Veterans should not have to go without

necessary medical care because of the inefficiencies in the current system. Further, as the IG report stated, the waste in the current system significantly exceeds the added cost of prescription drugs under a system proposed by H.R. 709. In addition, it is reasonable to expect that the VA's drug purchasing power will increase, thereby making the cost of drugs even less.

Other concerns have been raised that quality of care will be diminished if this legislation is enacted. I suggest that the opposite will occur. If access to prescription medication is increased, more veterans will have the benefits of affordable prescription drugs and physicians will be available to more adequately service the veterans that directly need their attention.

As the IG's report found, most "priority group 7" veterans use the VA only for prescriptions since they prefer to use their private physicians. This could be attributed to the high rate of turnover of VA medical staff, the difficulty in getting an appointment with the same doctor time after time, or the lack of coordination of care in the current system.

The veterans in the First district of Mississippi most often utilize either the VA hospital in Jackson, Mississippi, or Memphis, Tennessee. Both of these medical centers are teaching facilities which depend on relatively short-term staff, a problem which is compounded by the high turnover of full time VA medical staff. This creates a lack of continuity of care in these facilities as compared to what is offered by a hometown doctor.

This is not a new concept. The VA already has a system in place to provide prescription drugs to veterans whose prescriptions are written by a private physician. However, under current law, only veterans who are "permanently housebound or in need of regular aid and attendance" may obtain their prescriptions in this manner. Typically, this system is used to treat long-term conditions such as high blood pressure, asthma, or diabetes. The VA could expand this existing mail order program to serve more veterans.

A model for the implementation of this expanded service could be the Department of Defense, which has for years allowed private physicians to write prescriptions which are filled by the Military Health Services System. As of the year 2001, the Department of Defense filled approximately 30 million prescriptions a year which were written by civilian physicians, about one-half of the total number of prescriptions which were handled. The DoD does not require a second visit to a military physician.

The Department of Defense has improved its technology to improve medication safety. Its computer system has a shared patient database which screens against adverse drug reactions and potential drug stockpiling. Just like a retail pharmacy, the military pharmacy can always call the prescribing physician if there are any questions about the prescription.

As we all work together to improve access and quality of care for our nation's veterans, our focus should be on the veteran and not the bureaucracy. We must pursue solutions that serve the veterans who served us. Congress has correctly made veterans health care one of our highest priorities. This is reflected by substantial funding increases and the enactment of legislation to expand hospital services, outpatient care, and retirement benefits. The Veterans Prescription Access Improvement Act will further strengthen that commitment.

I thank the Committee again for your consideration of this legislation.

HONORABLE STEPHEN F. LYNCH

TESTIMONY BEFORE THE VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH, MARCH 19, 2003 2PM

Thank you Mr. Chairman and Members of the Subcommittee for this opportunity to testify in support of HR 372, the Veterans Pharmacy Access Bill that I introduced earlier this year.

This bill would simply establish a Pilot Program in VISN One New England, to allow non-VA Doctors to write prescriptions for veterans that would be honored at VA Pharmacies.

I filed this bill as a direct result of meeting with constituents of mine, veterans, who came to me when I was first elected to tell me about their problems accessing the Veterans' health care system.

As this Committee well knows, the VA is mandated to schedule routine primary care appointments within 30 days of the day of request, as well as specialty care appointments. Additionally, patients are supposed to be seen within 20 minutes of their scheduled appointment time. Unfortunately, in many cases these goals are not being met.

Today, there are over 235,000 veterans nationwide on a list, waiting to see a Doctor. Of that number, there are over 20,000 veterans in VISN One, New England.

Although the VA has recently made moves to limit access for veterans to health care with the suspension of enrollment for so-called Priority 7 and 8 veterans, as well as the initiative reported last year to scale back their outreach activities, I believe that these initiatives send the wrong message to our veterans.

Like many members of this Committee, I believe that the VA healthcare system should not be a discretionary funding measure. We must fully fund this system through mandatory appropriations. However, the reality is that until we in Congress make that determination, funds are limited and must be stretched further each year.

So, I believe we must be willing to look at initiatives that are creative and assist the VA in ensuring that timely access is available for our veterans.

In a report from August 2001[1], the General Accounting Office (GAO) reported that VA health care facilities that reduced provider involvement in services that do *not* require one-on-one physician-patient interaction saw a decrease in the wait for appointments. We believe by giving veterans the option of using the VA's prescription drug service, without requiring VA doctors to okay decisions already made by non-VA affiliated physicians, we can cut down on the wait time that our veterans are experiencing for Doctor's appointments.

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[1] See *VA Healthcare: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress* (GAO-01-953, Aug. 2001)

We have spoken to VA officials about this proposal and have heard their concerns about continuum of care issues. I understand these concerns; like the VA I believe that our veterans deserve the best care possible. However, if veterans are unable to access the system whatsoever, then I have grave concerns for their individual care.

I also understand the VA's concern about the potential increased cost that veterans accessing the system solely for prescription drugs will bring. However, I think that this logic is flawed; we know that Priority 7 and Priority 8 veterans have been accessing the system in greater numbers over the past several years because of the outpatient pharmacy benefit. We know that these individuals are attracted to the system precisely because of the lack of a prescription benefit under Medicare and the VA's comparatively low-cost benefit.

Mr. Chairman, these veterans are already accessing the system, causing longer waiting times precisely because they must see a VA physician in order to participate in the pharmacy benefit.

Many of these veterans sought care from VA because they had been given an expensive prescription by another medical care provider, and they did not have insurance benefits that would pay the cost of that prescription. Frequently, these veterans were covered by Medicare, and did not understand why they should need to see two providers at government expense, when it was the same condition that was to be treated.

We in VISN One New England have seen a roughly one third increase in new patients being seen in the network since 1998. The VA expects the number of new patients to double in the next five years. Over 60% of the new veterans coming into the system in New England are the so-called Category 7's and 8's.

Many veterans come to the VA solely to take advantage of the prescription drug benefit offered. However, currently the VA will not fill prescriptions for veterans' authorized/recommended by non-VA affiliated doctors. This bill attempts to establish a process whereby veterans can come to the VA to have their prescription drug needs filled without duplicating doctors visits and tests. Mr. Chairman, I thought that by establishing a Pilot Program in VISN One New England, we could study the impacts that would result and see what works, what the problems would be, and if this is a proposal that could help the VA across the VISN's.

Once again, I would like to thank the Chairman and members of this Subcommittee for your courtesy today. I would be happy to try to answer any questions you may have and I look forward to working with all of you in the future.

Testimony by Representative John L. Mica
House Veterans Affairs Health Subcommittee
March 19, 2003

I appreciate the opportunity to testify on behalf of H.R. 240, the Veterans Prescription Drug Equity Act, legislation which has received bipartisan support. I am pleased that your committee is considering this change in law because it will help clear up the veterans backlog and redirect VA physicians to treating sick patients.

The current backlog of veterans seeking medical attention has mushroomed to more than 30,000 in my State of Florida, and more than 200,000 nationwide – most of whom have been waiting over six months for their first primary care appointment. In my view, eligible United States veterans should not be on any waiting list nor be forced to wait more than a year for medical services which they are entitled to receive.

