Controlling Prescription Drug Costs: Regulation and the Role of Interest Groups in Medicare and the Veterans Health Administration

Austin B. Frakt
Steven D. Pizer
Ann M. Hendricks
VA Boston Healthcare System and
Boston University School of Public Health

Abstract Medicare and the Veterans Health Administration (VA) both finance large outpatient prescription drug programs, though in very different ways. In the ongoing debate on how to control Medicare spending, some suggest that Medicare should negotiate directly with drug manufacturers, as the VA does. In this article we relate the role of interest groups to policy differences between Medicare and the VA and, in doing so, explain why such a large change to the Medicare drug program is unlikely. We argue that key policy differences are attributable to stable differences in interest group involvement. While this stability makes major changes in Medicare unlikely, it suggests the possibility of leveraging VA drug purchasing to achieve savings in Medicare. This could be done through a VA-administered drug-only benefit for Medicare-enrolled veterans. Such a partnership could incorporate key elements of both programs: capacity to accept large numbers of enrollees (like Medicare) and leverage to negotiate prescription drug prices (like the VA). Moreover, it could be implemented at no cost to the VA while achieving savings for Medicare and beneficiaries.

This research was supported by the Department of Veterans Affairs Health Services Research and Development Service Grant No. IIR 04–233–1. This is an investigator-initiated, peer-reviewed grant. Although the authors interviewed some current and former Medicare and Department of Veterans Affairs administrators as part of this research, this article was neither reviewed nor approved by Medicare or Department of Veterans Affairs administrators prior to submission for publication. The views expressed in this article are those of the authors and do not necessarily reflect the positions of the Department of Veterans Affairs or Boston University. We thank Dan Plafcan, Lynn Wolfsfeld, Julia Prentice, and two anonymous reviewers for their helpful comments on earlier versions of this article.

Journal of Health Politics, Policy and Law, Vol. 33, No. 6, December 2008
DOI 10.1215/03616878-2008-032 © 2008 by Duke University Press

Introduction

In January 2006 Medicare became the nation's largest single provider of outpatient prescription drug coverage through its Part D program, authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (aka the Medicare Modernization Act [MMA]). All 43 million Medicare beneficiaries are now eligible to enroll in one of a variety of pharmacy benefit packages offered by private insurers, either drug-only or comprehensive health care plans. The MMA statute (Public Law 108–173) authorizes these private plans to negotiate with drug manufacturers for volume discounts, and it prohibits Medicare as a whole from doing so (for a convenient summary of the MMA, see Kaiser Family Foundation 2004). While the prohibition on direct Medicare–drug manufacturer negotiation has received considerable attention from policy makers, the media, and academe (see, e.g., Pear 2007a, 2007b; Frank and Newhouse 2008), it is only one of several important limitations imposed by the MMA on the administration of the Medicare drug benefit. Others include minimum numbers of drugs in each class that must be included on formularies, minimum coverage requirements, and community pharmacy access requirements, to name a few (MedPAC 2006).

Critics argue that Medicare's lack of authority to negotiate drug prices leads to higher expenditures for plans, beneficiaries, and Medicare (Montgomery and Lee 2006; Families USA 2005). Others have pointed out that providing Medicare the authority to negotiate directly with manufacturers would not lead to price reductions on its own. To achieve savings Medicare would also need the ability to exclude drugs from its formulary (Congressional Budget Office 2007). This ability to tighten the formulary would provide the leverage to negotiate bargains. Congress has debated repealing the prohibition on Medicare drug price negotiation. Legislation to do so—the Medicare Prescription Drug Price Negotiation Act of 2007—passed the House of Representatives on January 12, 2007 (HR 4) but failed a cloture vote in the Senate on April 18 (S 3). Interest remains among policy makers and certain advocacy groups in reducing Medicare drug prices, although there are good reasons to be cautious about large reductions in prescription drug prices. There is a question of how to determine the welfare-maximizing balance between current lower drug prices and future drug innovation (Danzon 1998). Additionally, it is possible that manufacturers could raise their wholesale prices or take a tougher position in negotiations with others to compensate at least partially for concessions to Medicare, though some economists argue that manufacturers are not able

to price-shift in this manner (Frank 2001). While these issues are worthy of attention, we assume for the purposes of this article that drug price reduction is good for beneficiaries and taxpayers.

Medicare's inability to negotiate prices is in stark contrast to another large public provider of prescription drug benefits, the Veterans Health Administration (VA), which negotiates directly with drug manufacturers and obtains very low prices.[1] The VA provides a pharmacy benefit with very low cost sharing to over 5 million VA patients annually (U.S. Department of Veterans Affairs 2006a) and applies more restrictive formularies than Medicare (Freking 2006).[2] The VA also has limited access. In 2003, for example, an estimated 173,000 low-priority veterans were denied access to VA care because of capacity constraints at VA medical centers (Wilkinson 2003).

Could Medicare get discounts similar to those obtained by the VA? As has been discussed elsewhere, Medicare would need more control over prescribing and distributing,[3] something Congress is unlikely to authorize (Pear 2007a, 2007b; *New York Times* 2007). This raises two interesting questions. First, why is Congress comfortable with the VA prescription drug benefit but not willing to authorize something similar under Medicare? Second, given the limitations on Medicare, is there a lower-resistance path to getting VA-like drug prices for more Medicare beneficiaries? The answer to the first question suggests one to the second.

The VA and Medicare prescription drug programs each advantage patients with different needs and concerns. The VA's might be preferred by those who need or want coverage from first dollar through catastrophic with no gap and who are not inconvenienced by formulary restrictions or heavy reliance on mail-order pharmacy services.[4] Others may need or be more comfortable with Medicare's more flexible formularies and commu-

1. The VA has access to discounted drug prices through (1) the federal supply schedule, managed by the VA and available to all agencies; (2) a federal ceiling price (aka the "Big-4 Price"), mandated by law to be 24 percent lower than the nonfederal average price; (3) a restricted federal supply schedule available only to the VA; and (4) national contract prices that reflect further negotiated discounts from manufacturers. Finally, the VA may negotiate for additional discounts (U.S. Government Accountability Office 2005; Families USA 2005).

2. A VA patient is an individual who actually receives care at a VA facility. A veteran can be eligible for VA benefits or enrolled in the VA without being a patient.

3. Under Medicare, prescribing is mediated through private drug plans, and prescriptions are filled by retail pharmacies. In contrast, the VA establishes pharmacy policy, directly employs prescribing physicians, and operates its own pharmacies.

4. The "gap" or "donut hole" is a range of drug spending under Medicare drug plans for which the beneficiary pays 100 percent of drug costs. For the statutory minimum benefit plan in 2006 this range was between $2,250 and $5,100 of total drug spending.

nity pharmacy access, despite the cost sharing and coverage gap that exist under most of its plans. Which type of coverage is preferable by objective measures is a new area of research with few results yet available in the literature. A preliminary result from a recent study suggests that the VA benefit is associated with less cost-related nonadherence relative to Medicare plan benefits (Neuman et al. 2007).

We attempt to explain the differences between the two drug benefit designs by observing that Congress acts as an agent for multiple interest groups. We conclude that important limitations on the Medicare drug benefit probably arose from the advocacy of drug manufacturers and retail pharmacies, among others. Relative to Medicare policy, these interest groups are less involved in VA policy. This suggests a practical approach to reducing the cost of providing a prescription drug benefit. A drug program that is more directly under the VA's purview but that builds on the financing structure of the new drug-only Medicare plans may not immediately arouse the kind of effective interest group opposition that typically restricts the options of Congress with respect to Medicare. Moreover, a drug program of this kind is likely to receive the combined support of Medicare and VA beneficiary advocacy groups, which increases the political cost to opposition relative to policy proposals that receive the support of only one or the other of these groups. We develop this idea in more detail and show that a combination of VA and Medicare could achieve improved access and lower costs for some Medicare-enrolled veterans.

