Health Affairs

PRESCRIPTION DRUG PRICING

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VETERANS HEALTH ADMINISTRATION

The Veterans Health Administration can often obtain very favorable prices for drugs and may be a model for Medicare and others.

The Veterans Health Administration is a large integrated health care system operated by the Department of Veterans Affairs (VA). By law, the VA can buy prescription drugs at discounted prices. But it also negotiates for even deeper discounts on its national formulary. Because of the agency's ability to purchase some drugs at prices much lower than most commercial and government payers, it is often cited as a model for broader federal negotiation of drug prices—or as a benchmark for other purchasers to use in obtaining comparable pricing.

Background

Through the Veterans Health Administration, the VA offers health care services to qualified members of the military once they leave active duty. Unlike most federal prescription drug benefit programs, the VA does not simply reimburse claims filed by pharmacies or other providers. Instead, the VA is itself the provider, operating an integrated network of 168 medical centers, more than 1,000 outpatient clinics, 250 brick-and-mortar pharmacies, and seven mail-order pharmacies (which deliver about 80 percent of the program's prescriptions). The VA employs over 200,000 health care professionals, including doctors, pharmacists, and other providers.

The VA health system covers about nine million of the approximately twenty-two million veterans in the US. Of that total, 4.9 million used the VA pharmacy system in 2016. Prescription drug spending by the VA is expected to total about $7 billion in 2017—slightly less than 10 percent of total health care spending in the system.

Like many federal programs, the VA has statutorily mandated access to favorable drug pricing. It also operates a national formulary and can exclude medications that the agency's formulary committee concludes are inappropriate for the patient population or should be subject to prior authorization. That, in turn allows, the VA to negotiate even deeper discounts in some cases, particularly when there are multiple suppliers of either the same (generic) ingredient, or a closely comparable brand medicine.

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The VA: What You Need To Know

The VA's ability to obtain deep discounts in some large therapeutic classes is often cited as a model for negotiating prescription drug prices in other federal programs, such as Medicare. The VA uses a mix of statutory and administrative tools to achieve its goals.

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DISCOUNTS GUARANTEED BY LAW

The 1992 Veterans Health Care Act granted the VA minimum discounts on drugs, similar to those received by Medicaid. Notably, the VA discount was enacted after the 1990 Medicaid rebate law, which guaranteed Medicaid a discounted price and also required manufacturers to give Medicaid the "best price" they offered. Once the Medicaid rebate law took effect, some manufacturers canceled discounts to other purchasers (including the VA) to avoid setting a best price that would also have to be offered to Medicaid.

The 1992 law set a ceiling on prices that manufacturers can charge the VA and several other federal purchasers (the Department of Defense [DoD], the Public Health Service, and the Coast Guard, collectively referred to as the "big four"). The price is based on the "non-federal Average Manufacturer Price," or the average sales price to purchasers outside the federal government.

The VA is also entitled to a guaranteed minimum discount of 24 percent off the non-federal Average Manufacturer Price (an amount similar to the minimum discount guaranteed to Medicaid), or a lower price to match the best price provided to non-federal purchasers. As in Medicaid, the discount is adjusted to recoup inflationary price increases. Finally, unlike private purchasers, the VA is allowed to negotiate prices lower than the existing "best price" without triggering an obligation for manufacturers to give the same price to Medicaid. In that respect, the VA has a stronger negotiating position than private purchasers have.

NATIONAL FORMULARY

For most of its history, the VA relied on formularies—lists of covered prescription drugs that are available for patients—operated by each of its separate facilities. Beginning in 1997, however, the VA established a national formulary, allowing the agency to leverage its purchasing power to obtain deeper discounts for individual therapies than any single facility might be able to obtain. The national formulary also helps ensure consistency of care across the VA system.

The national formulary is operated by the VA's Pharmacy Benefits Management (PBM) Services, which uses published policies and procedures to make decisions on which drugs to include in or exclude from the formulary.

PUBLISHED PRICES

The VA makes public its national formulary and a price list for most prescription drugs available in the system. Those lists serve as important benchmarks for other purchasers, although they do not necessarily reflect all negotiated discounts, since manufacturer agreements often require the final price to remain confidential.

LOW OR NO COST SHARING

Many VA beneficiaries have low or no copays or other direct costs for their care. The VA has recently shifted to a tiered drug copay system, with different cost sharing for preferred generics, nonpreferred generics, and brands. That change has lowered overall cost sharing in the system. The VA expects to collect about $530 million in copays in 2017, down from about $630 million the year before. It expects that amount to decline again to $450 million in 2018, even as the number of total prescriptions dispensed in the system rises towards 250 million.

LOW PER PRESCRIPTION COSTS OVERALL

Analyses consistently show the VA having the lowest per prescription costs among all federal purchasers.

In part, that reflects the success of the national formulary process in negotiating lower prices on some top-selling brands. It is also a function of the VA's ability to encourage prescribing of lower-cost generic alternatives.

