DEPARTMENT OF VETERANS AFFAIRS PHARMACEUTICAL PROCUREMENT POLICY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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DEPARTMENT OF VETERANS AFFAIRS PHARMACEUTICAL PROCUREMENT POLICY

TUESDAY, JULY 25, 2000

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Gutierrez, Doyle, Bilirakis, Carson, Snyder, and Shows.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The VA Subcommittee on Health will come to order. I've called for this hearing today to give our members and our witnesses an opportunity to place on the public record a potential change in federal procurement policy that may have a detrimental effect on the cost of drugs and medicine the VA buys for veterans in its health care system. We want to discuss what that effect may be. I appreciate everyone's cooperation with the subcommittee in appearing.

Before introducing our witnesses, I want to reflect on the record that I invited a—I want to put on the record that I invited a representative from the Office of Management and Budget to testify at this hearing, but OMB declined to appear. I find it curious that in a policy initiative so clearly imprinted with the fingerprints of our budget personnel at OMB, that no OMB official would be willing to come and defend what it wants VA and others to abide by. OMB deferred to VA to inform us of their plans. So it would be nice to have their opinion, too.

Without objection, my invitation letter to OMB Director Jacob Lew will be introduced and entered into the record of our hearing today. Also without objection, we have a letter that I wish to put in the record that I sent to Secretary Togo West on March 15, 2000, concerning this very same subject, a letter that remained unanswered as of this morning.

(See pp. 39 and 40.)

Mr. STEARNS. The Congress has paid very keen attention for years to the issue of VA's pharmaceutical policy. Any change, however trivial it may seem at first glance, gives us all some concern. We have a 10-year history of vigilance to ensure that veterans receive the VA drugs and medicines they need, and that VA doesn't have to spend an arm and a leg to get them. The pharmaceutical

industry, in the beginning a bit reluctant to participate in this program, has embraced VA's arrangement with drug manufacturers and marketers, and I think it is safe to say that VA enjoys the very best price advantage of any pharmaceutical buying institution in America. GAO has told us before that VA's discount from retail drug rates exceeds 80 or 90 percent in some procurement classes. The average discount basis, or "floor," is about 24 percent by law.

What motivated me to call this morning's hearing was testimony by Mr. Flynn, one of our witnesses today, at a hearing before the Committee on the status of the Federal Employees Health Benefits Plan. OPM manages the health benefits for the entire Federal Government, including the health plans of many employee organizations, such as the Special Agents Mutual Benefits Association, or SAMBA.

Parenthetically, OPM's reach in health plan management includes all Members and staff of the Congress. So in the interest of full disclosure, if drug discounts in federal health plans were to come about as I understand the planning here, then I and all my colleagues would stand to benefit, too, from this action. But of course, the Subcommittee is not concerned about our personal situations. We are most concerned about the impact of such a plan on the VA health care system and its patients. So I take this hearing very seriously.

My colleagues, let me quote from Mr. Flynn's prior testimony, and I quote—he said, and I quote, "I wanted to ask you about OPM proposing to allow SAMBA to purchase prescription drugs for its mail order program off a federal supply schedule at a discount. What is the status of SAMBA's access to the FSS for prescription drugs?"

This is what Mr. Flynn said. "I expect, Mr. Chairman, that we will have resolved that completely within a matter of days. We do know that we have now reached sort of a framework of agreement under which SAMBA will be available to access the federal supply schedule for prescription drugs for their mail order program. Details of that are being worked out, but it would be a 2-year pilot effort, and we look forward to seeing the results of that and whether or not the savings that were generated might be applicable to other areas of FEHBP."

Later, the Chairman asked Mr. Flynn, and I quote, "How much does the FEHBP program spend per year on prescription drugs?" And Mr. Flynn replied, "In round numbers, it is a dollar out of every four. We have a $20 billion-a-year program, which means $5 billion each year goes towards prescription drugs."

Today, the entire drug purchasing program of the Department of Veterans Affairs is valued at less than $2 billion. If Mr. Flynn's stated hopes could come true based on the SAMBA experiment, VA's program in the FSS goes from $2 billion to $7 billion annually, and even more, possibly, down the road.

I want to give Mr. Flynn and VA a full opportunity this morning to explain how they propose that VA will not be adversely affected by this plan for FEHBP, with SAMBA drug purchasing leading the charge. I am also especially interested in whether this expansion, with SAMBA now, or perhaps the entire FEHBP later on, needs an authorization from Congress.

Before going to our witnesses today, of course, I want to turn over to my colleague, Mr. Gutierrez, who is the ranking Subcommittee member on this, for any opening remarks he has.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman. I'm pleased that we are here today to discuss the issue of pharmaceutical procurement, and I thank the witnesses for appearing.

As we know, the Department of Veterans Affairs currently purchases pharmaceutical drugs and medical supplies for VA patients through the federal supply schedule, a program for volume buying that allows VA to receive these goods at below-average price per item. VA medical centers are the most significant federal purchasers of pharmaceuticals through the federal supply schedule. By buying in bulk, and negotiating the federal supply schedule with drug companies, this procurement keeps costs to a minimum for veterans who rely on VA facilities for their health care needs.

Recently, the Office of Personnel Management authorized the Special Agents Mutual Benefits Association, a federal employee health care benefits provider, access to the federal supply schedule for pharmaceuticals. By doing so, OPM instructed the Department of Veterans Affairs to permit approximately 16,000 federal employees, under certain restrictions, access to pharmaceuticals at a reduced cost. The goal of this pilot program is to determine if a prescription drug price similar to those specified in the federal supply schedule can be established to provide pharmacy benefits to millions of federal employees. I strongly support the goal of this endeavor.

I am deeply concerned about the rising costs of pharmaceuticals in recent years. For example, prescription drug premiums for federal employees have increased by 30 percent in the past 3 years. Some Americans, most of them senior citizens, are now traveling into Canada and other foreign countries to purchase their medications, because they can buy prescription drugs there for a price that on average is 40 percent lower than what they are charged in the United States.

I fear that our veterans population will be among the hardest hit by the increasing cost of drugs. We must remember that the vast majority of veterans rely on the VA for their health care, and do so because they have nowhere else to turn. And these men and women would face a great hardship if they are forced to pay more for medicines they need.

I strongly support efforts to ensure that our nation's veterans continue to have access to pharmaceuticals at affordable prices. However, I believe that all of us on this committee, while we work to assure that veterans continue to receive affordable prescription drugs, must commit ourselves to the critical goal that every American has access to affordable prescription drugs. The rising cost of drugs and the unwillingness of Congress to take real, credible action to give the American people life-saving or life-sustaining drugs at reasonable prices constitute a national crisis.

I urge my colleagues, our advocates for veterans, and most importantly, the pharmaceutical industry, to take action to protect

our veterans' ability to receive these drugs, while assuring that every other American has this right.

Mr. Chairman, I have the written testimony of the American Federation of Government Employees and the National Treasury Employees Union, and I ask that these be submitted for our hearing record.

Mr. STEARNS. So ordered.

(The statements appear on pp. 71 and 79.)

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

Mr. STEARNS. Now for an opening statement, the distinguished Chairman of the House Subcommittee on Commerce, Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I, too, commend you for scheduling this hearing.

Mr. Chairman, Dr. Snyder and I spoke very briefly before the hearing started on this particular subject. I don't know, he doesn't know, I'm not sure any of us really know whether this might be a good thing or might be a bad thing. But we certainly can't stand idly by and watch it happen without actually taking a real good look at it, and that's what we're doing here today under your leadership. And I know we're all, on behalf of the veterans and ourselves, very, very grateful to you.