In particular, a VA-Medicare prescription drug plan (PDP) could be made available to certain Medicare-enrolled veterans. Such a plan has the potential to provide a rich drug benefit to a large number of beneficiaries. Of the 43 million Medicare beneficiaries, about 10 million are also veterans. While about 3 million Medicare-eligible veterans already receive drug and nondrug benefits from the VA, the rest do not (Congressional Budget Office 2001).[5] A VA-Medicare PDP would be another prescription drug coverage option for these beneficiaries, one that likely would be more comprehensive and less costly than any other available to them.

The VA-Medicare PDP we discuss in this article would offer advantages to both programs and beneficiaries. Much as Medicare currently subsidizes private drug plans (whether employer offered or individually purchased), Medicare could subsidize the VA-Medicare PDP on a per-beneficiary basis. These funds would permit the VA to broaden the numbers and types of

5. The 3 million Medicare-eligible veterans who receive VA care in a given year represent 60 percent of all 5 million veterans (Medicare eligible and otherwise) who do so.

veterans it serves. Since the VA receives steeper discounts for prescription drugs than Medicare drug plans do, the per-beneficiary subsidy could be set lower than for private plans, producing savings to Medicare.

A VA-Medicare PDP would not be implemented without challenges, which we acknowledge and explore. First, we discuss the relationship between regulation and interest groups in Medicare and VA policy. Then we provide some necessary background on the VA and past efforts to integrate VA benefits with Medicare. Next, after analyzing how a VA-Medicare PDP could work, we investigate implementation issues. In the conclusion we focus on some of the more significant challenges that make prospects for this kind of integration uncertain.

The Roles of Regulation and Interest Groups in Medicare and VA Policy

The notion that government regulations on industry sometimes arise because of the advocacy of the regulated dates at least to the work of Stigler (1971), drawing on earlier work by Olson (1965). Stigler argued that, relative to the general public, groups of businesses potentially affected by regulation would be more intensely interested in regulatory outcomes and would more easily organize effective collective action to influence regulators. Among their goals would be government-created barriers to entry to keep out potential competitors and government-sanctioned price-fixing to reduce competition among established firms. Becker (1983, 1985) added to these ideas by suggesting that interest groups invest in "pressure" on regulators, allocating their limited resources across potential investments to achieve optimal returns. Laffont and Tirole (1991, 1993) added information asymmetries and an agency framework to develop formal models of regulatory capture and cartelization by regulation.[6]

These ideas suggest that differences between the VA and Medicare drug benefits may be rooted in differences in the degree of interest group involvement, differences in the interest groups themselves, and the potential returns to investment in advocacy. One distinction between Medicare and the VA is that the former has prominently and integrally involved private, for-profit entities in providing health benefits and services, while the latter has not.

6. The term *regulatory capture* means something different in the political science literature than in the economics literature from which we draw. Here it refers broadly to all government activity in an area of interest to business, encompassing the actions of legislatures as well as regulatory agencies.

Indeed, the structure of the new Medicare drug benefit, the first Medicare benefit to be *exclusively* provided to *all* beneficiaries through private plans, reflects the market-based approach preferred by the Republican administration and Congress that enacted the authorizing legislation. As a consequence, a great deal of government activity exists to manage and oversee the private components of Medicare, not least of which is its drug benefit. Consistent with the work of Leech et al. (2005), this government activity draws the attention of groups with obvious financial interests in decisions in this arena. As pointed out by Baumgartner and Leech (2001), issues that involve more money and affect more people attract more attention. In particular, groups interested in lobbying in this area of Medicare policy are mainly businesses and trade associations. Such groups organize around a policy issue more easily than the types of groups that are interested in VA issues, that is, nonprofits and citizen groups.

Evidence of industry interest in and influence over Medicare drug policy is abundant; the same cannot be said with respect to VA drug policy. The Pharmaceutical Research and Manufacturers of America (PhRMA) has been vocal on Medicare prescription drug issues and relatively silent on VA prescription drug issues. PhRMA's 2007 midyear lobbying disclosure form indicates that the group lobbied on issues related to Medicare, patent reform, trade, and safety, but not on VA issues (Associated Press 2007). PhRMA also played a major role in influencing key provisions of the MMA: no federal negotiation of drug prices, no cost control measures, and no legal drug reimportation (Connolly 2003; Harris 2003; Oliver, Lee, and Lipton 2004; Barlett and Steele 2004). Drug companies fought a "huge battle" against insurance companies over Part D formulary regulations (Pear 2004). Community pharmacies, perceiving a threat from mail-order pharmacies, lobbied for some protective provisions in the MMA, such as community pharmacy access rules (Frederick 2004; Kaiser Family Foundation 2004).

Other interest groups and political forces also shaped the MMA, as has been thoroughly documented elsewhere (Oberlander 2007 and references therein). Beneficiary advocacy, most notably in the form of AARP's engagement with Congress and its ultimate endorsement of the legislation, played a decisive role. AARP is credited with influencing (upward) the amount of subsidy for employers who maintain retiree drug coverage and the level of assistance to low-income beneficiaries, as well as helping convince Republican leadership to limit direct competition between traditional Medicare and private plans to a future demonstration (Iglehart 2004).

Different beneficiary interest groups are deeply engaged in influencing VA and Medicare policy. While veteran service organizations (VSOs) are

not monolithic, they tend to be aligned in an interest in expanding *access* to VA services (see, e.g., Jones 2007; Middleton 2007). Expanding VA access is generally achieved either by permitting the enrollment of lower-priority veterans (e.g., allowing veterans who do not currently qualify because of low income or service-connected disability to enroll) or by adjusting the definitions of priority groups (e.g., by considering a new condition "service connected"). Meanwhile, Medicare beneficiaries are represented by advocacy organizations, including AARP, that tend to focus on improving and expanding Medicare *benefits*. This is natural because, in contrast to VA benefits, access to Medicare benefits has relatively fewer barriers. The addition of a drug benefit under Medicare is, of course, one recent expansion. Another well-documented and large expansion was of home health benefits in the early to mid-1990s, subsequently contracted after the Balanced Budget Act of 1997 (Komisar 2002; McCall et al. 2003).

Returns to advocacy investment may explain why some interest groups invest more in influencing Medicare policy than in VA policy (Becker 1983, 1985). Each program — Medicare and the VA — is under the purview of different congressional committees: principally the House and Senate Veterans' Affairs Committees for the VA and the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor and Pensions for Medicare, though other committees also play important authorization and appropriation roles. Therefore, advocacy groups who lobby on Medicare policy would have to make an additional sizable investment to influence VA policy, and the size of investment in advocacy for major policy change is likely similar for the two programs. That investment would involve cultivating new committee contacts and working with new beneficiary groups. Thus the cost of advocacy is likely not commensurate with the number of beneficiaries affected. That is, the size of the Medicare population relative to the VA patient population makes lobbying on Medicare issues more cost-efficient than doing so on VA issues.

Finally, the historical composition of party coalitions might reinforce some of the differences between the VA and Medicare. Specifically, Medicare and the VA provide services to beneficiaries with historically different party affiliations. In the past, senior citizens have been considered part of the Democratic coalition and veterans part of the Republican coalition (Stolberg 2003; Teigen 2007). The Republican coalition also includes business groups and, in particular, pharmaceutical manufacturers. If the spoils of political victory go to coalition interests, then it is not surprising that the MMA has provisions clearly favorable to pharmaceutical manufacturers and arguably less so than it might otherwise for Medicare beneficiaries

(Pierson 1993). That the Republican coalition includes both veterans and pharmaceutical manufacturers may in part explain why VA policy is not as favorable to pharmaceutical manufacturers as compared with Medicare policy.

