Five reasons tying VA prices to Medicare Part D misses the mark

Some members of Congress are considering a government "negotiation" plan that would tie medicine prices in Medicare to those in the U.S. Department of Veterans Affairs (VA). This misguided approach is just the latest in a series of government price-setting proposals that threaten patients' access to medicines and future innovation.

Here are five reasons why the VA is a wrong model for Medicare.

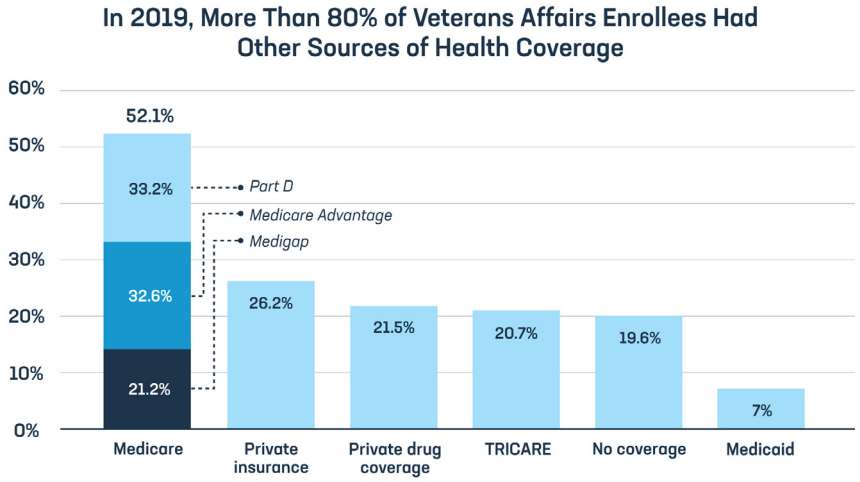
1. Unlike Medicare Part D, the VA uses a one-size-fits-all system that restricts access to medicines.

The VA employs a narrow, exclusionary formulary to generate savings, and comparisons of coverage between the VA and Medicare demonstrate that the VA offers fewer choices, particularly of the most cutting-edge and innovative medicines. Of the top 200 Part D brand medicines, approximately 74% were covered by Medicare, compared with just 52% that could be covered by the VA formulary. Similarly, the VA National Formulary covers just 40% of first-in-class Part D medicines, compared with more than 62% in Medicare Part D.

According to the GAO, "the VA can steer utilization toward a limited number of drugs within a given therapeutic class. Medicare Part D plans, on the other hand, generally have broad networks of pharmacies and as such may have broader formularies than VA's." Similar access restrictions are likely to appear in Medicare if Part D prices reference VA prices.

2. The majority of VA beneficiaries rely on other sources to help supplement their drug coverage, including Medicare Part D.

To gain access to the medicines they need, more than half of all veterans supplement their VA benefits with other sources of health coverage, including Part D. According to a 2019 VA survey, more than 80% of VA enrollees had other health coverage in addition to their VA coverage; among those enrollees, more than half supplement their coverage with Medicare. The VA approach is clearly not sufficient for many veterans. The suggestion of tying these same restrictions to patients with Part D could leave seniors and people with disabilities struggling to get their medicines.



SOURCE: US Department of Veterans Affairs. 2019 survey of veteran enrollees' health and use of health care. Washington, DC: US Department of Veterans Affairs; 2020:31-32.

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3. The VA relies on quality-adjusted life year (QALY)-based assessments to set prices for medicines.

QALYs involve assigning a value to a person's life based on their health status. Examples provided by Value Our Health illustrates this: a QALY for a patient with multiple sclerosis is worth half as much as a healthy, young individual, and a person over the age of 70 is worth approximately 30% less simply because of their age. It is widely acknowledged by patients, caregivers and experts alike that QALYs discriminate against the disabled, seniors, the chronically ill and communities of color. Despite this, the VA still uses this metric to determine prices. This is not the way patients should be treated, and it's not the way medicines should be priced.

4. Imposing the VA system on Medicare is wildly unpopular with seniors.

83% of seniors do not favor making Part D more like the VA system if it means some medicines currently available under Medicare were no longer covered. In fact, this policy proposal would upend a Medicare Part D program that nearly nine of every 10 beneficiaries say they are satisfied with.

5. Comparisons between Medicare Part D and the VA fail to acknowledge inherent structural distinctions between the two programs.

The VA health system is unique, using a closed system of providers and a centralized coverage, drug acquisition and distribution system. Because the VA directly purchases medicines from pharmaceutical manufacturers, its prices do not include retail distribution costs, such as dispensing fees to compensate pharmacists. Moreover, because the VA distributes medicines through their own closed military health care system, financed separately, the VA prices for medicines do not include costs for storage, overhead or dispensing.

Medicare Part D, on the other hand, is administered by nearly 1,000 different health plans, across 34 prescription drug plan regions nationwide, using local retail pharmacies. Medicare beneficiaries can choose among a number of local plans to find one that best meets their health care needs. It is unclear how medicines would be distributed or how retail pharmacies would be compensated in a system where the Secretary of Health and Human Services has to procure medicines directly through the VA procurement process.

Medicare needs to be modernized to work better for seniors and people with disabilities. However, changes to the program need to be measured and focused to address beneficiary concerns with high out-of-pocket costs. We are committed to working with policymakers to strengthen the program and improve affordability for people in Medicare.

There's a better way to lower costs for patients, but arbitrarily tying medicine prices to restrictive government programs like the VA isn't it. Learn more at PhRMA.org/BetterWay