Concerns have been raised that this program will adversely impact the VA. And we know that specifically that the concern is that it might increase VA prices for pharmaceuticals. And Mr. Chairman, this concern is not unfounded. In 1990, Congress required drug manufacturers to give state Medicaid programs rebates for outpatient drugs based on the lowest prices they charged other purchasers. Because of the size of the Medicaid market—being as large, of course, as it is—many drug manufacturers sought to minimize the impact of the 1990 Omnibus Budget Reconciliation Act by raising their drug prices to the VA. In some instances, drug prices to the VA rose by as much as 1000 percent. While this problem was corrected in the Veterans Health Care Act of 1992, it does demonstrate, Mr. Chairman, our concern, that VA discounts for pharmaceuticals could be adversely impacted if those discounts were extended to a significantly larger universe of purchasers.

Concerns have also been raised that drug manufacturers could shift costs to private payers if the pilot program is significantly expanded to cover all federal employee health plans. And of course, questions have also been raised on whether or not OPM even has the authority to establish this pilot program.

So it's clearly incumbent upon our subcommittee, Mr. Chairman, to ensure that the VA is not forced to pay higher drug costs because of this pilot program. And as you mentioned, as Chairman of the Commerce Health and Environment Subcommittee, I'm also interested in the impact that it may have on private health care providers. I know we're all anxious to hear from today's witnesses, and again, I thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. In order of arrival, Dr. Snyder, opening statement?

Mr. Doyle, from Pennsylvania.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Mr. Chairman, I want to thank you for convening this morning's hearing to further examine the impact that the rising cost of pharmaceutical drugs is having not only on the public sector, but on the Department of Veterans Affairs, and various federal employees' health care plans.

I realize that some individuals will choose to characterize the substance of today's discussion on the intricacies of bureaucratic procedure. But in my view, the issue demanding serious attention today is not OPM or SAMBA. Rather, the issue at the crux of the matter is, what can be done to address the escalating cost of prescription drugs, and pass those savings along to our country's senior citizens and veterans?

We're all well aware of the dynamics that inform the ongoing debate over the rising cost of pharmaceutical drugs. And it troubles me greatly when our veterans are drawn into the mix, and tacitly threatened with being the scapegoat if certain efforts are allowed to proceed. In this case, the effort is the SAMBA pilot.

It's not just my personal opinion that this hearing is, for all intents and purposes, an effort to distract and deflect attention from the larger issue at hand. In fact, a recent Washington Post article reported that the direct threats levied by entities who are opposed to the SAMBA pilot, that interestingly enough point to the same detrimental effects when it comes to providing a guaranteed prescription drug benefit that is affordable, dependable and voluntarily available to all beneficiaries. Quite frankly, I find the rationale that has been employed in impeding progress of prescription drug coverage for seniors just as questionable, and perhaps even more distasteful, when covertly using veterans as a pawn.

There is not one member of this committee who would advocate for raising the cost of drugs for veterans. This fact is well known, and should be commended, not used as a divisive tool. It's my hope that we can clarify the authority of OPM to designate the SAMBA pilot, as well as ascertain the guidelines for the pilot that have been agreed to, will protect veterans from any adverse actions manufacturers may take.

We should, however, not be distracted from the real issue at hand, nor be dissuaded from pursuing legislative remedies that will not only benefit our senior citizens, but our nation's veterans as well. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. At this time, Ms. Carson from Indiana, you're recognized for an opening statement if you'd like one.

Ms. CARSON. You go ahead. I didn't have my book.

Mr. STEARNS. Okay. Well, we'll give you the opportunity for questions. We'll now have the first panel, if they'd come forward.

Mr. William Flynn is Director, Retirement and Insurance Programs, the Office of Personnel Management; and the Hon. Edward A. Powell, Assistant Secretary for Management, Department of Veterans Affairs. You folks are both recognized for an opening statement in the 5-minute time limit. I understand we have Mr. Gary Krump, who has accompanied Mr. Powell, Deputy Assistant Secretary for Acquisition and Material Management. Welcome this

morning, and I appreciate your participation. We look forward to your opening statements.

STATEMENTS OF EDWARD A. POWELL, JR., ASSISTANT SECRETARY FOR FINANCIAL MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY GARY J. KRUMP, DEPUTY ASSISTANT SECRETARY FOR ACQUISITION AND MATERIAL MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND WILLIAM FLYNN, III, ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT

STATEMENT OF EDWARD A. POWELL, JR.

Mr. POWELL. Mr. Chairman, I am not going to make an opening statement. My written statement is sufficient, and so I waive that time.

[The prepared statement of Mr. Powell appears on p. 45.]

Mr. STEARNS. Okay, that's fine. Mr. Flynn, you're recognized for your opening statement.

STATEMENT OF WILLIAM FLYNN, III

Mr. FLYNN. Thank you, Mr. Chairman. I have just a few things I'd like to say.

First, I want to thank you and the members of the Subcommittee for convening this hearing today, and for inviting me to testify. In your invitation, you asked me to address several issues regarding our authorization to the SAMBA health plan enabling them to access the federal supply schedule for prescription drugs on a 2-year pilot basis.

As you know, OPM administers the Federal Employees' Health Benefits Program. It's the largest employer-sponsored health insurance program in the nation. Like other health insurance sponsors, we've witnessed rising premiums for our members over the past several years. Among the factors causing these increases, prescription drug costs are by far the most important.

Drug costs currently are increasing at a rate of 20 percent a year, and in 1999 they accounted, as you said, Mr. Chairman, for almost $5 billion, or one dollar out of every four spent in the program. In order to keep the program comprehensive and affordable, OPM and the participating health plans have taken a number of steps to mitigate rapid rises in premiums. Almost 9 million federal employees, retirees and members of their families depend on this program for their health needs.

Now, as part of this effort, we've encouraged health plans to take advantage of government discounts on the goods and services they use. And in line with this practice, the SAMBA health plan requested access to the federal supply schedule pricing for its mail-order prescription drug program in the year 2000.

With 16,000 enrollees, SAMBA is a relatively small health plan. Only certain law enforcement personnel are eligible to join it. Last year, its mail-order drug costs totaled $11 million. Assuming supply schedule access, SAMBA reduced its premiums 3 percent below what it otherwise would have been for the year 2000.

In response to their request, we determined that SAMBA met the requirements for access to the federal supply schedule. We determined that the health plan's contract was of a government cost-reimbursement nature, because SAMBA may only charge actual and allowable benefit and administrative expenses to its contract. SAMBA's profit is a fixed amount limited by negotiation to less than 1 percent of allowable expenses. And the health plan does not profit from access to the schedule. In addition, SAMBA's contract places a ceiling on administrative expenses that may be charged to the contract, and the SAMBA plan is exposed to risk if its premiums and reserves are insufficient to pay benefits, though that is a rare occurrence in the Federal Employees' Health Benefits Program.

Now, we're entering into this pilot based on the following principles: SAMBA's access to the schedule will be limited to 2 years, and will be for their mail-order program only; access to the schedule will not be extended to any other health plan in the Federal Employees' Health Benefits Program.

We and the Department of Veterans Affairs will develop an agreement to oversee and evaluate the pilot. Among other things, the agreement will enable us to resolve issues quickly, and terminate the pilot quickly if necessary. In our joint evaluation of the pilot, we'll look at financial and operational impacts, and investigate the feasibility of establishing a separate schedule for use in the federal employees' program.

Both OPM and the Department of Veterans Affairs will meet with pharmaceutical company representatives and discuss the pilot. That meeting is now being set up and should occur within the next week or so.

We understand the implications that SAMBA's access might have on agencies that purchase drugs for their members. Four agencies—the Department of Veterans Affairs and Defense, Coast Guard and the Public Health Service—today have statutory access to pharmaceutical discounts, and consume 95 percent of the drugs purchased from the schedule. Other agencies, such as the Bureau of Prisons, sometimes benefit from these discounts, and sometimes pay a higher price.

The price paid by these other agencies depends on whether or not the supplier chooses to establish a second-tier price for buyers not otherwise entitled to the statutory discount. Many suppliers have not established second-tier prices since the volume from other buyers is so low—only about 5 percent today.

Now, under this pilot, SAMBA is not entitled to the statutory discounts. And it must pay the second-tier pricing where that exists. We estimate that SAMBA's total volume of purchases will amount to about three-tenths of 1 percent of the total volume of drugs currently purchased from the schedule.