Last year, after meeting with a number of my local veterans organizations, leaders and health care providers, I found that two-thirds of veterans now on waiting lists are seeking access to the VA's pharmaceutical program. I believe that the VA's policy of filling only prescriptions written by VA doctors is contributing to this backlog.

The VA's Inspector General stated its support of permitting the filling of private prescriptions written for enrolled veterans in a December 2000 report. The Inspector General also determined that the VA could save over $1 billion a year by allowing prescriptions written by outside physicians or health practitioners.

By allowing veterans currently on waiting lists to obtain their prescriptions through private health care physicians, the VA would better fulfill its mandate of providing veterans with medical services on a timely-manner. My proposal would also relieve the demand on infrastructure and personnel.

To provide immediate assistance to our deserving veterans, I introduced the Veterans Prescription Drug Equity Act. My legislation permits veterans currently on waiting lists for their first primary VA exam for 30 days or longer to obtain medication through the VA's pharmacy program with prescriptions written by private physicians. The cost of filling these prescriptions would eventually be borne by the VA anyway, so this legislation should not result in significant additional costs.

This is not a new concept. The Department of Defense currently allows private physicians to write prescriptions which are filled by the Military Health Services System – more than 30 million prescriptions a year. The VA could use this as a model for the implementation of an expanded prescription drug program.

This is the time for some innovative thinking and solutions to ensure our veterans complete access to quality health care. My goal and intent of this legislation is to improve medical services and prescription drug benefits. This could be done in several ways such as a cost-share program, higher co-payments or on a provisional basis until the veteran is able to meet with a VA physician.

I urge you to consider my proposal as a way to eliminate the unduly long waiting lists around the country. Our action will give us all an opportunity to continue assisting those who have faithfully served our nation.

I thank the committee again for your consideration of H.R. 240, the Veterans Prescription Drug Equity Act

Testimony by Representative Lane Evans
House of Veterans Affairs Health Subcommittee
Hearing on the Availability and Eligibility for Pharmaceutical Services Provided by the Department of Veterans Affairs
March 19, 2003

Thank you, Chairman Simmons. I appreciate your invitation to testify on the "Veterans Prescription Drug Benefits Act" at this important hearing. My bill enables VA to respond to the needs of veterans in a world of limited resources. I am pleased several veterans' organizations have already expressed support or interest in the concept behind my legislation. I request that their letters be included in the hearing record.

I want to acknowledge my colleagues who will be testifying today on measures they have introduced. Congressman Wicker has previously testified in support of his bill to provide veterans the opportunity to have non-VA physician prescribed medications filled by VA. While providing a prescription benefit, this proposal would not provide a new funding mechanism for this benefit. I believe this is a major concern because without the additional funding needed to provide this benefit, the existing shortfall in funding for veterans health care would grow dramatically. The gentle lady from Connecticut, Mrs. Johnson brings a similar bill to our Subcommittee's attention. Congressman Mica's bill links the problem of waiting times to veterans' improved access of prescription drugs. Congressman Lynch's bill would attempt to assess the cost-effectiveness of administering a non-VA prescription drug benefit through a smaller network-based demonstration at VA. I appreciate all of my colleagues' efforts and I have tried to craft my bill in a manner that takes cognizance of some of the concerns each of their bills raise.

At this Subcommittee's legislative hearing in Sept. 6, 2001, when asked to comment on the idea of a prescription drug benefit, Secretary Principi told the Subcommittee that, while he could understand the need for such a benefit for veterans, he believed the cost would be great—between $9.2 billion and $15.9 billion a year in additional costs because of new demand for such a benefit. On the other hand, the VA Inspector General actually thinks VA would save $1 billion a year by avoiding some duplication of examinations veterans have already received from non-VA physicians.

I believe the VA's estimate of the cost of this benefit may be too high and also believe the IG that there would be "offsetting savings". I do believe, however, there would be some new costs from new demand associated with this benefit. That's why, in this time of budget shortfalls, I considered it critical to find a way to pay for this new benefit. The optimal way I found to cover the most veterans would be to use Medicare funds. If Congress is truly serious about enacting a Medicare prescription benefit for America's seniors, I see no reason why we should not start with our veterans.

I believe my bill would do several things:

- It would allow veterans who only want to receive prescription drugs from VA to use Medicare for a VA-administered prescription drug benefit.
- It would cover the costs of the benefit, including the costs of administering, filling and dispensing the drug. This would give many of our Priority 8 veterans who are now "locked out" of VA health care, a way to tap into subsidized prescription drug coverage as Medicare beneficiaries.
- It would allow Priority 1 veterans to have the same benefit covered by VA without trading off access to VA services.

I believe the revenue stream through Medicare is the chief distinction between my bill and the other bills that are being discussed today. I also believe it is critical for us to find some way to reimburse VA for the costs of this new benefit for veterans.

As any Member of this Committee knows, it has been difficult for us to pass constructive Medicare subvention legislation. I believe we have an advantage with the legislation I have proposed since the benefits would be for veterans who are using Medicare rather than VA for their health care. This is also a "new benefit" rather than VA attempting to receive funding for something it has already been doing like previous subvention bills.

Mr. Chairman, again, I appreciate the opportunity to be here today and I am happy to answer any questions you may have.

The Honorable Nancy L. Johnson

Testimony before the Subcommittee on Health of the House Committee on Veterans' Affairs

March 19, 2003

Thank you, Mr. Chairman, for inviting me to speak here today on a major obstacle our nation's veterans face in obtaining comprehensive health care and access to prescription drugs.

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.

My legislation, which I introduced last Congress, would ease the process by which veterans with private health insurance or Medicare coverage obtain prescription drugs through the VA healthcare system. Specifically, it would allow an eligible veteran, with a prescription written by a private physician, to fill that prescription at a VA pharmacy from the current VA formulary. My legislation differs from other prescription drug access proposals because it specifically limits the prescriptions to drugs listed under the VA formulary in order to limit the cost of implementation. Under current law, the VA does not have the authority to dispense prescriptions written by private sector physicians.

As chairman of the Ways & Means health subcommittee, I recognize the unique challenge that the VA faces in its mission to provide comprehensive quality health care service to veterans. However, strict adherence to that same mission has resulted in lengthy delays in the delivery of quality care to both veterans with private health coverage and those veterans that are entirely dependant on the VA as their healthcare provider. In order to ensure timely delivery of health care, the VA must focus on the barriers veterans face in receiving care including streamlining access to prescription drugs.

The Honorable Nancy L. Johnson

Summary of the Veterans Prescription Drugs Access Act of 2002

March 19, 2003

The Veterans Prescription Drugs Access Act of 2002, introduced in the 107th Congress as H.R. 5286, would require Department of Veterans Affairs pharmacies to dispense medication to veterans enrolled in the health care system of that Department for prescriptions written by private physicians. The prescriptions would be limited to medications available on the VA formulary.

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

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to discuss whether VA should provide veterans with pharmaceuticals prescribed by physicians or other health-care professionals who have no affiliation with VA. The subcommittee is considering four different bills concerned with this issue. I would like to generally provide the Department's views on the subject and the specific bills under consideration, and answer any questions you may have.