While peripheral elements of Medicare policy (with respect to drugs and otherwise) will no doubt evolve, significant movement in the positions of major interest groups with respect to the structure of the drug benefit is less likely. Therefore, without an exogenous shock, major elements of the Medicare drug benefit (e.g., price negotiation, formulary requirements, community pharmacy access) are unlikely to change. The idea that policy inherits the robustness of the coalition of interest groups that support it has been developed by others (Sabatier and Jenkins-Smith 1999). In this context it implies that the differences between Medicare and the VA with respect to drug price negotiation, formulary generosity, community pharmacy access, and other major components of their drug benefits ought to be stable over time.

Given these constraints, what could be done to reduce drug prices for Medicare beneficiaries? The foregoing analysis suggests that a proposed initiative to reduce drug prices would be more likely to succeed the less it is administered through Medicare because of the intense involvement in Medicare policy of interest groups that favor higher prices. Clearly the smaller the initiative (the fewer beneficiaries receiving lower prices), the less likely it will attract strong opposition. Additionally, a program that gains the support of multiple types of beneficiary interest groups has greater chances of political success. Moreover, the current political climate is very supportive of veterans, a popular group with the public and both political parties. Finally, for practical reasons, taking advantage of existing administrative structures improves the chances of successful implementation. One possibility that seems to satisfy these criteria is a VA-administered pharmacy benefit, partially financed by Medicare, provided to certain Medicare-enrolled veterans. Such a program might initially avoid intense opposition from manufacturers and pharmacies because it would not be administered by Medicare and could be relatively small (at least initially). It might gain the support of both Medicare and VA beneficiaries because it could be viewed as both an expansion of VA access and an improvement in Medicare benefits (for a certain eligible subpopulation). Finally, it would benefit from VA administrative structure, streamlining implementation. We elaborate below on what such a partnership might look like and describe some of the substantial obstacles it would face. Before that, however, we

cover some background about the VA health care system and prior efforts to integrate VA and Medicare.

Background

The VA Health Care System and Pharmacy Benefit

The VA offers a comprehensive medical benefit to veterans through the largest integrated health care delivery system in the United States. Almost 8 million veterans are enrolled in the VA, and over 5 million of them receive VA care annually (U.S. Department of Veterans Affairs 2006a).[7] Veterans seeking VA care are assigned a priority status based on service-connected disability, income, and other special considerations (e.g., POW status, exposure to herbicides in Vietnam or radiation in Japan). Priority status determines cost-sharing requirements and can affect access to care. For example, because of capacity constraints at VA medical centers, as of January 17, 2003, the VA suspended new enrollment of veterans in the lowest priority category.[8]

The VA medical benefit includes an outpatient prescription drug benefit that has lower out-of-pocket costs than can be obtained through individually purchased Medicare private plans. Recent evidence also suggests that the VA pharmacy benefit is associated with higher levels of medication adherence, relative to Medicare PDPs (Neuman et al. 2007). For a modest co-payment — at most $8 (in 2007) and waived for high-priority patients — VA pharmacies fill prescriptions written by VA doctors. Prescriptions from non-VA doctors are not filled by VA pharmacies. The benefit has no deductible, no cap, and no gap (or "donut hole") (U.S. Department of Veterans Affairs 2006b).

The VA prescription drug benefit is subject to a national formulary. In addition, each of the VA's twenty-one regions (or Veterans Integrated Service Networks [VISNs]) has its own formulary. By policy, regional formularies may differ from the national one only by including additional drugs

7. Enrollees are those who have signed up to receive VA benefits but have not necessarily done so in a particular year.

8. The VA has eight priority groups, some of which have subgroups. Veterans in the lowest priority group (priority 8) became ineligible for VA health benefits in 2003. Priority 8 veterans who had already enrolled for VA care were permitted to remain enrolled (U.S. Department of Veterans Affairs 2003).

in any class not designated as *closed*, though at least one study has found regional formularies that omit drugs on the national list (GAO 2001). In addition to four closed classes, the national formulary has two classes designated as *preferred*, which means they include drugs whose use is encouraged over others.[9] The remaining *open* classes have no restrictions. Finally, VA patients have access to nonformulary drugs through a waiver process and with the same cost sharing as formulary drugs (Sales et al. 2005). The VA's formulary policies are effective in driving prescribing patterns, achieving substantial price reductions from manufacturers, and dramatically decreasing drug spending (Huskamp et al. 2003).

It has been argued that the VA's formulary is more restrictive than those of Medicare drug plans, each of which has its own formulary (Yong 2007; Galen Institute 2007). Unlike the VA, Medicare drug plan formularies have inclusion requirements. In particular, they must include "all or substantially all" drugs in six categories,[10] making these categories open classes (CMS 2005a, 2005b). Such open class requirements weaken the bargaining position of Part D plans with respect to drug manufacturers (McAdams and Schwarz 2007).

Another difference between the VA and Medicare is the way prescriptions are filled. While Medicare prescriptions can be filled at neighborhood retail pharmacies, most VA prescriptions are filled by VA-run Consolidated Mail Outpatient Pharmacies (CMOPs) and delivered to patients by mail. In total, VA's seven CMOPs filled nearly 100 million prescriptions in 2006.

In summary, the VA prescription drug benefit is different from Medicare's. It has lower beneficiary cost sharing and is associated with higher rates of adherence than Medicare plans, but it comes with some additional constraints. For some drug classes and compared with some Medicare drug plans, its formulary is more restrictive. It also relies heavily on mail-order prescription fills with no community pharmacy network. Whether these differences make the VA benefit attractive to a given beneficiary depends on his or her price sensitivity, specific drug needs, and prescription filling preferences, among other things.

9. As of 2000, the closed classes were angiotensin-converting enzyme inhibitors, HMG-CoA reductase inhibitors, luteinizing hormone-releasing hormone agonists, and proton pump inhibitors; the preferred classes were alpha blockers and calcium channel blockers (Huskamp et al. 2003).

10. The six categories that must include "all or substantially all" drugs are antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant, and HIV/AIDS (McAdams and Schwarz 2007).

Prior Efforts to Integrate the VA and Medicare

The general idea of integrating the VA and Medicare (aka VA/Medicare subvention) is not new. Legislation that would have authorized Medicare to pay the VA for care of dual VA-Medicare beneficiaries has been introduced in nearly every congressional session since 1990.[11] None has become law. Under a three-year pilot program advocated by former VA Undersecretary for Health Kenneth Kizer in 1999, the VA would have offered a managed care plan to low-priority dual VA-Medicare beneficiaries. The VA would have received the Medicare Advantage capitated payment for enrollees in its plan, but only after it had expended the level of effort provided to low-priority veterans in the past. To further protect Medicare's trust fund, total annual liability to Medicare would have been capped at $50 million.

More recently, in 2003, former VA Secretary Anthony Principi formed a group to study a VA-Medicare HMO under the Medicare Advantage program (U.S. Department of Veterans Affairs 2003). This VA Advantage plan was to be offered to low-priority Medicare-enrolled veterans who were not yet enrolled in the VA. The VA was to receive the Medicare Advantage capitated payment for its enrollees and provide comprehensive care through the VA health care system. The VA Advantage effort concluded in 2004 when its chief champion, Secretary Principi, left the government. Legislation drafted by the study group would have authorized a pilot VA Advantage plan in the form of an employer-sponsored Medicare Advantage HMO.

One of the many complexities associated with VA/Medicare subvention is the provision of comprehensive VA benefits to a potentially large number of new beneficiaries. These beneficiaries would not necessarily live near VA facilities, and VA facilities would not necessarily have the capacity to address all the health care needs of enrollees. Relative to integrating the VA and Medicare to provide comprehensive benefits, doing so just for *one* benefit — outpatient prescription drugs — is simpler, though it still has significant challenges.

