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108TH CONGRESS }
2d Session }

SENATE

{ REPORT
108-419

VETERANS PRESCRIPTION DRUGS ASSISTANCE ACT

NOVEMBER 19, 2004.—Ordered to be printed

Mr. SPECTER, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany S. 1153]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 1153), to amend Title 38, United States Code, to permit Medicare-eligible veterans to receive an out-patient medication benefit, to provide that certain veterans who receive such benefit are not otherwise eligible for medical care and services from the Department of Veterans Affairs, and for other purposes, having considered the same, reports favorably thereon and recommends that the bill, as amended, do pass.

INTRODUCTION

On May 23, 2003, Committee Chairman Arlen Specter introduced S. 1153, the proposed "Veterans Prescription Drugs Assistance Act." S. 1153 would create a program to allow Medicare-eligible veterans to obtain outpatient prescription medications from the Department of Veterans Affairs (hereinafter, "VA") on the order of any duly licensed physician. Further, it would require VA to collect a copayment for any medication provided under the program. And finally, the bill would declare that non-service connected, Medicare-eligible veterans are ineligible to receive any other health care services from VA during any calendar year in which such veteran is enrolled in the outpatient drug program created under S. 1153.

COMMITTEE HEARINGS

On June 22, 2004, the Committee held a hearing to receive testimony on, among other bills, S. 1153. Testimony was heard from: Senators Kent Conrad, Jon S. Corzine, and Hillary Rodham Clinton; The Honorable Tim McClain, VA's General Counsel; Dr. Michael J. Kussman, Acting Deputy Under Secretary for Health, Veterans Health Administration; Mr. Donald L. Mooney, Assistant Director for Resource Development, Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Paul A. Hayden, Deputy Director, National Legislative Service, Veterans of Foreign Wars; Mr. Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans; Mr. Carl Blake, Associate Legislative Director, Paralyzed Veterans of America; and Mr. Richard Jones, National Legislative Director, AMVETS.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearing, the Committee met in open session on July 20, 2004, and by a vote of 10 yeas and 5 nays reported favorably S. 1153.

SUMMARY OF THE COMMITTEE BILL AS REPORTED

S. 1153, as reported (hereinafter, the "Committee bill"), consists of two sections, summarized below, that would:

1. State that this act may be cited as the "Veterans Prescription Drugs Assistance Act"; and
2. Authorize the Secretary to operate a program to provide prescription medications on the order of any duly licensed physician to Medicare-eligible veterans provided that the veteran has a service-connected disability or, in the case of non-service connected veteran, that he or she is enrolled in a separate VA prescription drug program, agrees to forgo VA medical care for the enrollment-year, and agrees to pay any applicable copayments established by the Secretary.

BACKGROUND AND DISCUSSION

Sec. 1. Short title

Section 1 states that this act may be cited as the "Veterans Prescription Drugs Assistance Act".

Sec. 2. Eligibility of Medicare-eligible veterans for outpatient medication benefit

VA operates one of the most comprehensive and generous prescription drug programs in the nation. VA provides to all veterans who are enrolled for VA care appropriate prescription medications, at the nominal charge of \$7.00 per 30-day supply. VA dispenses medications, however, only to those veterans who are enrolled for, and who actually receive, VA-provided care. VA does not, for example, provide medications to veterans—even to veterans who are enrolled for VA care—unless those medications are prescribed by a physician who is employed by, or under contract with, VA. In other words, to receive medications from VA, the patient must be getting care from VA. No veteran—not even a veteran who is entitled to

priority access to care by VA—is dispensed medications based on a prescription which is written by an “outside” physician.

Of course, in most cases, such distinctions are irrelevant; the typical VA enrollee receives the full range of care from VA and relies on no other provider for care. It is also true, however, an unknown number of veterans who have access to care by non-VA providers have enrolled for VA care not because they genuinely seek VA care but principally, or even entirely, to gain access to inexpensive (from the veteran-patient’s perspective) prescription medications. Nothing in the past, and nothing currently, bars enrollment to those who have access to care from another provider. And prior to VA’s January 17, 2003, decision to restrict new enrollments for VA care to “priority” veterans (generally, those with service-connected disabilities or incomes below statutorily-established thresholds), the requirement that a veteran seeking inexpensive medications be enrolled for VA care—and actually be a VA patient—was, from the veteran’s perspective, at worst an inconvenience. Such a veteran could enroll for VA care, receive an examination from a VA doctor, and then receive medications as ordered by the examining VA physician. He or she could also simultaneously receive overlapping or even duplicate diagnostic and other care by another provider.