Mr. Chairman, VA has in recent years faced an extraordinary demand for services. Many veterans enrolling in the VA system are seeking only pharmacy benefits. This has put unprecedented demand on VA for prescription drugs since open enrollment became effective in 1998. The growth in VA enrollment is due, at least in part, to the lack of a meaningful drug benefit for many seniors. I expect this demand to continue unless action is taken to address this federal health care issue. As more and more veterans have enrolled in the VA system seeking affordable prescription drugs, VA has been unable to provide all enrolled

veterans with services in a timely manner, and we have been forced to place many veterans on waiting lists for primary care. This difficult situation has generated great interest in having VA begin to fill prescriptions from outside providers.

Let me begin by saying that I plan to work closely with this committee as well as the Senate to find a solution to the vexing problem of waiting lists. A limited program under which we would fill prescriptions written for veterans by non-VA physicians may be part of that solution. We are particularly interested in exploring an effort that might allow us to fill prescriptions of enrollees who are unable to obtain timely services from VA until such time that we are able to eliminate waiting lists and fully serve all veterans who seek care. In addition to meeting an urgent need, such a program would provide us with valuable data upon which to make policy decisions in this area.

We have also had an opportunity to review the five bills currently being considered by the subcommittee. I want to explain why we are unable to support those specific bills, particularly those that would provide the Department with broad-based authority to routinely fill prescriptions written by non-VA physicians. I will first briefly describe each bill.

Discussion Draft

Mr. Evans, the Ranking Minority Member on the full committee, has prepared a detailed draft bill to authorize VA to furnish drugs and medicines ordered by non-

VA physicians and other care providers to veterans with service-connected disabilities rated at least 50 percent (enrollment priority category 1 veterans) and to other veterans eligible for Medicare benefits. Medicare-eligible veterans would have to choose the new drug benefit in lieu of all regular VA health-care benefits available to enrollees today, and do so during an annual open season. Veterans in enrollment priority category 1 would receive the benefit in addition to the benefits of regular enrollment. VA would have broad authority to establish copayments and annual premiums, and all amounts collected from the Medicare eligible veterans would be deposited in the Medicare Trust Fund. In turn, HHS would have to transfer from the Medicare Trust Fund, to VA, sufficient funds to cover VA costs. Finally, the bill would permit VA, during the first five years, to limit participation in the program for administrative or fiscal reasons. However, by the end of five years, VA must provide the benefit to all those who seek benefits during the first year.

H. R. 709

H. R. 709 would direct the Secretary to furnish any veteran with drugs and medicines prescribed by any licensed physician if needed for the treatment of an illness or injury of the veteran. The provision of such pharmaceuticals would be subject to the same copayment requirements applicable to drugs and medicines furnished to veterans when prescribed by a VA physician. (The copayment is currently $7 for each 30-day supply of medication.) The bill would require the Secretary to furnish the pharmaceuticals without regard to whether the veteran was enrolled in the VA health care system.

H. R. 372

H. R. 372 would do virtually the same thing as H. R. 709, the first bill I described, but on a very limited pilot basis. Thus, it would direct the Secretary to furnish veterans with drugs and medicines prescribed by any licensed physician if needed for the treatment of an illness or injury of the veteran, subject to the same copayment requirements applicable to drugs and medicines furnished to veterans when prescribed by a VA physician. However, VA would have to exercise the authority on a pilot basis in VISN I in New England. The pilot would last for two years, and the stated purpose for it would be to assess the advantages and disadvantages of having VA furnish these drugs and medications. The bill would require that VA report to Congress regarding the pilot.

H. R. 240

H. R. 240 would direct the Secretary to furnish any veteran with drugs and medicines prescribed by any licensed physician, or other health-care professional not affiliated with VA, subject to two conditions. First, as with the first two bills, the provision of pharmaceuticals would be subject to the same copayment requirements applicable to drugs and medicines furnished to veterans when prescribed by a VA physician or health-care professional. Second, the veteran would have to initially make an appointment with a licensed VA physician or other VA health-care professional for the sole purpose of obtaining the prescription and having it filled by VA. VA would have a 30-day

period to provide such an appointment and to fill the desired prescription. VA would be required to fill the prescription written by the non-VA health-care professional only if it was unable to furnish the drugs or medicines, through a VA prescription, within 30 days. As we interpret the bill, only veterans enrolled in the VA health care system could have prescriptions filled under this authority.

Mr. Chairman, I said earlier that the Department does not support broad-based legislation like the first three bills I described. As you know, the Department now provides enrolled veterans with a complete spectrum of health-care services on both an inpatient and outpatient basis. With very limited exceptions, we furnish drugs and medications to those veterans only in the course of providing them with medical care. Our prescription benefit is only one component of the continuum of care that we furnish veterans. It is not an "add-on" or "carved-out" benefit.

To provide veterans with a so-called "add-on" pharmacy benefit would constitute an expanded service that, without additional new funding, would tend to erode the comprehensive medical care benefits that veteran users of the VA health care system now enjoy. VA estimates that on average, it cost VA $664 per veteran in FY2002 for outpatient prescriptions and we expect that amount to increase this fiscal year. Those costs assume that VA would fill prescriptions in accordance with VA's national formulary. Without that limitation, the cost of filling prescriptions would be significantly higher.

As you also know, we currently fill many prescriptions from veterans through our Consolidated Mail Outpatient Pharmacies (CMOPs). At the present time, our CMOPS are operating at near capacity. A recent study suggested VA would need to expand CMOPs significantly by 2005 just to keep up with workload being generated by prescriptions written by VA providers. VA would need new capital infrastructure, and lead-time, to assume any significantly increased workload from prescriptions written by private physicians. It is also unreasonable to expect that VA could quickly and easily expand capacity in local medical center pharmacies. VA pharmacies are often constrained by space, but more importantly, recruiting and hiring pharmacy personnel is very difficult. The marketplace for pharmacists is currently extremely competitive. In short, we would want to make certain that adding new workload from privately written prescriptions would not simply result in degradation of services currently available to veterans.

Mr. Chairman, with respect to the bills you are considering today, H.R. 709 is the most far-reaching, and would be prohibitively costly. Under that measure, every Medicare-eligible veteran in America would be eligible for pharmacy benefits from VA. For all the reasons discussed above, we must oppose enactment of that bill. H.R. 372 would also provide a virtually unlimited benefit, but in only one geographic area. We think it is very difficult to justify providing benefits to veterans in only one location, even on a pilot basis. That is particularly the case with this bill because the veteran seeking benefits would not be required to

forego other VA healthcare benefits if he or she chooses to take advantage of the new benefit. Thus, we also oppose that measure.

The draft bill prepared by Mr. Evans would, in short, provide a comprehensive pharmaceutical benefit to all Medicare-eligible veterans in America. As such, it is potentially very expensive. Moreover, this Administration currently has a Medicare modernization framework before the Congress to provide a pharmaceutical benefit to Medicare beneficiaries. The Administration intends to ensure all Medicare beneficiaries have access to drugs through this benefit.

H.R. 240 is a somewhat more limited measure in that veterans could obtain benefits only if they are unable to obtain them from VA within 30 days. In our view, H.R. 240 appears to be aimed at addressing the problem VA has with being unable to provide all enrolled veterans with timely access to a primary care visit during which they could receive appropriate medications. However, we believe the bill would need some revision to actually solve that problem.