Mr. Chairman, the SAMBA pilot will be used simply and exclusively to establish a baseline and experience against which to assess the desirability of establishing a separate schedule for the federal employees' health program. We think it's a smart business decision.

That concludes my statement. I'd be glad to try to answer any questions you or the Subcommittee members may have.

[The prepared statement of Mr. Flynn appears on p. 50.]

Mr. STEARNS. Good. Thank you, Mr. Flynn. I have the first round of questions.

On June 13, at the hearing before the Subcommittee on Civil Service of the Government Reform Committee, you seemed to indicate in your speech that you'd already worked out the framework for SAMBA, which is the Special Agents Mutual Benefits Association—you worked out a framework, and I guess, assume this is an agreement that you have actually put in place, and you have it in writing, and it's ready to be implemented. So my first question is, have you established a definitized program on this in written form?

Mr. FLYNN. We have, Mr. Chairman, a letter from the Department of Veterans Affairs, dated July 14, that outlines that agreement, and further contemplates the establishment of an evaluation plan. The only thing left for us to do now is to complete that evaluation plan. It's in draft form, and hasn't yet been agreed to but should be shortly, and then put it into place as we oversee the operation of the pilot for SAMBA, for the 2-year period.

Mr. BILIRAKIS. Mr. Chairman, would you yield a moment?

Mr. STEARNS. Yes, I'd be glad to yield.

Mr. BILIRAKIS. Did you say, Mr. Flynn, a July letter from the VA?

Mr. FLYNN. That's correct, sir.

Mr. STEARNS. Mr. Flynn, I had a copy of this, and when we read it over, it looked like an offer. It didn't look like a written plan. Has your Department actually put in writing an implementation plan? Is there anything in writing about how you intend to do this, and the directives for enforcing it? Yes or no?

Mr. FLYNN. Yes, sir, we have a draft plan in place——

Mr. STEARNS. Okay.

Mr. FLYNN (continuing). For the implementation and evaluation of the program.

Mr. STEARNS. But that's just what I'm trying to find out, because based upon this July 14, or July 13, letter, it appears that you're making an offer. But I think—I had assumed that you had a written plan. So now you're confirming it this morning that yes, indeed, you do have a written plan to implement this.

Since this would impact, we think, the Veterans' Administration, and the veterans of this country, I would like to have a copy of that written plan. Would you oblige me to give us a written copy of this plan, so we can look at it to see exactly what your intention here is?

Mr. FLYNN. Absolutely, Mr. Chairman.

Mr. STEARNS. Thank you, Mr. Flynn. Your statement today also indicates that SAMBA already reduced the premiums to its members by 3 percent based upon the impending agreement with VA. How is it that a discount not yet given results in a lower premium? I think we're a little concerned to already see this starting to have an impact when it's not yet given. Is the Treasury already subsidizing this proposed arrangement before the fact?

Does that make any sense? Do you understand what I mean?

Mr. FLYNN. I understand the question. Mr. Chairman, as I mentioned in my prepared statement, this issue came to our attention first last June, when the SAMBA health plan, in a slightly different variant, essentially proposed access to the federal supply

schedule for its mail-order benefit. And we've been involved in discussions with the Department of Veterans Affairs about that. It was essentially our responsibility to make a determination that under the federal acquisition regulations, SAMBA was a cost-reimbursement contractor and entitled to access.

We made that judgment in December of last year, just prior to the start of the 2000 contract year. And because of a number of concerns raised by both the Department of Veterans Affairs and others—valid concerns, I might add—it has taken us to this point to reach an agreement on the framework, and as you mentioned, the plan under which access to these prices will be granted.

Because it's just simply pricing—it's not a question of the physical delivery of drugs, and ultimately drugs to the members of the SAMBA health plan—because it's just a question of pricing, there is the possibility that we could adjust pricing retroactively to the first of January. That hasn't been settled yet. But we do believe, at a minimum, prospectively from the 14th of July, SAMBA is authorized access to this pricing.

Mr. STEARNS. This committee understands that you've interpreted Part 51 of the federal acquisition regulation differently from several legal sources that we have consulted with. Could you explain to this committee how a health insurance plan for special agents—these folks, the SAMBA people—are getting a federal subsidy, would be proposed to have a federal subsidy that is in the same league as the Department of Defense, the VA, how you can do it unilaterally and under this Part 51 of the federal acquisition regulation without Congress's, even, input or oversight?

Mr. FLYNN. Mr. Chairman, the first point that I would make is that in your question you indicated that we were operating on the same basis, or at the same level, as the Department of Veterans Affairs or the Department of Defense. And that is clearly not the case, and it is not something that we've ever asserted in this process.

What we have asserted is that under Part 51 of the federal acquisition regulations, certain contractors who do business with the government, under contracts of a cost-reimbursement nature, may have access to federal supply schedules based on a judgment by the contracting officer. Our contracting officer in that case made the judgment. It was supported by our legal counsel. And on that basis, we then approached the Department of Veterans Affairs for access to second-tier pricing.

Mr. STEARNS. Okay, following what you just said—that you could next make the leap to extend this subsidy to all the Federal Employees' Health Benefits Program. Is that what I interpret you to say, that you could go——

Mr. FLYNN. No, sir.

Mr. STEARNS (continuing). From SAMBA to the FEHBP?

Mr. FLYNN. If I created that impression, Mr. Chairman, I was in error in doing so.

First of all, broadly speaking——

Mr. STEARNS. But you just said you could go to the special agents, who—you think you have the right to offer it to them. So what would prevent you from just going to the whole 10 million Americans who are under the FEHBP?

Mr. FLYNN. That's a good question, and I'll try and clarify the differences by grouping into three categories here.

Broadly speaking, there are about 285 health plans that participate in the Federal Employees' Health Benefits Program. The overwhelming majority of those plans are health maintenance organizations, whose contracts with us are not of a cost-reimbursement-type nature. The indemnity plans that participate in the program, sometimes known as fee-for-service plans—such as the Special Agents' Mutual Benefit Association—are the types of contracts that we characterize as of a cost-reimbursement nature. So it's only a very limited subset that would be potentially granted access.

But the other thing that I will say is that the culmination of the agreement that we've reached here is that, moving forward, there is an agreement between us and the Department of Veterans Affairs that no other health plan, other than SAMBA, will be granted access. And SAMBA's access will only be for a 2-year pilot period, in order to evaluate the effectiveness of that experiment, and the desirability of creating a separate schedule for the federal program itself.

Mr. STEARNS. My time has expired. The ranking member, Mr. Gutierrez.

Mr. GUTIERREZ. Mr. Flynn, approximately how many federal employee health beneficiaries use what OPM has deemed cost-reimburse providers?

Mr. FLYNN. Mr. Gutierrez, I might answer that more specifically for the record, but in round numbers, about 70 percent of the almost 9 million total participants—employees, retirees and members of their families—participate in fee-for-service-type health plans in the Federal Employees' Health Benefits Program. So again, in round numbers, it would be between 6 and 6.5 million—if my multiplication is correct, about 6.3 million.

Mr. GUTIERREZ. Thank you. A Federal Diary article appeared in this Sunday's Washington Post, placing SAMBA's enrollment at 42,000. Your statement that SAMBA covers average—I'm sorry, offers coverage to 16,000 enrollees. Which number is correct?

Mr. FLYNN. That's probably just a distinction between the number of policy holders—that is to say, the employee or the retiree who has actually signed up—and then the extension of that to members of their family. I think as a rule of thumb, you can consider that there are about 2.5 people on average per family, so if you have 16,000 enrollees, which is correct, extending that to 42,000 may be a little high. I think it's probably more in the neighborhood of 32,000. But I think that's the primary difference in the number.

Mr. GUTIERREZ. The article also quotes an OPM official saying that the demonstration has controls that aim at avoiding "the unintended consequence of increasing cost to other federal agencies by virtue of granting SAMBA this access." Can you share some of the controls you have in mind?