A VA drug-only benefit for Medicare-enrolled veterans has been proposed in the past. In the 109th Congress, Senator Arlen Specter (R-PA) and

11. Such legislation was introduced by senators Paul Wellstone (S 1786, introduced May 21, 1996), James Jeffords (S 2054, introduced May 8, 1998), and John Thune (S 963, introduced April 28, 2005) and by representatives Jim Bates (HR 5463, introduced August 3, 1990), Randy Duke (HR 1778, introduced April 21, 1993), Bob Stump (HR 4068, introduced September 12, 1996), Jim Saxton (HR 1191, introduced May 17, 2001), and Sue Kelly (HR 4992, introduced March 16, 2006), among others.

Representative Scott Garrett (R-NJ) introduced bills calling for the establishment of an outpatient prescription drug benefit furnished by the VA to any Medicare-enrolled veteran.[12] Both bills would have required that the VA fill prescriptions written by any physician and that the benefit be budget neutral. All costs were to be covered by enrollee premiums and co-payments with no costs covered by Medicare. At the close of the 109th Congress both bills were in committee.

There are common reasons why past VA/Medicare subvention proposals have not been implemented. During our research we spoke with current and former Medicare administrators, VA management, and Congressional Budget Office staff. Information from these sources was consistent and indicated that the principal reason for failure of VA/Medicare subvention proposals was budgetary, though there were other reasons as well. Past proposals to shift money from Medicare to the VA were intended to be budget neutral overall. In some cases, there was some possibility that reform would have resulted in a net loss to Medicare (with, perhaps, a net gain for the VA). This raised the concern that any such subvention would put additional strain on an already fragile Medicare budget. More generally, our interviewees indicated that policy makers were (and still are) predisposed to be wary of mixing Medicare and VA funding, that doing so would set a worrisome precedent in their minds and would raise concerns (whether warranted or not) about losing control of Medicare spending. Simply put, Congress is resistant to mixing funding streams for no net savings and with a perception of risk to Medicare. A common notion expressed by our contacts was that if the VA needed additional funding for its operations it should go directly to Congress and not siphon funds from Medicare.

Beyond financial considerations, there were other factors that dampened enthusiasm for subvention. Several were on the VA side. Were the VA to receive Medicare payment it would have to meet all Medicare criteria for reporting, accounting, access, and other regulations or would require a waiver granted by an act of Congress. Either approach is a high hurdle for the VA. Meeting all Medicare requirements is challenging for any provider or insurer and would require substantial investment and changes in accounting and reporting practices. Shepherding legislation through Congress also requires substantial skill, patience, and commitment. Finally, there is an issue as to the fairness of competition between the VA and private Medicare

12. The bills were the Veterans Prescription Drugs Assistance Act (S 614, introduced June 9, 2005) and the Improving Medication Access for Veterans Act (HR 6282, introduced September 29, 2006).

plans and providers for beneficiaries. Concerns among insurers and providers about additional competition from the VA may have played a role in blocking progress on integration efforts.

Many of the factors that reduced policy makers' enthusiasm for VA/Medicare subvention do not apply in the case of a VA-Medicare PDP. Such a program could save money overall and, more important, could do so on the Medicare side. Reporting and accounting issues are dramatically reduced when considering a drug-only benefit as compared with a benefit that provides comprehensive coverage, simplifying the investment the VA would need to make to satisfy Medicare reporting requirements. Still, a VA-Medicare PDP would involve mixing Medicare and VA funding and would represent competition to private Medicare plans and providers, points we return to in subsequent sections.

A VA-Medicare PDP

In what follows, we discuss a new, hypothetical partnership between the VA and Medicare: a VA-Medicare PDP that offers VA-purchased and -distributed pharmaceuticals through a partially Medicare-financed drug-only benefit made available to certain Medicare-enrolled veterans. We believe this concept could appeal to both VA and Medicare stakeholders because it extends coverage and reduces government spending; it could be financially viable because it builds on features of the stand-alone prescription drug plans now available under the new Medicare Part D program; and it could be administratively feasible because most of the organizational structures that would be needed already exist. Most important, though, we believe some version of this idea could be politically practical because it builds on operations that have been tolerated by interest groups representing drug manufacturers and pharmacies and because it could start on a small scale.

Beneficiaries who enrolled in a VA-Medicare PDP would rely on traditional fee-for-service Medicare and not the VA for nondrug services. The VA-Medicare PDP would fill prescriptions written by *any* doctor, not just VA physicians. In turn, the VA would receive a capitated payment or subsidy from Medicare for VA-Medicare PDP enrollees, just as other Medicare drug plans do. But, because the VA purchases drugs more cheaply than Medicare drug plans, the subsidy could be set lower than the standard Medicare drug-plan subsidy. Thus a drug benefit provided through a VA-Medicare PDP would be cheaper to Medicare than a Medicare drug plan.

The subpopulation of Medicare-enrolled veterans eligible for the VA-

Medicare PDP could include, at a minimum, low-priority Medicare-enrolled veterans not currently permitted to enroll in the VA. Veterans in Medicare currently enrolled in the VA or of high enough priority to be permitted to enroll would remain eligible to receive comprehensive VA benefits. These were the eligibility rules considered for VA Advantage (as described above). In what follows, we also consider two possible alternatives: (1) Medicare-enrolled veterans of any priority not currently enrolled in the VA, and (2) any Medicare-enrolled veteran whether currently enrolled in the VA or not.

We note that if enrollment were expanded to include either of these latter two eligibility groups, this could lead to a dramatic change in the way the VA serves high-priority veterans. In turn this would have significant implications for the VA's structure and role. Currently, some veterans receive care at the VA to obtain prescription drugs through the VA system (prescriptions are given and filled only for patients who first see VA doctors). If a VA drug-only benefit were available, those patients may choose to stop using the VA for all but pharmacy services. That is, if they were only seeing VA doctors to obtain VA drug fills, then a drug-only benefit would obviate their need to see VA doctors for that purpose. If large numbers of current patients were to cease using the VA for anything but pharmacy benefits, significant changes to the VA's budget and workforce would follow. A large downward shift in patient volume for nonpharmacy benefits might therefore be seen as a threat by some within the VA. On the other hand, if eligibility is limited to veterans who cannot currently receive VA benefits, then this can only represent a possible expansion of the numbers and types of veterans the VA serves. Since this is consistent with the VA's self-image and mission, it may be more attractive to VA policy makers.

Implementation Issues

There are many details to be worked out in implementing the VA-Medicare PDP just described, far too many to be thoroughly addressed in this article. In what follows, we consider some of the main implementation issues. Some other issues critical to the program are not explored in depth. In particular, numerous statutory and regulatory changes would be required to implement this kind of partnership. For instance, the VA does not have the authority to operate a Medicare Part D plan or to receive funds to provide services for veterans who would not otherwise receive them, among others.

Finally, in what follows we assume that the VA will continue to negoti-

ate the same volume discounts currently received. This assumption will be revisited in the concluding discussion.

Cost

The cost of a VA-Medicare PDP would be borne by three payers: Medicare, the VA, and enrollees. In this section we estimate the cost of a VA-Medicare PDP, compare it with the cost of a Medicare PDP, and describe how it could be shared among these payers. Our methodology for estimating cost is based on our own prior work (Frakt and Pizer 2006; Nugent et al. 2004), recent studies that compare VA and Medicare plan drug costs (Families USA 2007; Sikora and Schiavone 2006; Shearer 2007), and one simplifying assumption. We emphasize that by "cost" we mean cost borne by those financing the benefit (Medicare, the VA, and enrollees), not cost to the provider for implementation. That is, our interest is in cost to the taxpayer and the beneficiary.

First we describe the cost of a Medicare PDP. Medicare subsidizes all Medicare PDPs with a capitated payment set at 74.5 percent of an average premium, computed based on a weighted average of plan bids for the statutory minimum drug benefit (Kaiser Family Foundation 2004). Except in the case of low income or dual eligibility,[13] the beneficiary pays the remaining 25.5 percent of premium. In 2006 the average monthly out-of-pocket (OOP) premium for such coverage was about $30 (Frakt and Pizer 2006). Therefore the Medicare subsidy was about $90 per enrollee per month, for an average risk beneficiary (the amount may differ for a specific beneficiary because of risk adjustment).