Now that we have our appropriation for the current fiscal year, we expect to quickly make significant headway toward reducing the time it takes for enrollees to obtain an appointment with a VA primary care provider. When enrolled veterans are able to receive timely primary care, there is no need for them to seek care, including prescriptions, in the private sector. However, we all know that there will always be situations when care cannot be provided as quickly as we would like. Let me give you just one example. We may have a small community based outpatient clinic staffed by a physician and a nurse practitioner. If one of those providers leaves, it sometimes takes a considerable length of time to recruit and hire a replacement. During that period, it may be very difficult to

provide primary care in as timely a manner as we would like and expect. That is the type of situation in which I would like to have the authority to fill prescriptions written by non-VA providers. I want to be able to provide enrolled veterans with assurances that they will always be able to receive medications when they need them and to reduce the financial burden of out-of-pocket drug expenses that they will incur while waiting for VA medical care. I look forward to working with you to take care of that kind of problem.

While we will continue to work with the Congress on this issue, I have also directed VA staff to explore and provide me recommendations for administrative approaches to initiate a time-limited program during which we would fill prescriptions written by non-VA providers for enrolled veterans who are now waiting for VA care and who want only prescription drugs. Such an endeavor would allow us to remove these veterans from the roles of those waiting for care and allow VA physicians to concentrate on the patients who need and want comprehensive VA care. It would also provide valuable data on the number of veterans seeking VA care only to obtain pharmaceuticals, and the number desirous of comprehensive services. Any approach we take to address this critical issue, whether through legislation or administrative action, must be a measured approach. I believe a solution must be carefully designed to ensure that no veteran enrolled in the VA system is required to wait an unreasonable length of time for health care. We must also take care to ensure that the actions we take have no unintended consequences that could adversely affect VA's ability to provide timely, quality health care to enrolled veterans.

This concludes my prepared statement. I would be happy to respond to your questions.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO

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

WITH RESPECT TO

H.R. 240, *VETERANS PRESCRIPTION DRUG EQUITY ACT*; H.R. 372, *TO AUTHORIZE PHARMACIES OF THE DEPARTMENT OF VETERANS AFFAIRS TO FILL PRESCRIPTION FOR DRUGS AND MEDICINES WRITTEN BY PRIVATE PHYSICIANS*; H.R. 709, *VETERANS PRESCRIPTION ACCESS IMPROVEMENT ACT*; AND *THE VETERANS PRESCRIPTION DRUG BENEFIT ACT OF 2003*

WASHINGTON, DC MARCH 19, 2003

MR. CHARIMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to present our views regarding the Department of Veterans Affairs' (VA) authority to fill prescriptions for drugs or medicines written by private physicians.

The Veterans' Health Care Eligibility Reform Act of 1996 provides all veterans enrolled in Categories 1-8 full access to all of the health services described in VA's Medical Benefits Package, which includes prescription drugs. VA pharmacies, however, for the most part are precluded from filling prescriptions issued by private physicians. They will only provide the drug if the prescription is rewritten first by a VA provider.

More and more veterans, however, are turning to private physicians for appointments because they cannot get a timely VA appointment. VA's own estimates show over 200,000 veterans waiting six months or more for an appointment. Veterans who seek care from a private physician, however, usually do not have a prescription drug benefit as generous as the VA's Medical Benefits Package. These veterans come to VA with prescriptions from their private physicians already written and in-hand only to find out that they cannot get their prescription filled until they see a VA physician. The VA Inspector General noted "frequent comments in

patient medical records reflecting the frustration of veterans in having to go through VA's extended process of scheduling exams and tests and then spending sometimes the entire day at the medical center solely, from their perspective, to have their prescriptions filled or refilled."

In addition, the VA Inspector General also found once veterans received appointments with VA physicians these VA physicians "routinely review and approve the orders of the private physicians... [and] exams frequently duplicate tests and exams that have already been performed by the patient's private physician and are conducted to allow the VA physician to support filing a prescription that the patient brought from his/her private physician."

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 the VFW has reevaluated its past position and now firmly believes that VA should be given the authority to fulfill prescriptions written by private physicians. VA, of course, must develop the necessary quality assurance systems needed to monitor private prescription fills or refills such as consulting with the private physician when a prescribed drug is not on VA's drug formulary.

While each one of the bills considered here today would provide VA the authority to fulfill prescriptions written by private physicians, H.R. 709 would achieve this upon enactment while H.R. 240 would limit the veteran to waiting 30 days; H.R. 372 would conduct a two year geographically limited pilot program and the Veterans Prescription Drug Benefit Act of 2003 would limit the benefit to Medicare-eligible veterans who choose to disenroll form VA health care. Therefore, we believe that *Veterans Prescription Access Improvement Act* would immediately make additional resources available for veteran healthcare by enhancing the delivery of prescription services to veterans and as such we would like to offer our support for H.R. 709.

Mr. Chairman, this concludes our testimony and I would be happy to answer questions that you or members of the subcommittee may have.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
ELIGIBLILITY AND AVAILABILITY FOR PHARMACEUTICAL SERVICES PROVIDED BY THE DEPARTMENT OF VETERANS AFFAIRS (VA)

MARCH 19, 2003

Mr. Chairman and Members of the Subcommittee:

The American Legion welcomes the opportunity to submit testimony on this important issue. In fiscal year 2001, VA's expenditures for pharmaceuticals increased by approximately 20 percent. Under current law, to use the VA pharmacy, veterans must first be enrolled and receiving care at a VA medical facility. As VA's enrolled patient population continues to reach record-high levels and its actual user rate grows proportionately, heightened demands for timely access to health care adversely impacts on pharmaceutical services. In fiscal year 1999, VA filled nearly 11 million prescriptions (30-day supply). By fiscal year 2001, that rose to about 26 million prescriptions.

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

- Failure of many health maintenance organizations and preferred providers organizations;
- Dramatic increases in cost of private health care premiums;
- No affordable Medicare prescription plan;
- Dependency on costly maintenance medications;
- VA's improved delivery of quality of care;
- VA's medical and prosthetics research;
- VA's renowned specialized services, to include long-term care; and
- VA's reputation for patient safety.

Clearly, millions of first-time users of the VA health care system are now voting with their feet and enrolling in the benefit created by a grateful nation "... ***to care for him who shall have borne the battle***." This dramatic change presents bittersweet ramifications. Many steadfast rules that governed a 20th Century hospital-based system are evolving slowly as VA transforms into a modern, cost-efficient, integrated health care delivery system.

Today's discussion will focus on suggested alternatives to specifically address VA's current pharmaceutical practices and policies. The American Legion believes that VA's pharmacies are very much a vital part of its integrated, holistic approach to medical care. The VA pharmacy

was established to support the nation's largest health care delivery system and was never intended to become simply a local corner drug store.

Some concern must be expressed about the overall cost of filling a larger percentage of prescriptions. With an anticipated 39 percent increase in enrollees VA projects over the next several years and a projected increase in actual utilization by a traditionally older and sicker population, additional funding and pharmaceutical personnel will certainly be needed to meet the projected pharmacy demands suggested by the bills.

A GAO report from December 2000 estimated VA could save over $1 billion if the requirements (examinations, visits, tests) that have been put in place and must be met to allow the rewriting of an outside physician prescription by VA physicians were eliminated. They also estimated that reducing this workload might alleviate some of the delays and restrictions to access to health care. Concerns raised in the past have questioned the quality and safety aspects of filling private prescriptions without examinations or testing of the veteran by VA.