Mr. FLYNN. Yes, Mr. Gutierrez, I'd like to be able to do that. They're actually outlined in not only the letter of July 14, but other documents that the Department of Veterans Affairs and we have shared and agreed to.

First, as I mentioned earlier, the SAMBA health plan is not entitled to the pricing that is set by statute. It's only entitled to second-tier pricing.

Secondly, it is for a 2-year pilot. It is not intended to be extended.

And thirdly, the volume that we're talking about here amounts to about three-tenths of 1 percent. If you were to consider 1,000 pills by the side of the table, it would be three pills out of that group of 1,000 pills.

Finally, we have a number of oversight mechanisms in the Federal Employees' Health Benefits Program generally—audits by independent public accountants, audits by our Office of Inspector General—and in this particular case, special procedures to ensure that there is no diversion of drugs to audiences other than the enrollees and members of their families.

So I think there are a number of protections built in here, not only to make sure that the benefit is administered properly, but that we get information that enables us to evaluate it so that there are no unintended consequences rippling over into the programs that other agencies administer who also participate in obtaining drugs from this contract, from the schedule.

Mr. GUTIERREZ. Mr. Powell, is that your understanding of the agreement?

Mr. POWELL. Yes. And I think it's important to note that from the start, VA has always had a concern for protecting——

Mr. STEARNS. Mr. Powell, can you move the mike just a little closer to you?

Mr. POWELL. Sorry. Chair's a little low this morning.

Yes, we've always had a concern to protect veterans' benefits derived from this very well-thought-out and effective Federal Supply Schedule. As the pilot has evolved, we've taken great care to address the issues. As Mr. Flynn has stated, it is a 2-year pilot. It is discrete. We will develop measures to identify, as carefully as we can, any indications that we are being adversely impacted.

There is an element, if I might add, that I find curious. We are hoping to set up a separate schedule; that is the goal here. I'm not quite sure I understand why our pricing should be impacted. SAMBA is a relatively small group compared to what we do. The pilot's goal is look at FSS functionality to give us insight as to how to design a schedule for the OPM group.

The new schedule will be something the pharmaceutical companies will bid for in an open market. We're not dictating anything to the pharmaceutical companies. I would suspect that this would be a good opportunity for them.

Mr. GUTIERREZ. Let me see—back to Mr. Flynn. Do you expect that the OPM will authorize additional cost-reimbursed providers to purchase drugs off the supply schedule, if the demonstration is successful?

Mr. FLYNN. Mr. Gutierrez, we have stated ahead of time that we have no intention whatsoever of allowing additional cost-reimbursement contractors to purchase drugs off this schedule.

If this pilot is successful, what we're talking about doing is looking at, investigating the feasibility of creating a separate schedule for the federal employee program.

Mr. GUTIERREZ. I see. Very good. Mr. Powell, back to you. Has the VA consulted any of the pharmaceutical manufacturers with whom it negotiates for drugs about the pilot project it intends to participate? If so, what has been their response?

Mr. POWELL. We have had numerous conversations with them. I think it would be better if I let Mr. Krump answer that, since he's the one who's had the direct conversations. I would prefer not to be in the middle so you will hear direct communication.

Mr. KRUMP. Thank you. Yes, sir, what we have done is contacted industry representatives, and in many cases, the industry representatives have contacted us. And what we are in the process of doing is setting up a meeting along with OPM, to brief industry and their representatives to sit down and walk through what the procedure is. There has been a good deal of misinformation, at least at the outset, and we believe that the best way to resolve this is to get all the folks in one room and explain what the thrust of this activity is, what it is that we intend to do and what our preferred outcome is.

Whether or not they will accept, it would be premature for me to say. But they are at least willing to listen and talk.

Mr. GUTIERREZ. Okay. Last week, Mr. Powell, the Senate passed an amendment offered by Senator Jeffords and others to allow U.S. wholesale distributors and pharmacists to re-import drugs originally purchased in FDA-approved facilities. If the House passed such language, it appears that the VA could negotiate significantly greater discounts by realizing some of the savings pharmaceutical manufacturers pass on to—for reasons unknown to me—passed on to other industrialized nations, such as Italy and France. Do you agree this could offer the VA an increased opportunity to recognize savings? How about Federal Employees' Health Benefits Program? Basically, if we can't get a better price from them, why not just re-import it? They're FDA approved, and if I can buy them in France and import them there in this global economy, why don't we just do that? Wouldn't that be a savings?

Mr. POWELL. First, I would have to say that's a little beyond the scope of my course, in terms of being able to comment on that particular piece of legislation. I would also say VA, or any organization in the acquisition business, has a responsibility to make sure they're purchasing those products as effectively and efficiently as possible. To the extent new legislation opened up an avenue to us to acquire pharmaceuticals, then I feel we have a responsibility to at least investigate it.

Mr. GUTIERREZ. I'd say I guess my point is, you know, in this global economy where everybody's looking—if we were in the private sector, I'm sure we would negotiate with whomever for the best price for whatever goods. And it just seems to me that if our pharmaceutical industry here in the United States of America is shipping to Italy and France and Canada certain pharmaceuticals at a given price, and the FDA-approved facility is producing those, re-importing those back to the United States at a lower significant price just seems to be something we should look at. And while it may be beyond the scope of what you were prepared to come and answer today, I think it's something that we might just have to look at, given the trends in this global economy of ours.

Thank you very much, Mr. Powell.

Mr. STEARNS. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Mr. Flynn, I want to commend OPM for their open-mindedness. I'm still not convinced that this is a good idea because we know that drugs or pharmaceuticals are awfully expensive, but we should be open-minded to new ideas, if you will. But at the same time, we've got to take in consideration the overall effect of what our actions might be, and try to at least reduce the unintended consequences as much as possible.

And I am pleased. I don't know whether you initiated the discussions with the VA, whether VA initiated them with you, or whether you did it somehow in concert. But the fact of the matter, the fact that you're discussing this with VA and trying to work things out with them and whatnot I think is very admirable. And I mean that.

You say in your statement that drug inflation averages 20 percent. We already know that. We know that drugs are expensive; we know the good that they do. FEHBP is a model program and has been lauded as a good approach for health insurance for all Americans. It relies on the private marketplace, variety, choice, and most important, competition to keep prices and costs low.

So I guess I would ask you: what's the record of drug cost inflation, as against that 20 percent that you originally mentioned, in the FEHBP over the past several years? Is that rate higher or lower or about the same as in the health care environment in general?

Mr. FLYNN. Mr. Bilirakis, I know that we have looked at what prescription drug cost trends have been in the overall economy over the past several years, and tried as best we could to compare that with our own experience.

I think that it is comparable, with the proviso that if you look at the average age of the population covered by the Federal Employees' Health Benefits Program, there is a significant number of retirees, full coverage for retirees from their employer-sponsored plan into retirement. You see a differential there.

So that produces a small absolute delta. But the trend, generally speaking, the trend in the increase in costs from one year to the next is roughly comparable, even though the absolutes might be a little different because of the higher average age of the FEHBP population.

Mr. BILIRAKIS. All right. But—and I guess it surprises me, but then again, why not? And I'm sure your information is a lot better than what I would have.

How would that compare, though, with the VA? The VA costs, the increases?

Mr. FLYNN. I would defer to——

Mr. BILIRAKIS. Are they a lot lower, Mr. Powell? What are—the VA percentage increases sort of thing?

Mr. POWELL. We were just talking about that. We'll have to provide the information for the record, Congressman. I don't want to mislead you. I know we have saved a tremendous amount of money, as we perceive it, by having this schedule. I do want to reemphasize we are very attuned to that fact. We are going to be

very careful how we evaluate this pilot because no one has any intention of the FSS being disrupted.

Mr. BILIRAKIS. Well, I guess there wouldn't be concern here if we did not feel very strongly, all of us, that the VA percentage increases are lower, considerably lower.