Following VA’s January 2003 change in enrollment policy (which continues to this day), what had been inconvenience to gain access to VA-dispensed drugs became an actual impediment. Currently, if a non-“priority” veteran was not enrolled for VA care prior to the Secretary’s January 17, 2003, decision to restrict new enrollments, he or she cannot enroll now. As a consequence, a non-“priority” veteran with access to care from an alternate provider, e.g., from a Medicare-reimbursed physician, who might have otherwise sought out overlapping care from VA is now precluded from doing so. The Committee bill is intended to provide some relief for the Medicare-eligible population among those veterans.

S. 1153 would allow Medicare-eligible veterans who are not enrolled for care with VA to gain access to VA’s prescription drug program at highly-advantageous prices (from the veteran’s perspective), but at no cost to the Government. VA fills and distributes more than 100 million prescriptions every year to more than 5 million veteran-patients. VA’s volume purchasing power, coupled with its management of a formulary program, places VA in a relatively favorable position when it negotiates prices for prescription drugs from the manufacturers and vendors of such products. According to the National Association of Chain Drug Stores, the average “cash cost” of a prescription in 2003 was \$59.28. The average price paid by VA for a prescription medication in 2003 was, by contrast, just under \$25. Examples of retail prices for a number of highly-prescribed prescription medication drugs compared to VA costs for those drugs are provided in Table 1. The point is this: VA is able to secure significant discounts relative to retail prices—sometimes discounts approaching 90 percent or more—due to its negotiating power and prowess. The Committee bill would allow Medicare-eligible veterans to gain access to these significant discounts by providing to VA a written prescription from a duly-licensed physician, typically their Medicare-reimbursed physician.

TABLE 1

[Price data as of November 12, 2004]

	VA's cost	drugstore.com	CVS.com
Simvastatin (10MG), 30 tablets	\$7.80	\$69.99	\$78.99
Lisinopril (10MG), 30 tablets	2.11	18.99	14.09
Aciphex (20MG), 30 tablets	19.60	119.99	138.99
Atenolol (50MG), 90 tablets	1.41	10.99	16.19
Terazosin (2MG), 30 capsules	1.48	13.99	23.89
Hydrochlorothiazide (25MG), 90 tablets	0.74	¹ 8.99	9.99
Ranitidine (150MG), 60 capsules	19.83	32.99	38.69
Furosemide (20MG), 90 tablets	1.22	¹ 8.99	15.30

¹ 100 tablets.

The main target of the relief that would be afforded by S. 1153 is, of course, the Medicare-eligible veteran who is now, due to his or her non-“priority” status, precluded from enrolling for VA care. There are a number of veterans, however, who now receive VA care (the precise number of such veterans is unknown and is, apparently, unknowable) who do not genuinely desire VA care and who, once an alternative means of access to VA-prescribed medications is available, will choose to abandon VA care. The Committee bill would require such veterans—if they are non-service-connected and if they choose to rely on VA as a source for prescription medications only—to agree to forego VA care for the year in which they choose to obtain a “medications-only” benefit from VA. It has been posited that this requirement would require veterans to forego VA care in order to obtain “cheap” medications. That concern is misplaced.

In the first place, millions of non-“priority” veterans today have no choice at all insofar as access to drugs at VA-negotiated prices is concerned. To characterize the reported bill as limiting choice or forcing unwelcome choices misses this vital point. The purpose of the Committee bill is to allow Medicare-eligible veteran-patients who are now locked out of VA and who now pay retail prices for drugs to choose to secure access to VA-negotiated discounts. Clearly, for those millions of veterans who are now shut out of VA care the value of that choice is clear; discounted drugs is a far superior choice to the retail price status quo.