Major questions must be asked while evaluating possible changes to the current pharmaceutical policies and practices:

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

H.R. 709, Veterans Prescription Access Improvement Act

Section 2 of this Act would give VA pharmacies the authority to dispense medications to veterans on prescriptions written by private practitioners.

The American Legion is concerned about the funding of this program. The VA system is already overly taxed in their pharmacy services, given that 900,000 veterans currently use VA for prescription medication. Without enactment of this measure, VA projects an increase of 207 percent in their outpatient pharmacy expenditures, from $3.2 billion in FY 2002 to $9.95 billion in FY 2012. This increase is caused by many factors to include an increase in utilization, medical inflation, and new drug therapies.

The intent of H.R. 709 is to expedite the dispensing of drugs and medications through the VA pharmacy. The mission of the VA health care system is to provide timely access to quality health care – simply filling prescriptions somehow does not seem to mesh with the concept of an integrated health care system. No public or private health care delivery plan allows beneficiaries to purchase access to just their prescription benefit, especially by merely paying just the co-payments.

VA is not an a la carte health care delivery systems – just pick and choose the health care services desired. Should VA just allow veterans to access labs for tests or x-rays ordered by private practitioners?

H.R. 372

This bill directs the Secretary of Veterans Affairs to provide a pilot program to assess the benefits of providing its pharmacies to fill prescriptions for drugs and medicines written by private physicians.

The pilot program will take place over a two-year time frame in what is now Veterans Integrated Service Network (VISN) 1. After that time, the Secretary must submit a report to Congress, within 180 days addressing: VA's assessment of the benefits to veterans of the pilot program; VA's assessment of the effect of the pilot program on the VA, including the effects on delivery of health care to veterans; any other findings and conclusions with respect to the pilot program; and any recommendations for continuation of the pilot or for extension of the pilot program to other VISNs or all VISNs.

This legislation is a variation of H.R. 709 and The American Legion expresses the same reservations.

H.R. 240, Veterans Prescription Drug Equity Act

This bill would amend title 38, United States Code, to require VA pharmacies to dispense medications to veterans for prescriptions written by private health care practitioners if the veteran, after having made an appointment to see a VA physician to get a prescription, waits longer than 30 days.

The backlog of veterans waiting to see a VA physician is greater than 200,000. Many veterans wait months and even years to receive care through VA. Veterans are waiting because VA has not been provided adequate funding to handle the enormous influx of veterans who are turning to VA for health care. The increase in enrollees has taxed their already overworked and under funded system.

This legislation is yet another version of H.R. 709 and The American Legion expresses the same reservations.

Draft legislation, the Veterans Prescription Drug Benefits Act of 2003

This proposed legislation would offer Medicare-eligible veterans to the ability fill non-VA physicians prescriptions in VA medical care facilities.

Section 2 of this bill directs the establishment of a prescription drug benefit program for Priority Group 1 veterans and Medicare-eligible veterans who choose to enroll in the program. There are several caveats to enrolling (however, some of them do not apply to Priority Group 1):

- If a Medicare-eligible veteran chooses to enroll into the drug benefit specific program, the veteran has to disenroll from the VA health care system.

- An annual enrollment period of two months, conducted at the end of each fiscal year. During that period, a Medicare-eligible veteran, who is not a Priority Group 1 veteran, may enroll.

- The veteran will be assessed an annual premium for drugs and medicines.

- The veteran will pay a co-payment established by the Secretary. These co-payment amounts may vary.

- All co-payments and annual fees, with the exception of those collected for Priority Group 1 veterans, will go to the Medicare Trust Fund.

Section 2 (f) directs the Secretary of Health and Human Services (HHS) to transfer to the Secretary of VA, the amounts it cost VA for drugs, medicines, processing, filling and dispensing the prescription, and overhead costs such as labor, equipment, space and utilities. These amounts received by HHS will be deposited into the Medical Care Collection Fund (MCCF).

Section 2 (g) covers liability issues as they pertain to VA health care professionals and filling outside prescriptions written by non-VA doctors.

Section 2 (h) directs the Secretary to develop and maintain a database of enrolled veterans and also of those who have applied for enrollment. Additionally, it calls for the implementation of a computerized patient profile system that will help to identify known drug interactions; contraindicated drugs; available "best value" treatment alternatives; and patient safety issues.

Section 2 (i) mandates an annual report to Congress that will include, among other things, the tracking of participants, cost analysis and tracking of transferred amounts from HHS to VA.

Theoretically, this is a new benefit program for Medicare-eligible veterans that want to use **only** the VA's pharmaceutical services. However, The American Legion has some concerns:

- How will this program impact on Medicare-eligible veterans in Priority Groups 2-8 with service-connected medical conditions? Must they disenroll to access the VA pharmacy through this program?

- What happens if HHS funds transfer fails to cover the actual cost of the program? What process will be used to fully fund the program? Will this be scored as third-party reimbursements, an offset against annual discretionary appropriations? Why must VA collect the enrollment fees and co-payments, transfer these collections to HHS, then HHS transfer funds back to VA?

- Will VA be staffed with qualified pharmaceutical personnel to meet increased pharmaceutical demands?

Summary

The cost of pharmaceuticals is clearly a national debate throughout the health care industry, to include the nation's largest health care delivery system. For many veterans currently enrolled in the VA health care system, having access to an affordable pharmacy system is among the major factors in their health care planning. Service-connected disabled veterans, catastrophically ill veterans, and economically indigent veterans depend on the integrated health care system as their primary health support system.

If the Secretary of Veterans Affairs and his professional staff believed that changing the current pharmaceutical practices and policies would increase timely access to care, improve quality of care, or maximize management efficiencies, surely one of these proposals would have appeared in the President's budget request. However, each of VA's pharmaceutical-based legislative initiatives were focused on addressing the health care needs of their "core constituency – veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs."

None of these proposals appear to address The American Legion's fundamental concerns. The VA health care system is a comprehensive program that addresses the total range of veterans' health needs. While The American Legion understands the proposed legislation attempts to solve a current demand on the system, each fails to address the overall problem of delivery and demand for services from a growing patient population.

The American Legion looks forward to working with the Subcommittee to ensure America's veterans are provided an effective and efficient pharmacy benefit through VA.

This concludes my testimony.

STATEMENT OF
ADRIAN M. ATIZADO
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 19, 2003

Mr. Chairman and Members of the Subcommittee:

On behalf of the 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on four pieces of legislation before the Subcommittee.

The agenda includes H.R. 240, the Veterans Prescription Drug Equity Act; H.R. 709, the Veterans Prescription Access Improvement Act; H.R. 372, to authorize pharmacies of the Department of Veterans Affairs (VA) to fill prescriptions for drugs and medicines written by private physicians; and a pending draft bill, the Veterans Prescription Drug Benefits Act of 2003. These bills address the issue of timely access by disabled veterans to VA pharmacy benefits.

For the past eight decades, the DAV has been devoted to one single purpose: building better lives for our nation's disabled veterans and their families. DAV has never wavered in its commitment to serve our nation's service-connected disabled veterans, their dependents, and survivors.

Although not on the agenda, we find the need to briefly comment on the funding crisis in the VA health care system. The Subcommittee has recognized the necessity for veterans to have timely access to quality medical care. Unfortunately, the year-to-year uncertainty of funding levels has prevented the VA from adequately planning for and meeting the growing needs of veterans seeking treatment. We believe these measures under consideration address only a part of the larger issue; therefore, we count on your support to make timely, quality VA health care a reality for our nation's sick and disabled veterans, by changing VA health care funding from a discretionary to a mandatory program.