Mr. STEARNS. Will the gentleman yield for one second?

Mr. BILIRAKIS. Sure.

Mr. STEARNS. Mr. Powell, can you provide us an answer to Mr. Bilirakis' question?

Mr. POWELL. I will provide it for the record, Congressman.

Mr. STEARNS. Okay.

Mr. POWELL. I don't—any number that I gave you at the moment would—I would be nervous that it would be inaccurate. I want to make sure we get it right because it is important——

Mr. BILIRAKIS. Well, I'm pursuing the fact—I'm going on the premise that they're a heck of a lot lower.

Mr. POWELL. I think that's reasonable.

Mr. BILIRAKIS. Now, this statement in the July 14 letter, "access to the existing FSS for some pharmaceuticals by health insurance carriers within the FEHBP will never be extended beyond the SAMBA health plan pilot." Come on. That's not a contract, is it? How can we be sure?

Mr. POWELL. That wasn't intended to be a contract. It was a memorandum of our understanding based on meetings we had in order to provide some longevity. Obviously the administrations are going to change. The pilot is going longer than I will be in my position, or perhaps Mr. Flynn will be in his. We wanted to memorialize everybody's intention going forward because we don't have assurances necessarily that we're going to be the ones managing this process two years from now. We wanted everyone to understand what our goals are.

Mr. BILIRAKIS. We can take a look at the pilot at the end of 2 years, or just short of the 2 years, or whatever the case may be. But in the meantime, an awful lot of damage could be done. Look at the results of a 1990 act that we passed regarding pulling in Medicaid, if you will, an awful lot of damage was done. We came back and tried to fix it in 1992. I guess we fixed it to some degree.

Can we somehow have some assurances that there are not going to be any higher increases in VA pharmaceuticals during this pilot period of time, above and beyond what has been the case on an ordinary basis up to now? Can we get some assurances there?

Mr. POWELL. The only assurance I can give you is that in the MOU, we are going to work out a matrix to define those costs we are going to observe in order to determine whether there's been an adverse impact above and beyond the normal increases you would expect from market forces.

We are very sensitive to this. We don't have an absolute formula I can present to you today, but it is something we will be working on. As Mr. Flynn has said, you will certainly get a copy of the MOU.

Mr. BILIRAKIS. Well, you know, I'm concerned. Here we are, practically at the end of this administration. Changes—I think it's probably one of the problems, as far as our government functions, is the fact that we have changes in the administrations every so

many years, which in a way I guess is good, but in another way—you laugh. In another way——

Mr. POWELL. I suppose that's probably a point of view.

Mr. BILIRAKIS (continuing). It causes some problems. So all the best intentions in the world now, but can it go—who knows what happens after this year?

Mr. Chairman, I'd hate to see adverse consequences—you know, Dr. Snyder said heck, it's a 2-year pilot program, there may not be any harm in it. And there may not be. But in the meantime, there also could be an awful lot of harm that maybe we could not undo. And I'd like to see some safeguards during this particular period of time, that VA pharmaceutical costs would not exceed what they have been, you know, the past increase percentages have been. Thank you very much.

Mr. STEARNS. Good point. Let's see—Dr. Snyder, in order of the arrival, is open for your questions?

Dr. SNYDER. Thank you, Mr. Chairman.

I assume that you all are entering into this as a legitimate study, you don't know what the answer's going to be. Is that a fair statement?

Mr. FLYNN. From our perspective that's true.

Mr. POWELL. Yes.

Dr. SNYDER. I was—because in my view this is different than what happened with Medicaid in 1990. Do you agree with that also?

Mr. FLYNN. Yes.

Mr. POWELL. Yes.

Dr. SNYDER. There was a GAO letter or something that came out within the last year, discussing this issue of—I think it was a discussion of Tom Allen's bill, H.R. 664, which I'm not a co-sponsor of, by the way, and which—GAO then made the comment that GAO has concluded that the effect on schedule prices of opening up the FSS will "depend on the outcome of negotiations between the VA and drug manufacturers. Because of the uncertainties related to these negotiations, it is not possible to predict how schedule drug prices will change." Now, that was dealing with a bill that has much broader implications than the study you're talking about. But it seems to me that the GAO agrees with you all that we don't know what the potential impact would be.

And so it seems to me that that points us in two divergent directions. One is that since we don't know, this could turn out to be a really good thing for federal employees without negative impact on veterans, which I think is what you all are expecting to happen. On the other hand, you know, we get surprised somehow.

So my question is, if we're entering into this with an open mind, as far as a study—I think you've sensed some reluctance on the part of committee members. We would like some assurances that we can maximize the good if the good occurs, but if the bad occurs that there's not going to be so much pride involved in this thing that you all are going to be reluctant to back off and say, well, this didn't go well. I guess that's more of a human emotion question than a specific protocol for a study, but that's, I think, the drift of what several members of the committee are at. Do you all have any comment on that?

Mr. FLYNN. Mr. Snyder, or Dr. Snyder, I would agree with that sentiment. You yourself pointed that what we have under consideration here as a pilot effort is much different in scope and complexity in nature than other things that have been looked at in the past.

By the same token, clearly there is some downside potential to this as well. And we have to be—the two Departments, and OMB and others—candid with ourselves as we look at our experience and make a judgment about whether or not we are producing the results that we thought we would produce, or are producing something different.

I can tell you that what we're about at OPM is finding comprehensive, affordable health care for 9 million members, retirees, and members of their family. If this pilot project does not produce that, or produces effects that are inconsistent with that, or effects that are unrelated but nonetheless harmful in nature—whether it's to the population served by the Department of Veterans Affairs, or other major populations here—that we will approach this with the idea that if it is causing damage or not producing the intended results, then we will stop it right away and look for other options.

Dr. SNYDER. One of the concerns I have, I guess, about this is I always hate to see—I know I speak for everyone on this committee. We care about veterans. We care about military retirees. We also care about federal employees. In fact, it's our federal employees who staff the VA, obviously, and the VA hospital system. And I would think one of the down sides—there's a big downside from doing nothing, as I think Mr. Gutierrez pointed out; we've got a real problem with the expense to employers who provide health insurance, including the Federal Government, from increasing drug prices. And so it's—really, nothing is not a solution, in my opinion. We're going to have some real negative impacts on the federal budget if we don't get a handle on some of this.

We talked about the 16,000 enrollees, going back to this little mini-theme of not playing off our federal employees versus our veterans. Do we know how many of our 16,000 enrollees in SAMBA are veterans, or active, or Guard or Reserve, or military retirees?

Mr. FLYNN. Dr. Snyder, no, I don't have that information. I'm not sure that we can extract it, but if we can, I'd be happy to try and provide it.

It's probably the case, because of the nature of the health plan that it is, that its membership is predominantly male. And if that's the case, you can generally make some assumptions about the veteran status of that population. We'll try and do the best we can, but I don't have that number.

Dr. SNYDER. Well, that's what it looked like to me when I saw the employer groups that were involved, that there probably are a significant number of veterans that are actually federal employees.

My last question is—I assume you all have read the written statements from our friends at DAV and HIGPA. Do you all have any comments you want to make about anything you saw in their written statements?

Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. Mr. Doyle is recognized.

Mr. DOYLE. Thank you, Mr. Chairman.

Well, I think—first of all, I want to thank you gentlemen for your testimony today. I think it's gone a long way to assuage some of the concerns that the committee does have—and also to congratulate you for thinking out of the box. I mean, this is what we've—I hear many of my colleagues talk about, you know, running government like a business, and looking for better ways to be more efficient. And I think this pilot that you're exploring is an effort to do that.

Obviously, there is a real problem, not only within the Federal Government, but in the private sector, too, with the rising cost of pharmaceuticals, and trying to get a handle on what we can do to deal with that. And this pilot, which will comprise three-tenths of 1 percent of the total volume of drugs purchased within this VA system seems to me, just in and of itself, that if this would cause some sort of increase in the price of drugs for the VA, that there should be an investigation that goes on far outside the government, but into the pharmaceutical industry. I just don't see how one can impact the other adversely.