Second, the reported bill would not require any veteran to “disenroll” from VA health care. Those who are enrolled today and enjoy the health care and prescription benefits currently provided by VA would be completely free to remain as enrollees for VA care. But, as VA itself has acknowledged, many Medicare-eligible veterans have been forced in the past to enroll for VA care in order to gain access to VA-supplied drugs. Many would not have chosen to enroll for VA care had medications been otherwise available, and many do, in fact, choose to continue to see their Medicare-reimbursed physicians even as they simultaneously receive VA care. This may be wasteful, but it is in no way improper. However, many veterans would choose to rely solely on their Medicare doctors for care were they not forced to submit to VA care in order to gain access to VA medications—particularly when, as is provided by the reported bill, such a choice would not be irrevocable. Many of them still wish to see and in fact do see—their private providers using their Medicare benefit. The Committee bill would not force upon veterans any unwelcome choice; it cannot since it only adds to the

choices now available without denying a veteran the opportunity to change his mind and return to the status quo. It does, however, grant to veterans a new, a very welcome, choice: a choice to rely on VA for drugs only at significant discounts while continuing to rely on community-based, Medicare-reimbursed, care.

Finally, no veteran who chooses to enroll in the new “prescription-drug-only” program would be forced to forego any medical treatment. Under the terms of the reported bill, only Medicare-eligible veterans will have the option of participating in the new program. This simple, but important, fact addresses the concern that changing circumstances could somehow leave a veteran who chooses to enroll in the new drug program without access to adequate health care. All veterans who are given the opportunity to so choose will have guaranteed access to Medicare; only veterans who have access to Medicare will be given that choice. And all veterans who so choose will be able to regain access to the full range of VA-provided care.

One additional point merits emphasis: allowing veterans to voluntarily enroll in a “prescription-drug-only” benefit may result in a voluntary migration of veterans who do not need VA care (but who need or merely want discounted prescription drugs) away from VA care. In that event, the day might sooner approach when VA is able to revoke the current bar to new enrollments of non-“priority” veterans. Other suggested policy alternatives, e.g., fees or outright disenrollments, are clearly inferior to the program set forth in the Committee bill.

Finally, S. 1153 is not intended to be a subsidized price program for veterans. As is noted above, the legislation requires that VA fully recover from participating veterans the costs it incurs in procuring drugs provided to veterans who opt into this program and all expenses for administration of the program. Veterans who have access to a prescription drug program under Medicare may choose, quite rationally, to continue receiving both health care benefits and prescription drug benefits through Medicare. And those who are service-connected or poor, whether or not they are Medicare-eligible, will be fully able to receive all needed care from VA. But for many of the 9.6 million veterans who are age 65 and older and who live on fixed-incomes, the program created by the Committee bill will make life significantly easier at no expense to the Government. Such policy opportunities are few and far between.

COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, “CBO”), estimates that enactment of the Committee bill would cost \$55 million in 2005 and \$1.7 billion over the 2005–2009 period, assuming appropriation of the estimated amounts. Enactment of the Committee bill would not affect direct spending or receipts. Further, S. 1153 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would have no direct effect on the budgets of state, local, or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 27, 2003.

Hon. ARLEN SPECTER,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has prepared the enclosed cost estimate for S. 1153, the Veterans Prescription Drugs Assistance Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sam Papenfuss.

Sincerely,

DOUGLAS HOLTZ-EAKIN, *Director.*

Enclosure.

S. 1153—Veterans Prescription Drugs Assistance Act

Summary: S. 1153 would require the Department of Veterans Affairs (VA) to provide prescription drugs to veterans receiving disability compensation and certain other veterans even if those drugs are not prescribed by a doctor employed by VA. Additionally, the bill would require VA to operate a prescription drug program for veterans who are eligible for Medicare. This program would charge enrollment fees and copayments and VA would be required to run the program such that those fees and copayments would cover the cost of providing the prescription drugs to those veterans.

CBO estimates that implementing S. 1153 would cost \$55 million in 2005 and \$1.7 billion over the 2005–2009 period, assuming appropriation of the necessary amounts. Enacting the bill would not affect direct spending or receipts.