H.R. 240

Under this bill, a veteran would be required to make an appointment to see a VA physician for obtaining drugs or medicines prescribed by a non-VA physician. If VA were unable to see the veteran and provide the needed medication within 30 days, VA would be required to fill the prescription written by the non-VA practitioner. The bill also requires such prescriptions to be subject to copayments.

H.R. 709

This measure would authorize VA to provide drugs and medicines prescribed by a duly licensed non-VA physician to any veteran regardless if the veteran was enrolled in the VA health care system. This bill would also render drugs and medicines provided by VA subject to copayment requirements.

H.R. 372

This legislation would require VA to conduct a two-year pilot program located in Veterans Integrated Service Network (VISN) 1 to provide prescription drug and medication prescribed by a duly licensed non-VA physician. This bill provides the prescribed drug and medication furnished under the pilot program is subject to copayments. Furthermore, the bill requires the Secretary to submit to Congress a report within 180 days from the end of the pilot program, assessing the advantages and disadvantages and recommendations for continuance of such a program.

Pending Draft Bill

The Veterans Prescription Drug Benefits Act of 2003, introduced by Lane Evans, Ranking Member of the House Veterans' Affairs Committee, would require VA to establish a program to provide drugs and medicines subject to copayments to Medicare-eligible veterans and Priority Group 1 veterans (veterans with service-connected disabilities rated 50 percent disabling or greater). This bill would require VA to conduct an annual open enrollment period for Medicare-eligible veterans to enroll into this program in lieu of all other VA hospital care and medical services.

Concurrent with an annual enrollment period, a Medicare-eligible veteran previously enrolled into the aforementioned drug benefit program may disenroll. Also, Priority Group 1 veterans would be allowed to participate in this program adjunct to current VA hospital care and medical services. This bill would authorize the Secretary to limit enrollment for the first five fiscal years and ensure enrollment by the fifth year for Medicare-eligible veterans who applied during the first year of enrollment.

This measure would also require the Secretary to establish an annual premium for enrollment and different copayment amounts limited to not less than current and not more than actual cost to VA. Copayments received from furnishing drugs and medicines to Medicare-eligible veterans would be transferred to the Medicare Trust Fund and Health and Human Services would transfer funds to VA equal to the amount of costs incurred by VA under this program.

VA would also be required to implement a computerized patient profile for this drug benefit program within six years of enactment of this bill, and submit to Congress an annual report for the first five fiscal years of this program.

In large part, each measure seeks to improve the current process of filling prescriptions written by non-VA physicians. Current law directs the VA pharmacy to provide the medications and associated supply to a veteran who has a prescription from a non-VA provider, if a VA provider first rewrites the prescription except in specific circumstances such as sharing agreements with the Department of Defense (DoD). Veterans seeking to fill privately written prescriptions at VA pharmacies are scheduled for medical examinations to allow the VA physician to support the prescribed medication. Certainly, VA is experiencing a large influx of veterans seeking care, apparently to obtain medication through VA. The December 2000 report by VA's Office of Inspector General estimates over a $1 billion savings by eliminating the duplication of completing medical examinations and tests performed by VA.

All four bills would eliminate the duplication of tests and procedures already conducted by the veteran's private physician and would make available VA resources utilized in the current process. However, it is not clear whether streamlining the current process would be wholly beneficial to the VA health care system.

Due to insufficient funding, VA is struggling to provide timely health care to all veterans seeking care. Clearly, these bills seek to address this issue. However, we believe that providing an additional 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 increasing the overall pharmaceutical cost. We are also concerned H.R. 240, 709, and 372 do not provide for additional funding, staffing, or other resources, which would create an additional burden to the severely strained health care system.

We are also concerned that the pending draft bill could force service-connected disabled veterans, other than Priority Group 1, to choose between VA health care and care provided in the private sector under Medicare or Medicaid programs, even for service-connected conditions. Using the private sector to treat service-connected conditions undermines VA's primary mission. Moreover, although veterans could choose to re-enroll for VA health care benefits during the next "open enrollment period," there is no guarantee these veterans would not end up on an enrollment waiting list for care and lose their established patient status. Unlike the other three bills, the pending draft bill provides a funding mechanism; however, it shifts an additional burden to the beneficiary whom it intends to assist by establishing an annual premium for enrollment and copayments equal to or greater than the current amount.

DAV Resolution No. 224 supports the repeal of copayments for medical care and prescriptions provided by the VA. Copayments were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. We will continue to voice our objection to copayments on the basis that they fundamentally contradict the spirit and principle of veterans' benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of our grateful nation want our government to fully honor our moral obligation to care for veterans and generously provide them benefits and health care entirely free of charge.

It is important to note VA utilizes a cost-saving national formulary supplemented by 21 regional formularies. In consultation with the private physician, VA often substitutes the prescribed medication with a therapeutically interchangeable drug within its formulary. We are concerned these bills do not provide for appropriate quality assurance such as access to the veteran's complete health information. Such access is needed to aid in making medication decisions and to conduct a complete check for drug allergies.

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.

The DAV testified previously on the issue of VA filling prescriptions ordered by non-VA physicians in VA medical care facilities. We raised concern about VA taking on the role of a pharmacy. Additionally, we noted that 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 could jeopardize the viability of the entire system.

Though these measures would be beneficial to a large segment of the veteran population, these bills would also prevent VA from providing a full continuum of treatment for which the comprehensive health care benefit package was created. The possibility these bills may fundamentally change the very nature of the VA health care system is a great concern.

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 these important measures.

STATEMENT FOR THE RECORD

BY

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

TO THE

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON VETERANS AFFAIRS

CONCERNING

H.R. 709, THE "VETERANS PRESCRIPTION ACCESS IMPROVEMENT ACT"

H.R. 372, TO AUTHORIZE PHARMACIES OF THE DEPARTMENT OF VETERANS AFFAIRS TO FILL PRESCRIPTIONS FOR DRUGS AND MEDICINES WRITTEN BY PRIVATE PHYSICIANS

H.R. 240, THE "VETERANS PRESCRIPTION DRUG EQUITY ACT"

THE "VETERANS PRESCRIPTION DRUG BENEFITS ACT OF 2003"

MARCH 19, 2003

The Paralyzed Veterans of America (PVA) appreciates this opportunity to submit testimony for the record concerning H.R. 709, the "Veterans Prescription Access Improvement Act"; H.R. 372, to authorize pharmacies of the Department of Veterans Affairs to fill prescriptions for drugs and medicines written by private physicians; H.R. 240, the "Veterans Prescription Drug Equity Act"; and a pending draft bill, the "Veterans Prescription Drug Benefits Act of 2003."

Last Congress, we stated that we opposed a measure identical to H.R. 709. We noted that:

> The approximate $1 billion increase for health care slated for FY 2002 does not even cover salary increases and inflation for the coming year. Moreover, it is estimated that next year the cost of pharmaceuticals will be three times the rate of inflation. The [Department of Veterans Affairs (VA)] VA does not need to take on the role of the veterans' drug store. Now is not the time, when the VA does not have the resources necessary to provide sick and disabled veterans the health care they need, to further burden the VA with additional demands on these scarce resources.