In 2006 the statutory minimum drug benefit had a $250 deductible, 25 percent co-insurance up to $2,250 in total drug costs, 100 percent co-insurance (i.e., no coverage) from $2,250 to $5,100 in total drug costs (the "gap" or "donut hole"), and 5 percent co-insurance above $5,100 in total drug costs (the catastrophic coverage range) (Kaiser Family Foundation 2004). The OOP cost to the beneficiary depends on utilization. A beneficiary with statutory minimum coverage who reaches catastrophic coverage (i.e., has $5,100 in total drug costs) has spent $3,600 OOP in addition to the monthly $30 premium.

However, a beneficiary may purchase coverage that is richer than the

13. Certain low-income beneficiaries and those dually eligible for Medicaid or receiving Supplemental Security Income qualify for full or partial premium subsidies and reduced cost sharing.

statutory minimum. Doing so will not change the Medicare subsidy. It would still be $90 per month, on average. But it would change the beneficiary's premium and cost sharing. For example, a beneficiary who selected the Humana PDP Complete plan in 2006, the only national plan to cover brand-name drugs in the gap in that year, would have paid an average of $60 per month in premium (premiums vary regionally) with no deductible. Because its cost sharing is most similar to the VA's (brand gap coverage, no deductible), we use the 2006 Humana PDP Complete plan to help us illustrate how savings from a VA-Medicare PDP could be shared among payers. Cost sharing under Humana PDP Complete in 2006 varied with type of drug purchased and was never higher than 25 percent. Therefore, a Humana PDP Complete enrollee with $5,100 in total drug spending spent up to $1,275 OOP (depending on which drugs were purchased), in addition to the $60 monthly premium.

The VA-Medicare PDP we consider is similar to Humana PDP Complete in that it would not have a coverage gap. The most important difference, with respect to cost, between a VA-Medicare PDP and Humana PDP Complete is that the VA purchases drugs at a greater discount. VA drug prices have been estimated to be between 56 and 63 percent of those paid by Medicare, depending on methodology (Families USA 2007; Sikora and Schiavone 2006; Shearer 2007; Nugent et al. 2004). As an example of the type of cost-sharing arrangements that would be possible, in what follows we use a discount of 40 percent, that is, we assume VA drug prices are 60 percent of those paid by Medicare plans (our qualitative conclusions are robust to this assumption). If we make the additional simplifying assumption that this discount applies to all costs, not just the price of drugs, then we can apply this discount to Humana's Medicare-financed subsidy, premium, and cost sharing to estimate the cost of a VA-Medicare PDP. Doing so implies that a VA-Medicare PDP in 2006 would have cost Medicare $54 a month in premium subsidy (down from $90 for a Medicare PDP). To remain budget neutral to the VA it could have charged a monthly premium of $36 (down from $60 for Humana PDP Complete) with maximum cost sharing of 15 percent (down from a maximum of 25 percent for Humana PDP Complete). This represents a savings to Medicare and to the beneficiary with no additional cost to the VA, relative to what it would have cost for that beneficiary to enroll in Humana PDP Complete. Looked at another way, for only 20 percent more in premium relative to a statutory minimum plan ($36 vs. $30), the VA-Medicare PDP enrollee would have received coverage with cost sharing lower than the statutory minimum (no deductible, 15 percent co-insurance, and gap coverage vs. $250 deductible, 25 percent co-insurance, and no gap coverage).

The distribution of cost among payers illustrated above is not the only possibility. Were Congress to increase the VA's budget it could fund more of the cost, leaving less for Medicare and the beneficiary to fund. Or, if the savings to Medicare were to be shared with the VA (i.e., Medicare pays more than 60 percent of the customary subsidy but still less than 100 percent), then, again, beneficiary cost sharing could be reduced.

Finally, we note that actual costs will be a function of beneficiary utilization (i.e., risk). Were the VA-Medicare PDP to experience selection more adverse than that expected for Humana PDP Complete (i.e., enroll more high-risk patients), then costs would be higher. In our prior work we predict and discuss the degree of adverse selection expected for Humana PDP Complete (Pizer, Frakt, and Feldman 2008). Perhaps it was Humana PDP Complete's selection experience in 2006 that led to increased premiums and withdrawal of brand-name drug coverage in the gap for the product in 2007. Note that to the extent adverse selection is mitigated by risk adjustment (Pope et al. 2004) our conclusions do not change. If risk adjustment insufficiently accounts for the difference in selection between a VA-Medicare PDP and Humana PDP Complete, however, then there could be cost beyond that estimated here to be covered by one or several of the payers.

Take-Up

The number of veterans who could be eligible for a VA-Medicare PDP depends on eligibility rules. First, consider the proposed VA Advantage eligibility rules whereby only nonenrolled low-priority veterans would be eligible. We estimate the number eligible under these rules using 2000 U.S. Census data, that is, we estimate the number that would have been eligible in the year 2000 had a VA-Medicare PDP been offered in that year. The 2000 U.S. Census data include 10 million elderly veterans (see fig. 1). Of these, we estimate that about 6 million had a priority status that would have permitted access to the VA (see fig. 1, left panel).[14] These 6 million individuals, therefore, would not have been eligible for a VA-Medicare PDP under hypothetical VA Advantage eligibility rules. Consequently, about 4 million elderly veterans (about 10 percent of the Medicare population) would have been eligible to enroll in a VA-Medicare

14. That is, there were 6 million Medicare-enrolled, elderly veterans who would have been eligible for VA enrollment in 2000 because of high-priority status. Some of these veterans had already enrolled in the VA (and, of those, some were patients, i.e., they received care), and some were not. This figure of 6 million is not easily compared with the other numbers of veterans, VA enrollees, or VA patients given earlier in the text because of the added criterion of high-priority status.

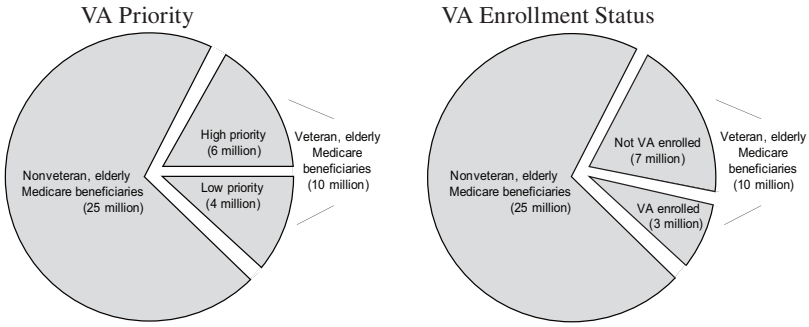

Figure 1 Elderly Medicare Beneficiaries[(a)] in 2003 by Veterans Status and VA Priority[(b)] and VA Enrollment Status. *Sources*: Authors' analysis of 2000 Census Data; United States Census Bureau (2007); United States Congressional Budget Office (2001).

(a) There were 41 million Medicare beneficiaries in 2003. These figures illustrate the 35 million of them who were elderly.
(b) Priority status imputed by authors using 2000 Census data. Low-priority veterans are those with priority status eight. High-priority veterans are those with any priority status number below eight.

PDP if it had been offered in 2000. If all 4 million enrolled, the population served annually by the VA would roughly double.

Next, consider the two possible eligibility expansions described previously. The first is to permit access to nonenrolled veterans of any priority. This would bring the number of eligible individuals up to about 7 million (see fig. 1, right panel). The second expansion would permit access to any Medicare-enrolled veteran, bringing the number of eligibles up to about 10 million. Therefore, depending on eligibility rules, a minimum of 4 million and a maximum of 10 million veterans would have access to a VA-Medicare PDP. Of course one could consider other, more restrictive eligibility rules to limit enrollment. Except where indicated below, for the remainder of this article we consider the VA Advantage eligibility criteria under which the 4 million nonenrolled low-priority veterans would be eligible.