S. 1153 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would have no direct effect on the budgets of state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 1153 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2004	2005	2006	2007	2008	2009
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for Veterans' Medical Care:						
Estimated Authorization Level ¹	27,957	28,888	29,706	30,608	31,117	32,104
Estimated Outlays	27,141	28,334	29,293	30,210	30,846	31,756
Filling Prescriptions from Non-VA Doctors:						
Estimated Authorization Level	0	64	274	443	476	511
Estimated Outlays	0	57	252	424	469	505
Medical Care Collections Fund:						
Estimated Net Authorization Level	0	0	0	0	0	0
Estimated Net Outlays ²	0	–2	–6	–6	–2	–1
Total Changes:						
Estimated Authorization Level	0	64	274	443	476	511
Estimated Outlays	0	55	246	418	467	504
Spending Under S. 1153:						
Estimated Authorization Level	27,957	28,952	29,980	31,051	31,593	32,615

	By fiscal year, in millions of dollars—					
	2004	2005	2006	2007	2008	2009
Estimated Outlays	27,141	28,391	29,545	30,634	31,315	32,261

¹ The 2004 level is the amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2005. The current-law amounts for the 2005–2009 period assume appropriations remain at the 2004 level with adjustments for anticipated inflation.

² These are net amounts reflecting both collections and the spending of those collections.

Basis of estimate: For the purposes of this estimate, CBO assumes that S. 1153 will be enacted before the end of calendar year 2004 and that the necessary amounts for implementing the bill will be appropriated each year.

Filling prescriptions from non-VA doctors

S. 1153 would require VA to provide prescription drugs to veterans who are receiving disability compensation and veterans who are receiving an increased pension because they are housebound or need regular aid and attendance even if the veteran has a prescription from a doctor not employed by VA. Under current law, VA only provides prescription drugs to veterans who have received a prescription from a doctor employed by VA. If veterans bring in prescriptions from a doctor in private practice, the department requires the veterans to receive an examination from VA doctors who write a new prescription before it will fill the prescription.

Using information from VA, CBO estimates that about 2.5 million veterans would be affected by this new requirement, though most of them (about 2.1 million) are enrolled to receive health care from VA. Because most of these enrolled veterans are likely to receive the majority of their health care from VA, CBO expects this proposal would not affect how VA provides prescription drugs to this population. However, those veterans who do not currently receive health care services from VA could now fill their prescriptions at a VA facility without receiving any other health care from the department. Under current law, veterans who have a disability rating of 50 percent or higher or who qualify because of low income receive all of their prescription drugs at no cost. Veterans who receive a prescription for a service-connected condition also receive that prescription at no cost, but must make a copayment, currently \$7, if they receive a prescription for a condition that is not service-related.

Because the bill would authorize a generous prescription drug benefit, CBO assumes that, under S. 1153, about 90 percent of the veterans not currently enrolled with VA to receive health care would now choose VA to fill their prescriptions. Based on information from VA, CBO estimates that the average per capita cost of providing prescription drugs to these veterans would be about \$920 in 2005. Assuming it would take about three years before veterans take full advantage of the program, CBO estimates that implementing S. 1153 would cost about \$60 million in 2005 before growing to more than \$400 million by 2007. We estimate costs of \$1.7 billion over the 2005–2009 period, assuming appropriation of the necessary amounts.

Medical care collections fund

As described above, those veterans who have a disability rating less than 50 percent and who do not qualify by reason of low income, have a copayment of \$7 when they fill a prescription at VA

for a condition that is not service-connected. These copayments are deposited in the Medical Care Collections Fund (MCCF). Subject to annual appropriation, VA can spend the money in the MCCF to provide medical care for veterans. As specified in law, any receipts to that fund are treated as offsets to discretionary spending to the extent that they are made available for expenditure in appropriation acts. Assuming that appropriations of the new collections are provided, estimated collections and new spending authority would offset each other exactly. Outlays would lag behind collections somewhat, so implementing this provision would result in small net discretionary savings over the near term.

Based on information from VA, CBO estimates that about 280,000 veterans would be required to make copayments for prescriptions from non-VA physicians that VA would be required to fill under S. 1153. Assuming that 75 percent of prescriptions filled for these veterans are for conditions that are not service-connected and that it takes three years before veterans take full advantage of this new benefit, CBO estimates that implementing this provision would increase collections by \$6 million in 2005 and \$125 million over the 2005–2009 period. Thus, CBO estimates that net outlays for the MCCF would decline by \$2 million in 2005 and \$17 million over the 2005–2009 period, assuming appropriation actions that allow the spending of all the additional collections.