Now we are nearing FY 2004, and the situation faced by the VA is even graver. The Administration has recommended a health care increase of $1.3 billion in a budget laden with unrealistic "management efficiencies" and enrollment fees and increased co-payments. This recommended increase falls far short of the amounts recommended by *The Independent Budget* and the full Committee. Even though the Budget Committee recently acted, stating that it was providing the resources needed to cover the Administration's request, we find it difficult to see how the Budget Resolution, containing fewer discretionary dollars than the Administration's request, will enable even this inadequate increase. In fact, the Budget Committee voted last week to actually cut VA health care and veterans' benefits by $25 billion over the next ten years.

Last Congress, there were estimates that a measure such as this could save the VA nearly $1 billion a year, savings we believe to be illusory. We have also seen estimates that it could cost far, far more than $1 billion, possibly even reaching as high as $15 billion. With the VA taking steps to drastically reduce access 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.

Likewise, we must also oppose H.R. 372 and H.R. 240. Both measures suffer under the same funding infirmities as H.R. 709. Furthermore, H.R. 372 would arguably provide a benefit foreclosed to veterans who rely solely upon the VA for their health care needs while H.R. 240 would benefit only certain veterans in one region and have a disparate impact on other veterans. At this crucial time, we believe that all veterans must stand together and fight for the health care system designed and operated to deliver health care that meets the needs of veterans.

Finally, PVA supports the "Veterans Prescription Drug Benefits Act of 2003." By providing a new Medicare drug benefit to veterans, this measure would begin to address a

vital need and concern of our elderly citizens – the need for affordable pharmaceuticals. We look upon this as providing a new Medicare benefit, and not a new VA benefit.

The increasing use of prescription drugs for medical treatment options has revolutionized the provision of medical care. Every year pharmaceuticals represent an ever-growing percentage of health-care expenditures. Medicare has not kept up with this revolution. By providing veterans with this benefit, facilitated through the VA and ensuring that VA does not spend scarce and inadequate resources, we can begin the process of reflecting the manner in which health care is delivered in this Nation.

This measure, unlike other measures addressed today, would not force the VA alone to bear the burden of addressing this national policy failure – and it, of the measures addressed today, does not suffer under what we consider to be risky and potentially catastrophic funding infirmities. The VA would merely be acting to facilitate a benefit offered to veterans, a benefit that would provide substantial pharmaceutical savings to the federal government because of VA's statutorily mandated discounts. In addition, this bill would reimburse the VA for expenses relating to the implementation of this benefit as well as costs incurred in administering it.

Although veterans seeking treatment for a service-connected condition, and veterans with service-connected disabilities rated at 50 percent or more are expressly exempted from the requirement of enrolling in order to receive care by virtue of 38 U.S.C. § 1705 (c)(2), we ask that the final version of this bill explicitly reiterate that veterans choosing this Medicare benefit, and foregoing their VA health care options are always able to seek treatment for service-connected conditions at VA facilities. Additionally we request that other veterans needing specialized services be afforded access to care.

PVA appreciates this opportunity to testify for the record concerning these important bills.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SIMMONS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
March 19, 2003

Hearing on the Availability and Eligibility for Pharmaceutical Services Provided by the Department of Veterans Affairs

Question 1: Since the Veterans Health Administration (VHA) is already permitting private prescriptions to be filled for a limited group of veterans (those with housebound benefits in state home, for example), would it not be possible to expand the benefit to include other enrolled veterans?

Response: Yes, it would be possible for VA to expand the benefit to other enrolled veterans. Please see our response to question 11 for details on VA's new Transitional Pharmacy Benefit program.

Question 2: Dr. Roswell remarked during the hearing that the report of VA's Inspector General, *Audit of VHA Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans*, has been referred to the National Leadership Board for review. Please provide the Subcommittee a report of the status of that review, along with VA's planned actions.

Response: The Under Secretary for Health referred the OIG's original 2000 report, the OIG's new draft update, and a VHA commentary on the methodology used to calculate savings to the VHA National Leadership Board (NLB) for consideration. The Executive Committee of the NLB recommended that the OIG consider revising the report and obtain guidance from VHA on successful methodologies for financial evaluations of healthcare.

VHA has met with the OIG to discuss the methodology used for both reports. VHA explained its concerns about the methodology used, including the failure of the OIG to consider possible increased demand for (prescription) services in its costing model. VHA provided written suggestions and data to the OIG to assist them in the review of their own calculations. OIG continues to re-examine its updated report.

Question 3: The Department of Defense (DoD) military health system processes prescriptions from non-DoD providers under the TRICARE program. Please describe the reasons that VA cannot establish a prescription drug program similar to the one available in the DoD structure.

Response: There are several reasons why VA cannot or should not establish a prescription drug program similar to the one available in the DoD structure. First,

the Departments are funded differently. DoD TRICARE is an entitlement program, while VA health care is a discretionary benefit. Prescription-benefit funding in DoD is commensurate with workload demand while, in VA, there is a risk that funding for an expanded benefit would need to be diverted from existing medical care programs if adequate additional resources for a prescription only benefit are not made available.

Second, VA medical care has historically been defined by the provision of *comprehensive* health care services for veterans. One of the many benefits offered to veterans as part of VA's comprehensive health care system is a robust prescription benefit. VA has maintained control over the costs of its prescription benefit by using sophisticated formulary management techniques and by assuring that prescriptions written by VA staff are consistent with the goals of the formulary management process. This comprehensive model of health care has allowed the VA to manage patient care in its entirety and ensure that the veteran is receiving optimal cost effective and safe care.

Third, VA's drug management practices are not included in DoD's TRICARE prescription program and, as a result, DoD's costs are considerably higher than VA's. In VA, a single primary care provider coordinates drug therapy. The TRICARE health care system has several different venues of care that can occur in the Medical Treatment Facilities (MTFs) or the TRICARE health care network. The pharmacy benefit and co-pays vary and are based not only on trade vs. generic pharmaceuticals, but also on the points of service. A TRICARE member has three means to fill a prescription, the MTFs, the TRICARE retail pharmacy network and the TRICARE Mail Order Pharmacy (TMOP). Each of these venues has a different method for managing the pharmacy benefit. In addition to the co-payment structure and the selection of a trade brand vs. a generic brand, the MTF is the only point-of-service that utilizes DoD's basic core formulary.

Question 4: What is the status of the requirement in PL 107-314 that requires VA and DoD to develop a joint pharmacy data transaction tracking system?

Response: VA and DOD are jointly implementing a plan that will provide the capability to exchange pharmacy data transactions between DOD's CHCS II (Composite Health Care System) and VA's Health**e**Vet strategy for VistA (Health**e**Vet-VistA) by FY 2004. VA and DOD will have the capability to perform comprehensive automatic drug interaction checks using medication information from VA and DOD facilities and mail order operations and DOD's network pharmacies. This interoperability will provide the two Departments the capability to perform checks on drug interactions and duplicate drug class orders that are available in DOD's Pharmacy Data Transaction Service. It will allow the Agencies to perform the clinically important drug allergy and drug adverse event checks as well.

The following chart provides current status, including major milestones and completion or target dates.