The proportion of eligible individuals who would actually enroll depends on a variety of factors. Some of those eligible already have employer-provided prescription drug coverage, and, of those, some would choose to retain it if it continued to be offered.[15] Some might prefer comprehensive coverage through a Medicare Advantage plan with drug and nondrug bene-

15. The future of employer-sponsored prescription drug coverage for retirees is uncertain (Kaiser Family Foundation 2006).

fits; others might elect to be uncovered for prescription drugs. (Note that under the most restrictive eligibility criteria described above, none of the 4 million potential enrollees is Medicaid eligible. Medicaid eligibility is a sufficient condition for high-priority VA status, and high-priority veterans would not be eligible for the VA-Medicare PDP.)

We can obtain a rough estimate of the number of VA-Medicare PDP enrollees by examining PDP enrollment in the broader Medicare population. According to CMS statistics, about one-quarter of Medicare beneficiaries had enrolled in a PDP as of June 2006. This is, perhaps, an underestimate of the proportion of eligible individuals who might enroll in a VA-Medicare PDP, since it includes beneficiaries who receive automatic or facilitated enrollment. Such auto enrollment or facilitated enrollment occurs for certain beneficiaries with low incomes, eligibility for Medicaid, or Supplemental Security Income. Excluding the auto- and facilitated-enrolled, nearly 30 percent of Medicare beneficiaries had enrolled in a PDP as of June 2006 (HHS 2006). Therefore, all other things being equal, perhaps as many as 30 percent of the 4 million eligible for a VA-Medicare PDP would enroll, or 1.2 million. This represents about 25 percent of the population served annually by the VA. Using this 1.2 million enrollment estimate and the cost savings estimate from the previous section, a VA-Medicare PDP would cost Medicare about $518 million per year less than a Medicare PDP. Of course the number of enrollees and the Medicare savings would be higher under either of the less-restrictive eligibility criteria described above.

This enrollment estimate does not account for the many differences between veterans and the broader Medicare population or between a VA-Medicare PDP and other Medicare PDPs. For instance, the VA-Medicare PDP benefit would have lower cost sharing and therefore would be more attractive than a Medicare PDP to some beneficiaries. On the other hand, it would have a restrictive formulary and rely on mail-order prescription fills, features that may be unattractive to some beneficiaries. Additionally, despite great strides in quality and performance, some veterans' perceptions of the VA are negatively influenced by its poor reputation of decades ago (Harvard University 2006; CBS Evening News 2006; Gaul 2005). This makes any plan associated with the VA a less-attractive choice for some veterans. Finally, the value of a plan to a beneficiary is relative to his or her other available options. So the relation of VA-Medicare PDP features to other drug plan designs in a beneficiary's market will also play a significant role in his or her enrollment decision.

Operational Capability and Capacity

There are two main operational issues associated with implementing a VA-Medicare PDP: managing the benefit and filling prescriptions from non-VA doctors. The VA-Medicare PDP benefit would differ from current VA benefits and, thus, would require a type of management new to the VA. At a gross level, VA-Medicare PDP beneficiaries would have a different VA benefit than other VA enrollees, one that includes only outpatient prescription drug coverage. At a fine level, the VA-Medicare PDP formulary could differ from any of the current national or regional VA formularies. A formulary difference might arise, for example, if the VA-Medicare PDP were required to adhere to some or all of the formulary requirements that are imposed on other Part D plans. (VA formulary modifications raise a significant issue with respect to price negotiation, one that is revisited in the conclusion.)

Because VA-Medicare PDP enrollees would have a benefit different from the current VA benefit, the VA would need the capability to determine if a given individual was qualified for coverage for a specific drug. This capability would require either new information technology infrastructure or contracting with a benefits management organization.

New information technology is also needed to accept prescriptions from non-VA doctors. Currently, VA doctors communicate with CMOPs electronically, mediated through VA medical center and outpatient clinic pharmacy operations. To accept non-VA prescriptions would require new software, both for non-VA physicians and for the VA. In addition, a procedure would be needed to validate the credentials of any doctor submitting a prescription.

Fortunately, there are models for these functions. Retail pharmacies accept and validate prescriptions from doctors at a wide range of institutions. Within the VA there is a program that already has the capabilities required: the Meds by Mail (MbM) program for beneficiaries of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA is administered by the VA and provides a comprehensive health care benefit to spouses and children of veterans with service-connected disabilities or who died because of service-connected disabilities. MbM differs from the standard VA pharmacy benefit in that it can accept prescriptions written by private, non-VA physicians. Prescriptions are submitted electronically and filled at one of the VA's CMOPs. Under MbM, over 500,000 prescriptions are distributed annually to the approximately 217,000 CHAMPVA beneficiaries.

The infrastructure of MbM could also help solve the problem of capacity. Suppose, as estimated in the previous section, approximately 1.2 million veterans chose to enroll in a VA-Medicare PDP. Would the VA have capacity to serve them? One way the VA might fill VA-Medicare PDP enrollee prescriptions from non-VA doctors is by using the infrastructure of the MbM program.[16] The MbM program would have to undergo something like a fivefold expansion to serve 1.2 million additional patients. Expansion of this size is possible and has been considered in the past. For example, the Department of Defense (DoD) has considered partnering with the VA to use the MbM infrastructure to serve its 6 million health care beneficiaries. A one-year pilot study of the concept showed that the DoD could provide its prescription drug benefit at lower cost through such a partnership (U.S. Government Accountability Office 2005). Additionally, the VA's CMOPs already have the capacity for a large expansion in service. Recent infrastructure enhancement projects at three CMOP locations (Tuscon, Arizona; Dallas, Texas; and Chelmsford, Massachusetts) have increased capacity and could serve an additional 1.5 million patients (Stroup 2007).

Discussion

Providing outpatient prescription drug coverage for Medicare beneficiaries continues to be an important economic, social, and political topic. Debate is ongoing over how Medicare Part D could or should evolve to better meet the needs of beneficiaries and conform to budget constraints. The VA is frequently raised as a model in this debate because of the low drug prices it obtains from manufacturers and the low out-of-pocket cost of the drug benefit it offers its patients. On the other hand, the VA is criticized as a poor model for the Medicare program because of the limited choice of drugs and pharmacies it offers.

In this article we have argued that the basic structure of the Medicare drug benefit would be politically difficult to change. Our argument is based on apparently entrenched interest group positions on key provisions, not least of which are formulary design, the prohibition on direct Medicare negotiation with pharmaceutical manufacturers, and community pharmacy access requirements. This led to a potentially more feasible idea: a partnership between Medicare and the VA that could provide access to the VA drug

16. In addition to greater capacity for distribution of pharmaceuticals by mail, a VA-Medicare PDP would need some mechanism for rapid dispensing of medications for acute-care needs (e.g., partnerships with some network of retail pharmacies).

benefit to a large number of Medicare-enrolled veterans who do not currently have it. The benefit would be partly funded through a capitated Medicare subsidy. But, because the VA purchases drugs more cheaply than Medicare drug plans, the subsidy could be set lower than the standard Medicare drug plan subsidy. Thus providing a drug benefit through a VA-Medicare PDP would be cheaper to Medicare than a Medicare drug plan. Depending on how costs were shared among Medicare, the VA, and beneficiaries, the plan could produce savings for Medicare, be budget neutral with respect to the VA, and be cheaper for beneficiaries than comparable Medicare plans. This VA-Medicare PDP would be an additional option for eligible beneficiaries. Therefore, beneficiaries who find the features of the VA benefit attractive could voluntarily enroll, and those who did not could obtain coverage through another Medicare plan.[17]

While the steady-state cost of a VA-Medicare PDP may be lower than that of a comparable Medicare PDP, there are start-up costs and potential expenditure offsets to consider. To implement a PDP the VA would need to augment its infrastructure for tracking patients, accepting prescriptions from non-VA physicians, and filling those prescriptions, among other things. As described in this article, the VA has some experience with these functions through existing programs but not for the purposes of a Medicare PDP and not for the additional volume of patients we predict would enroll. So some investment in infrastructure and systems would be required initially. There is also the potential that drug costs to a VA-Medicare PDP could be larger than we have estimated. One way the VA keeps drug costs low now is that its drug benefit is part of a comprehensive health program. Veterans cannot currently receive drugs from the VA without also seeing VA physicians. It is possible that if the VA paid for drugs prescribed by non-VA physicians and if those non-VA physicians did not provide the same kind of comprehensive care that those patients might have received at the VA, then drug costs for the VA may be larger than expected based on past experience.