Prescription drug program for Medicare-eligible veterans

S. 1153 also would require VA to operate a prescription drug program for those veterans who are eligible for Medicare. Under the program, veterans could enroll to receive prescription drugs from VA, but if they enrolled those veterans could not receive any other type of health care from the department. We do not expect that many veterans who are already enrolled to receive health care from VA would enroll in the new program. VA would be required to charge enrollment fees and copayments such that the program would cover all of its costs including administrative, dispensing, and pharmaceutical costs. Thus, CBO estimates that implementing this program would have no net cost.

One reason veterans would enroll despite the enrollment fees and copayments is that, under current law and practice, VA is able to receive significant discounts for the pharmaceuticals it purchases and would be able to pass those on to enrolled veterans. However, CBO expects that as the number of veterans enrolled in this program increases that VA's cost of pharmaceuticals also would increase. CBO cannot estimate the extent of that increase because it would depend on both the number of veterans enrolled in the new program and the manner in which pharmaceutical companies change their pricing systems. (The private companies could choose to raise prices across the board, to raise prices only for VA, or to raise prices for non-VA purchases.) If prices were raised for VA, the increased drug prices would affect both the new program, which must cover its costs, and VA's regular health care system, which is paid for with annual appropriations.

Intergovernmental and private-sector impact: S. 1153 contains no intergovernmental or private-sector mandates as defined in UMRA and would have no direct effect on the budgets of state, local, or tribal governments.

Estimate prepared by: Federal Costs: Sam Papenfuss. Impact on State, Local, and Tribal Governments: Melissa Merrell. Impact on the Private Sector: Heidi Golding.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its July 20, 2004, meeting. On that date, the Committee, by a vote of 10 yeas and 5 nays, ordered S. 1153, a bill to amend title 38, United States Code, to permit Medicare-eligible veterans to receive an out-patient medication benefit, to provide that certain veterans who receive such benefit are not otherwise eligible for medical care and services from the Department of Veterans Affairs, and for other purposes, reported favorably to the Senate.

AGENCY REPORT

On June 22, 2004, Deputy Secretary of Veterans Affairs, the Honorable Gordon H. Mansfield, appeared before the Committee on Veterans' Affairs and submitted testimony on, among other things, S. 1153. Excerpts from this statement are reprinted below:

STATEMENT OF GORDON H. MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Good afternoon Mr. Chairman and Members of the Committee.

I am pleased to be here to present the Administration's views on six bills that pertain primarily to the veterans health-care system.

S. 1153

Mr. Chairman, I will next address S. 1153, a bill that you introduced to provide all Medicare-eligible veterans with a new prescription drug benefit through the VA. As we know, the availability of prescription drugs to our seniors has been an extremely important issue for America, and one that was debated extensively last year by the Congress.

Your bill would provide Medicare-eligible veterans with a compensable service-connected disability this new benefit in addition to the health care benefits they are currently

eligible to receive from VA. Those who do not have a compensable service-connected disability could choose to receive the new prescription drug benefit in lieu of all other VA health care benefits. The bill would require that these veterans make an irrevocable election of drug or health benefits for each calendar year. The costs for this bill could be defrayed by any combination of annual enrollment fees, co-payments, and charges for the actual cost of the medication.

In December 2003, the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 to add a prescription drug benefit to Medicare. Starting in 2006, seniors without coverage will be able to join a Medicare-approved plan that will cut their yearly drug costs roughly in half, in exchange for a monthly premium of about \$35. Under this new law, every Medicare beneficiary will be able to choose from at least two drug coverage options, and Medicare-approved prescription drug plans also will be able to offer their enrollees supplemental insurance to further enhance their coverage. It is not clear how the expanded VA benefit proposed in S. 1153 would interact with this new Medicare benefit, and we are concerned that this proposal could have significant effects on other public and private health care programs by jeopardizing the current discount prices VA receives on pharmaceuticals. While we appreciate your novel approach and share your concern that veterans and all Americans have access to affordable prescription drugs, we cannot support this bill.

* * * * *

That concludes my prepared statement. I would be pleased to answer any questions you may have.

CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

* * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * *

Subchapter I—General

§ 1707. Limitations

(a) * * *

(c) *Notwithstanding any other provision of law, a veteran who makes an election authorized by section 1710C(b) of this title (other than a veteran covered by paragraph (4)(B) of that section) shall not, for the period of such election, be eligible for care and services under this chapter, except as provided in that section.*

* * * * *

Subchapter II—Hospital, Nursing Home, or Domiciliary and Medical Treatment

* * * * *

Sec. 1710. * * *

Sec. 1710C. *Drugs and medications; vaccines.*

Sec. 1711. *Care during examinations and in emergencies.*

Sec. 1712. *Dental Care [drugs and medicines for certain disabled veterans; vaccines.]*

* * * * *

§ 1710C

(a)(1) *The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.*

(2) *The Secretary shall continue to furnish such drugs and medicines ordered under paragraph (1) to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's annual income does not exceed such maximum annual income limitation by more than \$1,000.*

(b)(1) *Any medicare-eligible veteran may elect to be furnished by the Secretary, on an out-patient basis, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.*

(2) *In this subsection, the term "medicare-eligible veteran" means any veteran who*

(A) *is entitled to or enrolled in hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); or*

(B) *is enrolled in the supplementary medical insurance program under part B of such title (42 U.S.C. 1395j et seq.).*

(3) *The Secretary shall furnish to any veteran who makes an election under paragraph (1), on an out-patient basis, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.*

(4)(A) Notwithstanding any other provision of law and except as provided in subparagraph (B), a veteran who makes an election under paragraph (1) shall not be eligible for care and services under this chapter during the year covered by the election.

(B) Subparagraph (A) shall not apply with respect to any veteran who has a compensable service-connected disability.

(5) The furnishing of drugs and medicines under this subsection shall be subject to the provisions of section 1722A(b) of this title.

(6)(A) An election under paragraph (1) shall be for a calendar year, and shall be irrevocable for the year covered by such election. An election may be renewed.

(B) The Secretary shall prescribe the form, manner, and timing of an election.

(7) Before permitting a veteran to make an election under paragraph (1), the Secretary shall provide the veteran such educational materials and other information on the furnishing and receipt of drugs and medicines under this subsection as the Secretary considers appropriate to inform the veteran of the benefits and costs of being furnished drugs and medicines under this subsection, including materials and information on the consequences of making an election under paragraph (1) and on the fees, copayments, or other amounts required under section 1722A(b) of this title for drugs and medicines furnished under this subsection.

(c)(1) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility.

(2) Any immunization under paragraph (1) shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost to the Department. For such purpose, notwithstanding any other provision of law, the Secretary of Health and Human Services may provide such vaccine to the Department at no cost.

(3) Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.

* * * * *

§ 1712. Dental care [drugs and medicines for certain disabled veterans; vaccines]

(a) * * *

[(d) The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Secretary shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's

annual income does not exceed such maximum annual income limitation by more than \$1,000.

[(e) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility. Any such immunization shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost to the Department. For such purpose, notwithstanding any other provision of law, the Secretary may provide such vaccine to the Department at no cost. Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.]

* * * * *

Subchapter III—Miscellaneous Provisions, Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * *

§ 1722A. Copayment for medication

(a)(1) Subject to paragraph (2), the Secretary shall require a veteran (*other than a veteran covered by subsection (b)*) to pay the United States \$2 for each 30-day supply of medication furnished such veteran under this chapter on an outpatient basis for the treatment of a non-service-connected disability or condition. If the amount supplied is less than a 30-day supply, the amount of the charge may not be reduced.

* * * * *

(b)(1) *In the case of a veteran who is furnished medications on an out-patient basis under section 1710C(b) of this title, the Secretary shall require the veteran to pay, at the election of the Secretary, one or more of the following:*

(A) *An annual enrollment fee in an amount determined appropriate by the Secretary.*

(B) *A copayment for each 30-day supply of such medications in an amount determined appropriate by the Secretary.*

(C) *An amount equal to the cost to the Secretary of such medications, as determined by the Secretary.*

(2)(A) *In determining the amounts to be paid by a veteran under paragraph (1), and the basis of payment under one or more subparagraphs of that paragraph, the Secretary shall ensure that the total amount paid by veterans for medications under that paragraph in a year is not less than the costs of the Department in furnishing medications to veterans under section 1710C(b) of this title during that year, including the cost of purchasing and furnishing medications, and other costs of administering that section.*