A 2013 Government Accountability Office (GAO) report compared VA and DoD prices for the most commonly used therapies in each system. Both programs have the same guaranteed discount, operate formularies, and negotiate lower prices where possible. The GAO found that the average brand-name price paid by the DoD was actually lower than the VA average for the sample, but the VA generally obtained lower prices on generic drugs, resulting in a lower average cost per prescription. In other words, the VA's ability to negotiate lower prices is not necessarily the most important reason it is able to keep drug costs down: Instead, it is the VA's ability to ensure that physicians prescribe the most cost-effective medications more frequently.

Among other tools, the PBM Services group relies on an "academic detailing" program, in which a team of VA pharmacists develops prescriber education programs to promote guidelines on cost-effective use of medicines. This is a prominent example of applying the traditional pharmaceutical sales force detailing model to the goals of a payer or health system, rather than to increasing the prescribing of a specific brand.

The success of that approach was highlighted in a 2015 McKinsey review required by the Veterans Access, Choice, and Accountability Act of 2014. The report found that "VA performs well on the key dimensions of purchasing, distribution, and use of pharmaceuticals" and that "all physicians and pharmacists interviewed believed the VA formulary helps guide good clinical decision-making around prescribing, and they expressed strong buy-in to the formulary decision-making process."

Key Questions For Drug Pricing

There are several outstanding questions about how the VA does or could affect drug prices for other purchasers.

THE VA AS A MODEL FOR MEDICARE

The call for Medicare drug price negotiation often invokes the VA as a model to obtain lower prices. In theory, the federal government—and Medicare beneficiaries—could save significant amounts if they had access to the VA's prices for prescription drugs. However, there are obstacles to applying the VA model in Medicare. The core structural issue is that physicians, pharmacies, and other providers serving Medicare are not employed by, or otherwise organizationally part of, the Medicare program; their relationship to the program is that of an arm's-length contractor. In contrast, VA providers are part of an integrated system that both pays for and provides care to its defined population. It would be more difficult to implement a national formulary across disparate and unrelated Medicare providers than it is to implement a formulary across integrated VA providers.

Some private purchasers can replicate the VA system's level of control over its pharmaceutical program with direct ownership of facilities and employment of, or exclusive contracting with, physicians and other prescribers (for example, staff-model health maintenance organizations such as Kaiser Permanente). Medicare beneficiaries can and do enroll in capitated Medicaid Advantage plans offered by those providers.

However, the majority of Medicare beneficiaries access care using the fee-for-service side of the program and purchase stand-alone prescription drug coverage under Part D. Each of those stand-alone plans already relies on formularies and negotiates with manufacturers for discounts. Replacing those different private plans' formularies with a national one would fundamentally restructure the Part D benefit, eliminating the current feature of encouraging beneficiaries to shop for plans with formularies that best match their needs. In addition, without steps to encourage or ensure that Medicare prescribers comply with a national formulary, it could be difficult to negotiate lower prices than those already obtained by private plans. Beneficiaries might also experience higher costs or barriers to care if physicians continue to prescribe off-formulary medications.

Finally, even a successful strategy to apply VA-level pricing in Medicare could have negative effects on pricing for other purchasers. In 2000 the GAO found that one likely impact of extending VA or Medicaid pricing to the Medicare population would be an increase in prices for federal and private purchasers. Citing the experience after enactment of the Medicaid rebate law, the GAO stated that manufacturers would likely cancel other federal pricing agreements wherever possible to avoid having to extend those prices to the much larger Medicare population.

OTHER WAYS TO TAP INTO VA PRICING?

A 2016 state ballot initiative in California (Proposition 61) would have directed the state to buy drugs for its employees at VA prices. Proponents of the initiative argued that it could produce significant savings from the state's annual $3.8 billion in prescription drug spending.

Opponents (including the pharmaceutical industry) argued that its impact might instead be to cause manufacturers to cancel agreements with the VA, leading to higher prices overall. There were also questions about the enforceability of the measure. The initiative was defeated, and the actual impact of the proposed approach has yet to be tested.

Key Terms

- **Veterans Affairs (VA) Health Benefits:** In general, any member of the military having completed at least twenty-four months of active duty is eligible for comprehensive VA health benefits after leaving active duty, provided they are not dishonorably discharged. (Veterans with shorter service time are eligible if they are discharged because of disability or for other hardship reasons.) The enrollment process assigns different levels of priority to individual veterans, and aspects of the coverage (including out-of-pocket expenses for items such as prescription drugs) depend on priority status.
- **Formulary:** A list of medicines that are available within a hospital or other institution, or that are that are covered by a specific insurance policy.
- **Non-federal Average Manufacturer Price:** Defined in 38 U.S. Code Section 8126 as "the weighted average price of a single form and dosage unit of the drug that is paid by wholesalers in the United States to the manufacturer, taking into account any cash discounts or similar price reductions during that period, but not taking into account (A) any prices paid by the Federal Government; or (B) any prices found by the Secretary to be merely nominal in amount."

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