But you know, I understand we have concerns. I think this is more fear on the part of some of the camel's-nose-under-the-tent, that somehow we're going to take from this pilot a way to expand this schedule to other employees. And it's going to be something, as I understand, totally separate from what's going on in the VA.

So I see a lot of potential upside to what's going on here. And it seems to me that some of the safeguard guidelines that I've read, that you're putting into place, should assuage some of the fears that we have.

I'm curious, Mr. Flynn, in your testimony, you pointed to rising drug costs as the impetus for the SAMBA pilot. And we don't have anyone here today representing the pharmaceutical industry, but would you like to just share your thoughts on why you think costs continue to rise at such an accelerated rate?

Mr. FLYNN. I suppose, Mr. Doyle, if I had the answer to that, that I'd be sought after by a number of people, not just this subcommittee but others as well.

We are primarily an employer health-plan sponsor. Our expertise in matters of health policy, pharmacy pricing and that sort of thing is really quite, quite limited. I'm just not in a—I don't have the sort of wherewithal or the horsepower, I think, to answer that question definitively, other than to say that we've seen it—we and the health plans that participate in the federal employee program have undertaken a number of steps to try and mitigate and control it.

But ultimately, there's only so much you can do, whether creation of incentives to use generics wherever they're available and found to be therapeutically equivalent; the creation of pharmacy benefit managers that help health plans, that help physicians, that help the drugstores and the druggists manage this benefit properly; and a whole host of other things, I think, have all gone to help control costs.

But there is this sort of underlying engine of new drugs, price increases—and I guess I would also say, sort of offset by the idea that people are benefitting from drugs. They're living longer. They're in many cases living healthier. For people with chronic diseases, they're able to manage those diseases more. It's a very com-

plicated issue, and we're doing the best we can as a purchaser to deal with it. But we don't have that broad, overall perspective that others might.

Mr. DOYLE. How about you, Mr. Powell? When you look at price increases that the VA has to deal with, what information if any does the pharmaceutical manufacturers provide you with in justifying their cost increases?

Mr. POWELL. If you'll allow me, I'll defer to Gary Krump. He deals directly with those decisions, and can give you the specific details.

Mr. KRUMP. Yes, sir. I don't think we face anything different than any other negotiator when you're working head-to-head with the pharmaceutical companies. I think as Mr. Flynn pointed out, we negotiate, our mechanism of negotiating, there's nothing magic about the way we do business as compared to any other large health care negotiator.

In terms of what do they justify, we have a policy that we want best value for the product that we obtain for the Department. And that's the best combination of service, terms and conditions, delivery, price and product itself. We have a very excellent VA formulary, which allows us to negotiate a market basket of drugs which have specific clinically driven requirements that they must meet. As a result of that, some of the areas where the drug companies could say, "Well, we can substitute product A for product B," the clinicians have advised us what it is that they need to provide the best possible patient care, and we will *only* negotiate for those kinds of drugs. They may be generic drugs; they may also be brand-name drugs.

But in terms of additional items to consider, the pharmaceutical companies would have to provide us, if they've got it, any inflation-driven cost increases; if they've got any product-driven or any other business-related reason why the cost would increase, they have to provide that information to us, and that's part of the negotiation. In terms of how we go about doing business, if we were working for Columbia HCA or any other corporate health care purchasing activity—the British National Health, for that matter; the Canadian National Health—we would negotiate the same way. The members will have to show us that there's a basis for their proposal cost increases.

Mr. DOYLE. Let me just follow up on that too. The main focus of many of VA's missions is to bring more patients into the system. How would expanding the VA's patient base affect the price of drugs negotiated with the manufacturers?

Mr. POWELL. We wouldn't anticipate that that would be an issue.

Mr. DOYLE. Okay. Thank you very much, Mr. Chairman.

Mr. STEARNS. I thank my colleague. Ms. Carson, you are recognized for 5 minutes.

Ms. CARSON. Thank you very much, Mr. Chairman. I apologize for being late.

Mr. STEARNS. Oh, no. Glad to have your participation.

Could you pull the mike over to you closer a little bit? Thank you.

Ms. CARSON. Yes, I apologize for being late and having to leave. I've got a Banking Committee going on at the same time.

But I want to play the devil's advocate, no disrespect, because I appreciate veterans. I come from a family of veterans, Marines and soldiers and the whole thing. They're all over the place.

But why was the VA chosen, given that you've admitted that these are mostly men, that you are examining the prescription drugs that are used for men, when in fact if you had used another agency you would have gotten more of an inclusive kind of understanding of the drug cost, prescription drug costs? Because women sometimes have situations that are unique to being women.

Mr. POWELL. I would suggest, at least from my perspective, we never discussed it one way or the other. I think the issue of why we were chosen had more to do with our roles as keepers of the schedule itself. To your point, SAMBA actually has a more diverse population because of the family aspect. They would have children as well as spouses that we don't necessarily cover. Obviously we have female veterans, but we don't treat children. There would be a more diverse group in SAMBA than what VA normally see as patients. Now, whether SAMBA is representative of the other plans, in terms of their membership and that sort of issue, I just don't know.

Mr. FLYNN. Ms. Carson, if I could just add to that for a second, there's nothing—Mr. Powell's absolutely correct. Our approach to the Department of Veterans Affairs had to do with the fact that they administered this prescription drug contract. The availability of prescription drugs to members of the SAMBA health plan is not limited in any way to just men, but in fact includes their spouses, many of whom will be female, and their children, who are going to be male and female. I also don't know how representative of the population as a whole SAMBA is, but I suspect it's more closely representative than it is unrepresentative. So we will have the opportunity to see drugs made available to a broad, diverse group of federal employee program participants.

Ms. CARSON. Okay, so then I misunderstood. Your pilot project deals with veterans? The VA? Exclusively?

Mr. POWELL. Well, VA is involved. However, the pilot is actually for the SAMBA agents and their families. VA is already involved in the FSS. SAMBA happened to be a small group that we can manage within the context of what we were trying to discover: whether or not a separate schedule would be effective. It isn't necessarily that we looked out for SAMBA because we wanted to find a group that represented a certain type of employee of the Federal Government. It was just their size.

Mr. FLYNN. And I might just add to that by saying that actually the SAMBA health plan, which is an independent, private-sector health plan, is the group that came to us and requested this access on behalf of its 16,000 members. But its membership, with the single exception of the fact that they are mostly law enforcement personnel who work for a small number of federal agencies, is a membership which consists of federal employees, federal retirees, and their spouses and members of their family—just as if you were a member of the National Association of Letter Carriers health plan that is predominantly postal employees, or others like that.

Ms. CARSON. Is there a problem with allowing a look at the federal supply list by others, other entities that are not presently hav-

ing access, to looking at it? Does that preclude any competitiveness or opportunities to further examine the cost factors in these schedules? Isn't this pilot project sort of limited in terms of who gets to have access to looking at the federal supply list and what the cost factors are, et cetera? And that's generally what this is, when you're doing a pilot, so you can examine the whole cost of it. Why then do you deny others to look?

Mr. FLYNN. Um, that's——

Ms. CARSON. I like to ask confusing questions, because I don't know what I'm asking.

Mr. POWELL. I just want to make sure I answer your question correctly. Actually, my understanding is that, by statute, we have to limit. And so what we do in our schedules is public knowledge. People, when—I assume when you say "look at," you mean "use." Obviously when looking at our pricing and how we do it, that's available to anyone. In terms of being able to utilize those prices, we are limited by statute.

Ms. CARSON. Thank you very much, Mr. Chairman.

Mr. STEARNS. I thank my colleague. I understand, Mr. Flynn, that you have an 11:00 a.m. appointment, so we appreciate very much your staying over and being here this morning.