(B) *The Secretary shall take appropriate actions to ensure, to the maximum extent practicable, that amounts paid by veterans under paragraph (1) in a year are equal to the costs of the Department referred to in subparagraph (A) in that year.*

(3) *In determining amounts under paragraph (1), the Secretary may take into account the following:*

(A) *Whether or not the medications furnished are generic medications or brand name medications.*

(B) *Whether or not the medications are furnished by mail.*

(C) *Whether or not the medications furnished are listed on the National Prescription Drug Formulary of the Department.*

(D) *Any other matters the Secretary considers appropriate.*

(4) *The Secretary may from time to time adjust any amount determined by the Secretary under paragraph (1), as previously adjusted under this paragraph, in order to meet the purpose specified in paragraph (2).*

[(b)] (c) The Secretary, pursuant to regulations which the Secretary shall prescribe, may—

(1) increase the copayment amount in effect under subsection (a); and

(2) establish a maximum monthly and a maximum annual pharmaceutical copayment amount under subsection (a) for veterans who have multiple outpatient prescriptions.

[(c)] (d) Amounts collected under this section shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund.

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1729A. Department of Veterans Affairs Medical Care Collections Fund

(a) * * *

(b)(1) * * *

(4) *Subsection (a) or (b) of [S]section 1722A of this title.*

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MINORITY VIEWS OF SENATOR GRAHAM OF FLORIDA

This legislation is an important step forward to reduce the impediments to access for VA prescription drugs and to eradicate the duplication of government-provided health care services. The Chairman is to be applauded for introducing this legislation as it recognizes that VA's strong drug purchasing power should be extended to all Medicare-eligible veterans.

Where this legislation falls short, however, is that it prohibits all non-service connected veterans who elect the drug coverage under S. 1153 from seeking VA health care for one year.

Let me present my concerns.

First, and most importantly, this prohibition on care is both punitive and superfluous. Second, the views of the Veterans Service Organizations were not clearly understood at the Committee's markup.

The prohibition on care is punitive and superfluous

S. 1153 is predicated on the fact that veterans only want access to prescription drugs. If this is truly the case, I fail to see the harm in allowing veterans the opportunity to seek care. Indeed, the veterans in question are those covered by Medicare who are already receiving care from community physicians. They are seeking improved access to VA prescription drugs so as to avoid seeing a VA doctor for a condition which is concurrently being treated by a Medicare provider.

If non-service connected veterans do continue to come for VA care after access to prescription drugs is improved, it suggests that their other health care needs are not being met by community providers. An example is VA specialty mental health care which is unparalleled in the community. Because the prohibition on care could impact nearly 2 million low-income veterans, it is particularly punitive to ask these veterans to pay large out of pocket expenses for health care services which could be provided more economically from VA.

The Chairman argued that the prohibition on care was needed to eliminate "double dipping" between the Medicare and VA programs. Yet, logic holds that veterans would only use the VA system for health care services which are wholly unrelated to their prescription drug medication. No "double dipping" would occur. Veterans would receive care they needed from the source that they choose to meet those needs.

On the issue of cost, the VA Inspector General estimated that VA could save \$1 billion a year by obviating the need for VA to re-diagnose and re-issue prescriptions written by outside doctors. Again, these savings are derived from eliminating unnecessary doctor visits and tests related to a prescription medication. The IG said noth-

ing about precluding visits for other health care concerns in order to generate these savings.

Views of the Veterans Service Organizations (VSOs)

During the course of the markup there was some confusion about the position of the VSOs on this legislation, and I believe we need a clarification of where the various constituent organizations stand on this important question. Of the VSOs who testified before the Committee on July 22, 2004, only two groups support S. 1153, and both of these groups—the Veterans of Foreign Wars and AMVETS—specifically oppose the prohibition on access to health care for certain Medicare-eligible veterans.

In summary, the question before the Senate is: do we want to exclude veterans from seeking the health care they have earned? As the VFW testified at the Committee’s legislative hearing, “Veterans are unique in that they have an entitlement to Medicare by way of a financial contribution and have also earned the right to VA health care through virtue of their service to this nation. They must not be forced to give up their rights to either.”

The Committee rejected an amendment I offered that would have struck the prohibition on health care in S.1153. When this legislation is considered in the Senate, I intend to seek consideration of my amendment de novo.

