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The VA Drug Pricing Model: What Senators Should Know

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The Senate will soon debate Medicare drug price "negotiation," or repeal of the "non-interference" clause of the Medicare Modernization Act of 2003, which prevents government interference in the negotiations between drug companies and the private plans that market drug benefits in Medicare. During the recent House debate on price negotiation, several Members cited the experience of the Veterans Administration (VA), arguing that the VA model of drug price negotiation could work in the larger Medicare program. But the VA does not simply *negotiate* prices; rather, it *fixes* prices and then reduces the range of drugs offered to enrollees. Not only would the VA pricing model reap little savings in Medicare, but it would also fail to meet the needs of beneficiaries.

How the VA Fixes Drug Prices and Restricts Access. Unlike Medicare, in which beneficiaries can choose drug plans, each with its own formulary, the VA offers no choice. Serving as the sole purchaser of drugs, the VA maintains a single national formulary that physicians must follow.

The VA formulary is created through access restrictions on drugs. For drugs to be covered on the formulary, their makers must list all of their drugs on the Federal Supply Schedule (FSS) for federal purchasers at the price given to the most-favored nonfederal customer under comparable terms and conditions.[1] Additionally, drug makers must offer the VA a price lower than a statutory federal price ceiling (FPC), which mandates a discount of at least 24 percent off the non-federal average manufacturer price (NFAMP), with a rebate if price increases exceed inflation.[2]

If drug makers do not comply with these terms, all of their drugs are excluded from federal programs except the market-based Federal Employees' Health Benefits Plan (FEHBP) and Medicare Part D.[3] The VA's discounts are mandated by law, and drug makers capitulate primarily because they want to maintain access to Medicaid, which comprises about 20 percent of the drug market.[4]

Beyond this regulatory pricing process, the VA sometimes obtains larger discounts by committing to purchase and use only certain drugs, thereby denying other drug makers access to the formulary and the VA market.[5] In these cases, drug makers tend to concede for three reasons: the VA system represents a small share of their market (usually 2 percent to 3 percent); doctors who might prescribe their drugs in the future often train in the VA system; and the VA's "closed" health system means there is little risk that the VA's discounted drugs will find their way to the private market and undercut broader pricing strategies.[6] Facing substantial fixed costs and relatively low production costs, drug makers are usually willing to accept below-market prices rather than not sell at all when a market is

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small enough that the loss in marginal profits will not significantly reduce overall profitability.

While the VA's pricing practices do not consist of price-fixing mechanisms alone, they are not "negotiation" either. The VA does not use its buying power to negotiate with drug companies for lower prices. Instead, the government, acting through the VA, uses its power to deny manufacturers market access as a way to extort lower prices. But these lower prices come at the expense of fewer drugs for patients.

Blocked Drugs: The VA Formulary. The restrictiveness of the VA drug formulary is one of its least attractive features, particularly as a model for the seniors and disabled individuals in Medicare. Recently, the Lewin Group, a prominent consultancy that models health policy proposals, compared the formularies of the VA, the most popular FEHBP plan, and the two Medicare Part D plans with the highest enrollments, focusing on the 300 drugs most prescribed to senior citizens. Lewin found that, of the 300 drugs, 106 (35 percent) are *not* included in the VA formulary, compared to 16 (5 percent) in the FEHBP formulary, and 18 (6 percent) and 19 (6 percent) in the Part D plan formularies.[7]

A separate analysis by Alain Enthoven and Kyna Fong of Stanford University[8] explained that, overall, less than one third of the 4,300 drugs available to Medicare beneficiaries are on the VA national formulary.[9] A closer look at the VA formulary reveals that new and innovative drugs, which tend to be more costly, are often excluded. According to a study conducted by Columbia University Professor Frank Lichtenberg, only 38 percent of the drugs approved by the FDA in the 1990s and 19 percent of the drugs approved since 2000 are on the VA national formulary.[10]

Economically, because the VA market is relatively small and mostly fails to cover expensive breakthrough drugs, government price fixing and further access restrictions can achieve savings in drug prices. Politically, the VA is able to restrict access because many veterans have other public or private insurance that, in effect, supplements the VA coverage.[11] Recent estimates show that up to 40 percent of Medicare eligible VA enrollees are now accessing drugs through Medicare part D.[12] While the VA model may work well for the VA given its circumstances, it could not easily be applied to Medicare.

1. Gretchen A. Jacobson, Sidath Viranga Panangala, and Jean Hearne, "Pharmaceutical Costs: A Comparison of Department of Veterans Affairs (VA), Medicaid, and Medicare Policies," Congressional Research Service, *Report for Congress* RL33802, January 17, 2007, pp. 8–13, at *http://opencrs.com/rpts/RL33802_20070117.pdf*.
2. *Ibid.*
3. *Ibid.*
4. Fiona M. Scott Morton, "Prescription Drug Pricing and Negotiation: An Overview and Economic Perspectives for the Medicare Prescription Drug Benefit," Testimony before the Senate Finance Committee, January 11, 2007, at *www.senate.gov/~finance/hearings/testimony/2007test/011107fmtest.pdf*.
5. Gretchen A. Jacobson, Sidath Viranga Panangala, and Jean Hearne, "Pharmaceutical Costs."
6. Edmund F. Haislmaier, "Compromising Quality: The High Cost of Government Drug Purchasing," Heritage Foundation *Backgrounder* No. 1764, May 25, 2004, at *www.heritage.org/Research/HealthCare/bg1764.cfm*.
7. The Lewin Group, "Comparison of VA National Formulary and Formularies of the Highest Enrollment Plans in Medicare Part D and the Federal Employee Health Benefit Program," January 12, 2007.
8. Alain Enthoven and Kyna Fong, "Medicare: Negotiated Drug Prices May Not Lower Costs," National Center for Policy Analysis, *Brief Analysis* No. 575, December 18, 2006, at *www.ncpa.org/pub/ba/ba575/ba575.pdf*.
9. David Blumenthal and Roger Herdman, eds., *Description and Analysis of the VA National Formulary* (Washington, D.C.: National Academy Press, 2000), and "Observers Predict Shake Up in PDP Market in 2007," FDC Reports, Medicare Drug Reimbursement Guide, Vol. 2, No. 5, November 2006.
10. Frank R. Lichtenberg, ""Older Drugs, Shorter Lives? An Examination of the Health Effects of the Veterans Health Administration Formulary," *Medical Progress Report* No. 2, Manhattan Institute for Policy Research, October 2005, at *www.manhattan-institute.org/html/mpr_02.htm*.
11. The Veterans Health Administration (VHA), Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Policy and Planning, "FY 2005 Survey of Enrolled Veterans," August 22, 2006.