One thing is certain: central to the success of a VA-Medicare PDP is that the VA continues to receive steep discounts from drug manufacturers while providing its drug benefit to more patients. A necessary condition for the VA to retain its drug-pricing leverage is that it not be subject to the same open class requirements that govern current Medicare Part D plan formu-

17. Unlike some voluntary plan types in Medicare (e.g., medical savings accounts), a VA-Medicare PDP probably would not attract disproportionately healthy enrollees. On the contrary, a plan of this type would probably experience adverse selection and would consequently reduce average costs in other plan types (Pizer, Frakt, and Feldman 2008).

laries. As was raised in the recent debate over the Medicare Prescription Drug Price Negotiation Act of 2007 (HR 4, S 3), the proposed repeal of the prohibition on Medicare drug price negotiation, bargaining leverage is more than negotiating authority; it requires the ability to control prescribing, that is, to close drug classes (Congressional Budget Office 2007). That is, even if Medicare were to obtain the authority to negotiate directly with drug manufacturers (something very likely to be proposed again in Congress and perhaps supported by a new administration), that authority would not produce substantially lower drug prices if Medicare were subject to the same formulary requirements as Medicare PDPs.

Of course if a VA-Medicare PDP purchased drugs at VA prices, pharmaceutical manufacturers' revenue would decline with each additional enrollee, relative to what it would be if that individual enrolled in a Medicare PDP. In this article we have assumed that policy makers wish to increase coverage and reduce government and beneficiary costs if possible, but there are two potentially important consequences for beneficiaries that we have not explored. First, manufacturers would face tighter budget constraints for research and development. This raises the well-known question of how to determine the welfare-maximizing balance between current lower drug prices and future drug innovation (Danzon 1998). Second, it has been argued that manufacturers could raise their wholesale prices or take a tougher position in negotiations with others to compensate at least partially for the loss associated with higher volume of sales to the VA (GAO 2000; Yong 2007). Although evidence from international drug pricing studies suggests that such effects are likely to be small (Scherer 1993), and some have argued that price differentials across prescription drug markets are not related to cost shifting (Frank 2001), this question also deserves more attention in future research.

If we maintain the assumption that more coverage for less government and beneficiary spending is desirable, the most serious potential obstacle to implementation of a VA-PDP is political. Because of the VA's negotiating power, drug manufacturers could perceive a VA-Medicare PDP as a threat. Moreover, pharmacies, pharmacy benefits management firms, HMOs, and other insurers may feel threatened by increased competition from the VA for prescription fills and beneficiaries. While these groups have not invested heavily in influencing VA policy (relative to their investment in Medicare policy) in the recent past, any serious public debate about a VA-Medicare PDP would very likely gain their attention. On the other hand, there may also be powerful forces of advocacy on the other side. Veterans service organizations (VSOs) seeking expansion of eligibility for VA benefits and

Medicare interest groups (like AARP) seeking the option of better benefits at lower cost might be in favor of a VA-Medicare PDP. Proponents of a VA-Medicare PDP would have to weigh potential support and potential opposition when deciding on the eligibility rules for the proposed program. A larger number of eligible beneficiaries increases the number of individuals who could be covered and the potential savings but also comes with a risk of stronger interest group opposition.

Finally, it is certain that a VA PDP would have some impact on the Medicare Part D program and the policy debate about possible changes to it. At a minimum, a VA PDP would provide a potentially attractive coverage option for a substantial number of Medicare-enrolled veterans without incurring additional costs for the government. Beyond that, the impact on Part D depends on details of the VA PDP authorizing legislation, what budgetary and programmatic safeguards are included in it for the VA and Medicare, the ultimate size of the program, and industry response. A VA PDP could eventually look like any other Medicare PDP if formulary requirements are imposed similar to those currently imposed on Medicare PDPs that would take the bite out of the VA's negotiating power. On the other hand, it could provide ammunition to advocates who desire more tools for price control under Medicare, though those advocates already point to the VA's formulary control as the source of negotiating power lacking under Medicare. The ultimate impact of a VA PDP on Medicare's budget depends on its size. In this article we have illustrated a relatively small version that would save Medicare over $500 million annually, but we also suggested options that would expand the benefit, potentially producing additional savings.

References

Associated Press. 2007. Drug Trade Group Spent $10.7M Lobbying. August 17. prescriptionaccess.org/blog/?cat=129.

Barlett, D. L., and J. B. Steele. 2004. Why We Pay So Much for Drugs. *Time*, February 2.

Baumgartner, F., and B. Leech. 2001. Interest Niches and Policy Bandwagons: Patterns of Interest Group Involvement in National Politics. *Journal of Politics* 63 (4): 1191–1213.

Becker, G. 1983. A Theory of Competition among Pressure Groups for Political Influence. *Quarterly Journal of Economics* 98:371–400.

———. 1985. Public Policies, Pressure Groups, and Deadweight Costs. *Journal of Public Economics* 28:329–347.

CBS Evening News. 2006. VA: High-Quality Health Care at Low Cost. December 8. www.cbsnews.com/stories/2006/12/08/eveningnews/main2243606.shtml.

Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (CMS). 2005a. Medicare Modernization Act Final Guidelines—Formularies: Guidelines for Reviewing Prescription Drug Plan Formularies and Procedures. www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf.

———. 2005b. Why Is CMS Requiring "All or Substantially All" of the Drugs in the Antidepressant, Antipsychotic, Anticonvulsant, Anticancer, Immunosuppressant, and HIV/AIDS Categories? www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf.

Congressional Budget Office. 2001. Cost estimate: H.R. 4939, Veterans Medicare Payment Act of 2002. November 1. www.govtrack.us/congress/billreport.xpd?bill=h107–4939&type=cbo.

———. 2007. Analysis of H.R.4. www.cbo.gov/ftpdocs/77xx/doc7722/hr4.pdf.

Connolly, C. 2003. Drugmakers Protect Their Turf. *Washington Post*, November 21.

Danzon, P. 1998. The Economics of Parallel Trade. *Pharmacoeconomics* 13:293–304.

Families USA. 2005. Falling Short: Medicare Prescription Drug Plans Offer Meager Savings. December. www.familiesusa.org/assets/pdfs/PDP-vs-VA-prices-special-report.pdf.

———. 2007. No Bargain: Medicare Drug Plans Deliver High Prices. January. www.familiesusa.org/assets/pdfs/no-bargain-medicare-drug.pdf.

Frakt, A., and S. Pizer. 2006. A First Look at the New Medicare Prescription Drug Plans. Web exclusive, *Health Affairs*, May 23.

Frank, R. 2001. Prescription Drug Prices: Why Do Some Pay More Than Others Do? *Health Affairs* 20 (2): 115–128.

Frank, R., and J. Newhouse. 2008. Should Drug Prices Be Negotiated under Part D of Medicare? And If So, How? *Health Affairs* 27:33–43.