We have a copy of a letter from Blue Cross/Blue Shield, which is the largest participating organization, FEHBP, in which of course they're concerned about price controls and the fact that there would be cost-shifting if this moved to something, to the FEHBP. So I'd like you, if you'd be so kind as to answer this letter to us. And we'll give you a copy. It would be helpful for our record, and all my colleagues here, to understand what your argument is relative to the argument they are making.

Mr. FLYNN. We'll be happy to do that, Mr. Chairman.

Mr. STEARNS. All right. And—well, thank you. And now we'll call the second panel——

Mr. GUTIERREZ. Mr. Chairman?

Mr. STEARNS. Yes, Mr. Gutierrez?

Mr. GUTIERREZ. Mr. Flynn and Mr. Powell, I just have a question about the federal supply schedule. Now, the federal supply schedule, could you just tell us quickly why is it we're getting these prices, these unique low prices? Is it because they want to be—who gets—who has access to the federal supply schedule right now, and why is it that they have this wonderful arrangement?

Mr. POWELL. Well, there are a number of reasons. There are some things VA does that make it unique. We have a committed volume, which is very helpful to the manufacturers. It helps them set their——

Mr. GUTIERREZ. So volume is one of these?

Mr. POWELL. Volume is very important—committed volume. In other words, we give them very definite production schedules. Coming from a manufacturing background, I can tell you, having a committed volume is close to nirvana.

Mr. GUTIERREZ. Good volume?

Mr. POWELL. It's very important.

Mr. GUTIERREZ. Okay.

Mr. POWELL. We also, as Mr. Krump said, we have the formulary, which allows us to get somewhat away from, if you will,

branded drugs, so that we are in the generics realm. That allows us to——

Mr. GUTIERREZ. You're using generics? And a committed——

Mr. POWELL. Well, I think it's important, VA has a formulary. Generics are not exactly the same. The formulary and committed volume are the primary drivers.

I would also say, I think my staff are particularly good negotiators, and I do think they deserve credit for that skill. There are some other technical aspects. These issues are the ones being addressed by the pilot because it's not entirely clear whether or not, say, something like the formulary would be acceptable in a SAMBA environment. This is what we're trying to discover. Whether or not we can bring a formulary to bear, because SAMBA is an entirely different customer, if you will—although we don't think of veterans per se as customers. But there's an entirely different process by which drugs are prescribed. That's one of the issues we're trying to get at in this pilot.

Mr. GUTIERREZ. Let me just say that, then—because I know you have an appointment, Mr. Flynn—it just seems to me that if we're going to—that number one, I think to paraphrase what Mr. Flynn said, if there's a problem, you'll quit, you'll stop. If it has an adverse effect on the federal supply schedule and what veterans are getting today in terms of their prices, right? In this endeavor, you'll just stop and say—you'll say "uncle" and walk away from it.

But I just want to say that I hope that when that happens, you would inform this committee immediately. I mean immediately, so that we could call a hearing right away, because I think we need to be balanced in our approach. It's okay, and I think very fair and important, to say, God, this could have a detrimental impact on the veterans, and it's something that we should be concerned about, and say, be careful.

On the other hand, I think we should also say to you that we're going to be supportive. That is, as you enter this venture, we should say to you, you know, shame on the other side if, for reasons unexplainable or logical or reasonable, they decide to increase the federal supply schedule and the prices on the federal supply schedule. And that we would then call the pharmaceutical companies before this committee, and we would ask them—I guess a hypothetical question: why is a veteran in a foreign country getting a better deal on drugs produced here in the United States of America, many times because of the subsidy we as a Federal Government give institutions, hospitals and other research institutions—why are they getting drugs cheaper than we did because we tried to include 16,000 additional families? If we kept the committed production, and we kept the formulas the same, why did you do it?

So I just wanted to say that, you know, I think it should be—there should be a duality. That is, yes, be careful, we don't want to—we might not have money; it could have a detrimental effect on veterans. And on the other hand say, move forward and understand that there are those of us who fear what the pharmaceutical companies could do to our veterans and the detrimental effect—there are those of us that will take them on for you. Not for you; that's wrong, this word—with you, in order to achieve a cost savings and benefit to the American people.

Thank you very much, Mr. Chairman.

Mr. BILIRAKIS. Mr. Chairman, we didn't intend to go a second round, but if everybody wants to make an editorialized comment, that would be helpful.

Mr. STEARNS. I did——

Mr. GUTIERREZ. You know, it was really a question, Mr. Chairman. And you know, I think it's fair to, you know, First Amendment rights for us to be able to express ourselves, in terms of—and I'm sorry if you want to—you know, take this conversation that we're having, and this dialogue, and all of a sudden—was it editorializing? Ahh, it's editorializing. That's what the Congress of the United States does a lot of. Yesterday we were passing resolutions in the House of Representatives to make sure that the motto of the nation is—you know, and that got real scary.

And you know what was interesting, though, was when it came to a vote whether or not we should promote "In God We Trust" across the nation, for 15 seconds there was a silence. And I said, God has intervened. He's really angry that we're using his name in vain in the Congress of the United States. That's how I felt yesterday.

So yes, do we editorialize? Yes, we editorialize. I think that's why the people in our congressional district send us here to be their voice.

Mr. BILIRAKIS. Okay. Mr. Chairman?

Mr. GUTIERREZ. And in this situation, where I am not the voice of the people of my congressional district—and I don't want you to put another little thing in there. Phil and I already got our whacks——

Mr. BILIRAKIS. We're apt——

Mr. GUTIERREZ. Just the same, Mr. Chairman——

Mr. BILIRAKIS. Mr. Chairman?

Mr. GUTIERREZ (continuing). In the whole thing of bipartisanship, that we should be able to speak and talk. No, I don't want an additional 5 minutes. It gets me a little upset that I never have—how would I say this? Because I want to be very precise. I have never described or attributed words such as "editorializing" to the comments made of other members of this committee. I allow them the free rein to say what it is they feel. And I think that's the best way to go about it so that we can have the kind of comity we need in this committee in order to assure the American people the best representation possible. I like everybody here.

Mr. STEARNS. Good point.

Mr. BILIRAKIS. Mr. Chairman? Not in the way of a second round, Mr. Chairman. I just merely would like to request in writing—and this is ordinary, I think, in all hearings—from the VA the scenario of your negotiations. How do you negotiate? Mr. Powell, you've commended your people for their great negotiating jobs and that sort of thing.

I always have been very curious how that takes place, and in what way you do it, and what companies you're negotiating with.

Mr. POWELL. Would you like to have the individuals involved meet with you and your staff?

Mr. BILIRAKIS. Well, that may not be a bad idea. I'd like to get it—I think I'd like to get it, maybe the committee get it in writing

first. And possibly that might be a worthy idea, either come meet with our staffs or possibly have them come here sometime.

Mr. POWELL. I will encourage the meeting if you think it would be helpful.

Mr. BILIRAKIS. Absolutely. And in all probability, it's a very commendable process, so I think we should learn more about it. So I would ask unanimous consent, Mr. Chairman, that that be requested.

Mr. STEARNS. By unanimous consent, so ordered. Mr. Doyle, you're welcome to pass here.

Mr. DOYLE. I would just end by expanding on what Mr. Gutierrez said by saying, you know, you asked how we got this special deal for the VA. And the 1992 law is how it happened, and I think Mr. Stearns in his opening comments said somewhat diplomatically that the drug manufacturers were reluctant at first. They were brought kicking and screaming into this deal. But it's here now, and I think we should realize that the reason this existed, in addition to the good work that gets done by VA in negotiating these prices, was that Congress wrote the law.

Mr. BILIRAKIS. Well, if the gentleman would yield, this goes to what I requested. You say they're brought screaming and—if that were the case, then I think that would be reflected when we learn more about how negotiations take place.

Mr. DOYLE. Excellent. Thank you, Mr. Chairman.

Mr. STEARNS. Mr. Doyle, Mr. Gutierrez, Mr. Bilirakis, I appreciate your comments. And Mr. Flynn, we appreciate you staying over another 15, 20 minutes at this point to hear us out.

And now we'll call on the second panel.