Implementation Plan:	Target Dates:	Status:
Health Data Repository (HDR) Functional Requirements Defined	May 02	Completed
HDR Mapping Strategy Defined	December 02	Completed
Technical, Acquisition, and Implementation Strategies Defined	January 03	Completed
Testing of Installed Network, Hardware, Software	June 03	Completed
Demonstrate Interoperability between VA and DoD Pharmacy Information Systems	July 04	

Question 5: Concerns have been raised about the need to ensure that medications are properly and effectively used by the patients. Is this a legitimate concern, and why?

Response: The safe and effective use of medications is the cornerstone of modern health care and is of paramount importance. VA strongly believes that drug therapy must be coordinated, monitored, and managed by a single primary care provider. Drugs are a major cause of iatrogenic injury and adverse drug events (ADEs). Many ADEs are associated with medication errors and are thus preventable.

VA has experience demonstrating that providing pharmaceuticals as an integrated portion of a comprehensive health care benefit is effective and efficient. VA's clinical pharmacists are members of VA's primary care teams. VA clinical pharmacists, with a scope of practice authority, have the ability to initiate, modify, continue and monitor a patient's drug therapy under protocols. VA has established progressive pharmacy practice models to demonstrate improved patient outcomes and maximize the pharmacist's contributions to drug therapy within a primary care team. Many improvements have been realized and supported by advanced computerized and automated systems, expanded disease state management practices, and unique practitioner and administrative support.

Question 6: Could these worries be resolved through the implementation of a medication management program that would include credentialing of non-VA health care providers eligible to write prescriptions, drug utilization reviews and a call center to respond to patient-specific medication questions?

Response: Not entirely. While a medication management program as described above would be helpful, it would not include key components of VA's current system such as coordination of care, concurrent drug utilization management, adherence to prescribing guidelines, management of outcomes, polypharmacy, and reporting and management of adverse events.

If VA provided a prescription only service, the pharmacist could still provide 1) counseling on new prescriptions; 2) verification for the appropriate drug dosage and instructions; 3) alerts to private physicians for any known drug interaction, drug allergy, or drug duplication; and 4) calls to providers to confirm any illegible prescription. However, these activities do not provide oversight for the safe, cost-effective use of medications, beyond the appropriate prescribing of a single medication. The pharmacist would not be able to monitor the outcome of prescribing to reach a therapeutic goal or to monitor side effects. The effective use of medications would be the sole responsibility of the prescribing private physician.

Question 7: As we have seen in the past with other federal benefits (such as the rapid rise in spending that resulted from the inception of a Medicare home health care benefit in the 1980's) the liberalization of a VA prescription drug benefit could result in inappropriate use and over-utilization. What key elements would be necessary for VA to design into a "prescription only" benefit to prevent fraud and abuse?

Response: There is no clear single solution or foolproof means to preventing fraud and abuse, inappropriate use, and over-utilization. However, special attention would need to be devoted to such things as verifying patient/provider relationships, verifying patient eligibility, monitoring individual patient prescription utilization patterns, duplicate drug checking (duplicate drug class checking, early refills, controlled substances utilization, etc.), and attempting to match drug therapy with a patient's know diagnoses.

Question 8: The RAND Insurance study from the 1970's is the classic means of determining cost in health care utilization. Those who rely on the RAND study have suggested, in effect, "if you build it, they will come." Certainly this has been true with VA's experience with CBOCs. Would the same be true for any bill that authorizes VA to serve as a pharmacy-only benefit to veterans, and why?

Response: VHA believes that high demand is a possibility. Increasingly, prescription pharmaceuticals are being relied upon more and more as the single most effective means to extend life and improve the quality of life for individuals suffering from disease. However, pharmaceuticals are expensive, and many people do not have affordable access to prescription drugs. In the absence of Medicare Drug Benefit, older Americans are especially disadvantaged inasmuch as they, as a group, are among the highest users of pharmaceuticals, but are

often unable to afford to pay for them. As a result, older Americans who are veterans and do not have affordable access to prescription drugs, represent a large group who could turn to VA if an expanded pharmacy benefit is provided.

Over 8 million veterans are eligible for Medicare. It is possible that all Medicare-eligible veterans not currently seeking VA care would consider a pharmacy-only benefit, if it were affordable and convenient. Thus, the projected number of veterans over 65 without a prescription benefit who might seek a pharmacy-only benefit could be nearly twice the current number of enrolled veterans.

Question 9: You stated in your testimony that a pharmacy-only benefit would "constitute an expanded service that, without additional new funding, would tend to erode the comprehensive medical care benefits that veteran users of the VA health care system now enjoy." However, the VA currently spends a significant amount of funds on re-examining, re-testing, and re-writing prescriptions that veterans obtain form their private health care providers, many if not most 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 of other enrolled veterans?

Response: There is no empirical data on the extent to which VA would be able to redirect funds spent on some medical services that might be avoided if a prescription-only benefit was available. Because of this, we have strong reservations about implementing such a program and are concerned about the unintended consequences of significantly increased demand if such a program was made available. Specifically, we believe the offset may not cover the additional costs of an expanded benefit and that the cost savings that might accrue from eliminating some medical services could be consumed by the increase in demand generated by a permanent, unlimited prescription-only benefit. If that is the case, not only would additional resources not be available for use in other areas of medical care, but there is also the possibility that the quality of care in other areas may be compromised by a diversion of resources resulting from significantly increased demand from a prescription-only program.

Question 10: You indicated in your testimony that waiting times and the need for prescription drugs are unrelated. Wouldn't you agree that some of those veterans waiting for an appointment are actually waiting to have a prescription written for them, or are holding prescriptions written by other providers outside the VA that they wish VA to provide?

Response: VA recognizes that provision of medications, as a component of its comprehensive medical benefits package, is a strong incentive for many veterans to seek health care from VA. We agree that some veterans on current waiting lists have prescriptions written by non-VA providers and are waiting for VA care primarily in order to receive medications at lower cost from VA. However, as we stated above in response to question 9, an analysis of the

utilization of new enrollees who indicated in the VHA New Enrollee Survey that pharmacy access was their primary reason for enrollment shows that their use of services was not limited to primary care and pharmacy.

Question 11: Please provide the Subcommittee an outline of the "administrative" prescription benefit that you summarized in your testimony.

Response: VA has developed a program to provide a time-limited prescription benefit to patients who have enrolled in VA, requested a primary care visit, and are waiting for a visit greater than 30 days. On July 24, 2003, I announced the formation of this Transitional Pharmacy Benefit program. An interim final regulation governing provision of the benefit was published in the Federal Register on July 25, 2003.

The new Transitional Pharmacy Benefit was developed to help veterans reduce the out-of-pocket medication expenses they incur while waiting for a primary care visit with VA. To be eligible for this time-limited benefit, veterans must meet all of the following conditions:

- They must have enrolled in the VA health care system before July 25, 2003.
- They must have requested their first primary care appointments with VA before July 25, 2003.
- As of September 22, 2003, they must be waiting more than 30 days for their first appointments with a primary care physician.

On September 22, 2003, VA began to accept prescriptions from Transitional Pharmacy Benefit participants and also began to collect cost, utilization and service quality data. Data will be collected at the end of each week and those data will be used to prepare program summary reports. VA will also monitor and evaluate the impact of the program on its current and future budgets and on its primary mission of providing health care to veterans. VA is continuing to explore other options for the provision of a prescription benefit and, in doing so, is carefully examining all legal, clinical, operational, and economic consequences of such proposed policies.