Imposing the VA Model on Medicare. The size of any market can be an important determinant of price, particularly if market share is moved toward some drugs and away from others. However, there is a point at which size can be a major impediment to obtaining a below-market price, even if drug makers are routinely restricted or denied access to the market. Imposing a single, restrictive formulary would be much tougher to implement in Medicare, which is 20 times the size of the VA and represents 40 percent of the pharmaceutical market.[13] Because Medicare is so large and expected to rapidly grow, an attempt to impose the VA pricing model on Medicare would undoubtedly result in price changes for all pharmaceutical consumers.

Drug makers would be not only unwilling, but also primarily unable, to extend below-average prices to such a large group. Medicare's prices will invariably approach the average market prices, and seeking to force prices lower will be nearly impossible unless significant costs could be shifted onto others. Analyzing the possibility of extending federal prices to Medicare, the Government Accountability Office concluded:

> Mandating that federal prices for outpatient prescription drugs be extended to a large group of purchasers, such as Medicare beneficiaries, could lower the prices they pay but raise prices for others. Such price changes could occur because drug manufacturers would be required to charge beneficiaries and federal purchasers the same prices. To protect their revenues, manufacturers could raise prices for federal purchasers. Furthermore, because federal prices are generally based on prices paid by nonfederal purchasers, manufacturers would have to raise prices to these purchasers in order to raise the federal prices.[14]

Extending federal prices to Medicare—and especially any of the additional price concessions received by the VA—would result in significant cost-shifting, as experienced after the enactment of the Medicaid rebate program in 1990[15]. With pharmaceutical companies having to look elsewhere for returns on their sizeable investments, they would be forced to charge higher prices to non-federal purchasers, including private health plans and other federal purchasers (because their prices are based on non-federal prices). Thus, government interference in Medicare pricing would likely accelerate the growth of drug prices for the entire country.

Moreover, closing off the market to uncooperative pharmaceutical companies, especially those offering high priced breakthrough drugs, or otherwise restricting access to a wide range of prescription drugs, would be no small political feat. Denying the Medicare population access to new drugs in the name of cost control could be a formidable political challenge for Congress and Medicare officials. After all, for seniors and the disabled, there is no realistic alternative to Medicare; in that sense they are quite unlike VA enrollees. But if the government were ambitious enough to deny or restrict market access to drugs—for both drug makers and patients—service utilization and costs in other parts of Medicare would increase, and beneficiaries who seek drugs elsewhere would face a greater financial burden.

The High Cost of Government Interference. Nonetheless, many in Congress advocate imposing the VA model on Medicare. Yet, if Congress fixes prices in Medicare and establishes a restrictive national formulary, the program would be less responsive to the diverse and ever-changing needs

12. "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage," News Release, Centers for Medicare and Medicaid Services, June 14, 2006 at *www.hhs.gov/news/press/2006pres/20060614.html*, and "Comparison of Outpatient Prescription Drug Coverage: Medicare, VA, VA-CHAMPVA, DOD-TRICARE Pharmacy," Centers for Medicare and Medicaid Services, at *www.cms.hhs.gov/partnerships/downloads/compshart.pdf*.
13. Fiona M. Scott Morton, "Prescription Drug Pricing and Negotiation."
14. Government Accountability Office, "Prescription Drug Prices: Expanding Access to Federal Prices Could Cause Other Price Changes," August 2000, at *www.gao.gov/archive/2000/he00118.pdf*.
15. Government Accountability Office, "Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain," June 1997, pp. 12–13, at *www.gao.gov/archive/1997/he97060.pdf*.

of beneficiaries and far more open to congressional budgetary pressures, such as the annual process of political gaming and ferocious lobbying by special interests. In addition, there would be a chain of other costs: billions of dollars in averted research and development expenditures by drug makers, forgone investment in an untold number of new drugs, and the considerable loss of valuable research and science jobs.

Medicare Part D circumvents these problems with its private competition framework and allows Medicare beneficiaries to choose the plan with the formulary that best meets their needs and preferences and to switch plans each year during open season. These competing private plans negotiate for lower prices with drug makers through formularies designed by experts. As a result, private plans face intense competition in the market, where there is pressure to be responsive to beneficiaries who wish to maintain access to a broad array of drugs at low prices. Medicare Part D does this while functioning within an open, private system of health care providers that allows seniors their choice of private doctors and hospitals, drug plans, and pharmacies.

If the VA's pricing practices were extended to a large market like Medicare, it would probably not lower drug prices or control costs. In fact, establishing a VA model in Medicare would probably have the opposite effect. The VA may indeed be adequate for the small market of veterans, who tend to have other drug coverage options. But as a model, it could not easily be applied to Medicare and would prove inadequate to meet the needs of the rapidly growing Medicare population which, now at least, enjoys the tangible benefits of a responsive, market-based system of consumer choice and competition.

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