Frederick, J. 2004. Amid Challenges, Drug Chains Stand Their Ground. *Drug Store News*, August 23.

Freking, K. 2006. Medicare Touting Success of Drug Benefit. *Washington Post*, December 5.

Galen Institute. 2007. The Facts: Medicare Part D and Prescription Drug Prices. January 9. www.galen.org/pdrugs.asp?docID=958.

Gaul, G. 2005. Revamped Veterans' Health Care Now a Model. *Washington Post*, August 22. www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html.

Harris, G. 2003. Drug Makers Move Closer to Big Victory. *New York Times*, November 25.

Harvard University. 2006. Healthcare Program Serving U.S. Vets Wins Government Innovation Award. July 10. www.innovations.va.gov/innovations/docs/HarvardNewsRelease.pdf.

Huskamp, H. A., A. M. Epstein, and D. Blumenthal. 2003. The Impact of a National

Prescription Drug Formulary on Prices, Market Share, and Spending: Lessons for Medicare? *Health Affairs* 22:149–158.

Iglehart, J. 2004. The New Medicare Prescription-Drug Benefit—A Pure Power Play. *New England Journal of Medicine* 350:826–833.

Jones, R. 2007. Testimony before the Committee on Veterans' Affairs Subcommittee on Health, U.S. House of Representatives, 110th Cong., 1st sess., September 30. www.amvets.org/HTML/what_we_do/testimony_030930.htm.

Kaiser Family Foundation. 2004. Prescription Drug Coverage for Medicare Beneficiaries: An Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173). January 14. Menlo Park, CA: Henry J. Kaiser Family Foundation.

———. 2006. Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits. December. www.kff.org/medicare/upload/7587.pdf.

Kizer, K. 1999. Statement before the Committee on Finance, United States Senate. U.S. Department of Veterans Affairs: Washington, DC. www.va.gov/OCA/testimony/other/04MY9910.asp.

Komisar, H. 2002. Rolling Back Medicare Home Health. *Health Care Financing Review* 24 (Winter): 2–55.

Laffont, J., and J. Tirole. 1991. The Politics of Government Decision-Making: A Theory of Regulatory Capture. *Quarterly Journal of Economics* 106:1089–1127.

———. 1993. *A Theory of Incentives in Procurement and Regulation*. Cambridge, MA: MIT Press.

Leech, B., F. Baumgartner, T. La Pira, and N. Semanko. 2005. Drawing Lobbyists to Washington: Government Activity and the Demand for Advocacy. *Political Research Quarterly* 58:19–30.

McAdams, D., and M. Schwarz. 2007. Perverse Incentives in the Medicare Prescription Drug Benefit. *Inquiry* 44:157–166.

McCall, N., J. Korb, A. Petersons, and S. Moore. 2003. Reforming Medicare Payment: Early Effects of the 1997 Balanced Budget Act on Postacute Care. *Milbank Quarterly* 81:277–303.

MedPAC. 2006. Report to the Congress: Increasing the Value of Medicare. Chapter 7: Part D Plan Offerings. Washington, DC. www.medpac.gov/documents/Jun06_EntireReport.pdf.

Middleton, S. 2007. Access to VA Health Care: How Easy Is It for Veterans? Addressing the Gaps. Testimony before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives, 110th Cong., 1st sess., April 18. www.legion.org/documents/legion/pdf/vt_healthcaregap_042707.pdf.

Montgomery, L., and C. Lee. 2006. Success of Drug Plan Challenges Democrats. *Washington Post*, November 26.

Neuman, P., M. K. Strollo, S. Guterman, W. H. Rogers, A. Li, A. M. C. Rodday, and D. G. Safran. 2007. Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors. Web exclusive, *Health Affairs*, August 21.

New York Times. 2007. Negotiating Lower Drug Prices. January 16.

Nugent, G., A. Hendricks, L. Nugent, and M. Render. 2004. Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices. *Medical Care Research and Review* 61:495–508.

Oberlander, J. 2007. Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act. *Journal of Health Politics, Policy and Law* 32:187–219.

Oliver, R., P. Lee, and H. Lipton. 2004. A Political History of Medicare and Prescription Drug Coverage. *Milbank Quarterly* 82:283–354.

Olson, M. 1965. *The Logic of Collective Action*. Cambridge, MA: Harvard University Press.

Pear, R. 2004. New Medicare Law Divides Drug Firms, Insurers. *New York Times*, September 26.

———. 2007a. Democrats' Drug Plan Has Pitfalls, Critics Say. *New York Times*, January 7.

———. 2007b. House Democrats Pass Bill on Medicare Drug Prices. *New York Times*, January 13.

Pierson, P. 1993. When Effect Becomes Cause: Policy Feedback and Political Change. *World Politics* 34:595–628.

Pizer, S., A. Frakt, and R. Feldman. 2008. Predicting Risk Selection Following Major Changes in Medicare. *Health Economics* 17:453–468.

Pope, G., et al. 2004. Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. *Health Care Financing Review* 25 (4): 119–141.

Sabatier, P., and H. Jenkins-Smith. 1999. The Advocacy Coalition Framework: An Assessment. In *Theories of the Policy Process*, ed. Paul Sabatier, 117–166. Boulder, CO: Westview.

Sales, M., F. E. Cunningham, P. A. Glassman, M. A. Valentino, and C. B. Good. 2005. Pharmacy Benefits Management in the Veterans Health Administration: 1995 to 2003. *American Journal of Managed Care* 11:104–112.

Scherer, F. 1993. Pricing, Profits, and Technological Progress in the Pharmaceutical Industry. *Journal of Economic Perspectives* 7 (3): 97–115.

Shearer, G. 2007. Confusing Inequitable Medicare Prescription Drug Benefit. *Journal of General Internal Medicine* 22:286–288.

Sikora, P., and H. Schiavone. 2006. Not Low Enough: Medicare Part D "Donut Hole" Prices Compared with Retail and VA Prices. Consumers Union, October.

Stigler, G. 1971. The Economic Theory of Regulation. *Bell Journal of Economic Management Science* 2:3–21.

Stolberg, S. 2003. The Nation: Baby Boomers Transform an Old Bloc. *New York Times*, June 15.

Stroup, T. 2007. Personal communication, January 23.

Teigen, J. 2007. Veterans' Party Identification, Candidate Affect, and Vote Choice in the 2004 U.S. Presidential Election. *Armed Forces and Society* 33 (3): 414–437.

U.S. Census Bureau. 2007. Statistical Abstract of the United States: 2007. 126th ed. Washington, DC: U.S. Census Bureau.

U.S. Department of Health and Human Services (HHS). 2006. Over 38 Million People with Medicare Now Receiving Prescription Drug Coverage. June 14. www.hhs.gov/news/press/2006press/20060614.html.

U.S. Department of Veterans Affairs. 2003. VA Announces Record Budget, Health Care Changes. Washington, DC: U.S. Department of Veterans Affairs.

———. 2006a. Fact Sheet. May. www1.va.gov/opa/fact/vafacts.asp.

———. 2006b. VA Prescription Co-Pays to Increase by $1. November 16. www1.va.gov/opa/pressrel/docs/CoPays.doc.

U.S. General Accounting Office (GAO). 2000. Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes. GAO/HEHS-00-118. August. Washington, DC: GAO.

———. 2001. VA Drug Formulary: Better Oversight Is Required, But Veterans Are Getting Needed Drugs. GAO-01-183. January. Washington, DC: GAO.

U.S. Government Accountability Office. 2005. Mail Order Pharmacies: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits. GAO-05-555, June. Washington, DC: U.S. Government Accountability Office.

Wilkinson, H. 2003. Veterans' Care Squeezed by VA: Many Lose Coverage under New Policy. *Cincinnati Enquirer*, May 25.

Yong, J. 2007. Republicans Criticize VA Drug Benefits. *The Hill*, January 17.