Mr. GUTIERREZ. You can blame us. You should claim you have the best excuse for being late ever.

Mr. STEARNS. Our second panel will be Richard Wannemacher, a representative of a key veterans organization, Disabled American Veterans. Mr. Wannemacher is DAV Assistant National Legislative Director. And also we have as a witness on panel number two Dr. Robert Betz, Executive Director of the Health Industry Group Purchasing Association. Let the record also reflect to my colleagues that Mr. Dennis Cullinan, the National Legislative Director of Veterans of Foreign Wars, was scheduled to testify but was unable to do so because of illness. He indicated to the Subcommittee staff that the VFW would be submitting a written statement which, without objection, will be made a part of the record of this hearing.

So at this point, we'll let you folks start for your opening statement. Mr. Wannemacher, welcome to our panel. Nice to see you again.

STATEMENTS OF RICHARD A. WANNEMACHER, JR., ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; AND ROBERT B. BETZ, EXECUTIVE DIRECTOR, HEALTH INDUSTRY GROUP PURCHASING ASSOCIATION

STATEMENT OF RICHARD A. WANNEMACHER, JR.

Mr. WANNEMACHER. Thank you, Mr. Chairman. Nice to see you.

Mr. Chairman, we're pleased to present the views of Disabled American Veterans, DAV, to the Subcommittee to assist in the examination of the Department of Veterans Affairs pharmaceutical procurement policy. I have submitted my full statement and ask that it be considered in the record.

As an organization of more than 1 million service-connected disabled veterans and an auxiliary, DAV ensures that disabled veterans and their families are adequately cared for by using the voice of our membership to participate in the governmental and political processes that affect the well-being of veterans.

DAV's National Legislative Department in Washington, D.C., promotes reasonable, responsible legislation to assist disabled veterans, their families, their widowed spouses, and orphans. As the principal advocate of America's 2.3 million disabled veterans—a role we take very seriously—it is not only our policy to seek reasonable, responsible legislation, but to help disabled veterans keep the benefits they have earned by spilled blood, and prolonged illness, and loss of mental well-being as a result of their military service.

In May of 1992, former Congressman Sonny Montgomery introduced H.R. 5193. The intent of this bill was to improve the delivery of health-care services to eligible veterans and to clarify the authority of the Secretary of Veterans' Affairs. H.R. 5193 became Public Law 102-585, enacted on November 4th, 1992. This bipartisan bill improved the manner in which the VA could obtain best price pharmaceuticals under the Federal Supply Schedule.

Under Title VI, drug pricing agreements—Public Law 102-585 amended Title XI to exclude the prices charged on or after October 1st, 1992, for prescription drugs purchased by the VA. Public Law 102-585 also amended Title XXXVIII, United States Code, to require agreements between the VA Secretary and covered drug manufacturers limiting the purchase price of drugs procured by the VA and certain other federal agencies.

As we understand the purpose of the proposed pilot, it would determine if a schedule comparable to the FSS should be established to expand discounts to provide pharmacy benefits to the Federal Employees' Health Benefits Program community. Mr. Chairman, the DAV is concerned that the expansion of the FSS, the VA would have to bear increased costs that could require either an increased appropriation of billions of dollars from Congress or the reduction of health care services to the hundreds of thousands of sick and disabled veterans who rely on the VA as their sole source of health care.

As VA officials have stated on numerous occasions in the last decade, the issue here is not the provision of one FEHBP plan with access to FSS. If outlays for pharmaceuticals to these programs are lowered through extension of FSS pricing, it is clear the pharmaceutical industry will move to retain profit margins through pricing strategy modifications—i.e., they will raise the prices in other venues to maintain profit margins.

And what has been the administration's response to all of this? "The Office of Management and Budget, OMB, will maintain sufficient oversight of the pilot to ensure that this initiative does not adversely affect the Department of Veterans Affairs and the federal budget."

I suggest a more accurate statement would be, "without the sacrifices made by veterans, we would not have the level of peace and prosperity we have enjoyed today." Few citizens serve and sacrifice for the nation, but all citizens benefit from the efforts of our citizen-soldiers.

Two years ago, the release of the blockbuster hit Saving Private Ryan graphically depicted the horrors and loss of life and limb experienced by America's citizen-soldiers as they overcame virtually insurmountable obstacles to successfully complete their mission. Many of those who saw the movie were horrified by the images on the large screen. They left the theater praising the efforts of those brave men who stormed ashore at Normandy in June 1944. More than any other movie, Saving Private Ryan has made the public aware of the horrors of war and the sacrifices made by those who served this great nation.

Our government's commitment to care for those who served in the armed forces continues to be eroded. Veterans are no longer a national priority. Now the famous words of President Lincoln, inscribed on the VA central office building—"to care for him who shall have borne the battle, and for his widow and his orphan"—no longer retain their true meaning. We are concerned that this pilot will increase the cost of pharmaceuticals purchased by the VA, and will result in diminished health care for sick and disabled veterans. We are not satisfied with the administration's statement that OMB will provide sufficient oversight to ensure that VA is not adversely impacted. Sick and disabled veterans must not be held hostage to the whims of the administration or the pharmaceutical companies. They must not experience further diminution of health care services.

This concludes my statement, and I thank you for the opportunity.

[The prepared statement of Mr. Wannemacher appears on p. 57.]

Mr. STEARNS. Mr. Betz? Dr. Betz, your opening statement?

STATEMENT OF ROBERT B. BETZ

Mr. BETZ. Thank you, Mr. Chairman, members of the Subcommittee. I am Dr. Robert Betz, the Executive Director of the Health Industry Group Purchasing Association. We are the only nationally chartered trade association of health care purchasing and supply chain organizations today.

I am here today because, according to the testimony given before the Civil Service Subcommittee by OPM to the House Government Reform Committee on June 13, in which the OPM has instructed the Department of Veterans Affairs to implement a demonstration project under which pharmaceutical prices available for federal agencies' procurement under the FSS will be available to federal employees' health benefit plans for the Secret Service. This plan, known as SAMBA, is a private entity, and accordingly does not have access to FSS pricing for pharmaceutical products under any existing law.

It may not be obvious, but the FSS serves the same role for the federal agency procurements as the prices that are negotiated in the private sector by HIGPA's members for the entities that we serve. If FSS were available to non-governmental hospitals, clinics

and health plans, the VA, as the agency that administers FSS, would be a direct competitor to HIGPA's members. In such a competition, the VA could enjoy a significant advantage over our membership. The full power of the Federal Government would give the VA negotiating leverage that is remarkably unlike the give-and-take that characterizes the arm's-length negotiating and bargaining between vendors and group purchasing organizations.

The VA also enjoys another unique advantage. It is negotiating on behalf of the entities that serve our nation's veterans. In negotiating with VA, vendors know that the concessions that they ultimately make are going to the benefit of the veterans. Now, seriously, commercial realities clearly are a factor in arriving at FSS prices for those items that are not already established by statute. Veterans are not just another slice of the market, however, that is indistinguishable from any randomly selected HMO. It is an advantage that OPM's SAMBA demonstration project proposes to destroy in one fell swoop.

According to OPM's June 13 testimony, SAMBA's demonstration effort will be used as a foundation for expanding FSS pricing to all FEHBP plans. Mr. Chairman, members of this committee, you know better than I do that the use of health plans instead of government bureaucrats to provide health benefits to government employees has made the FEHBP an important model for discussions on how to modernize government-run health programs such as Medicare and Medicaid.

It is more than ironic to my members, therefore, that OPM's FSS proposal and demonstration have, by administrative fiat, turned the whole structure of FEHBP on its head. It would convert a significant segment of the pharmaceutical market, where prices are currently negotiated by the private sector represented by my members, into a government-run system administered by employees of the VA.

The FEHBP plans currently include some of the very best commercial health plans available today. You're looking at Blue Cross/Blue Shield, Humana, Kaiser Permanente, Prudential Healthcare. And health care provided for federal employees is given in some of the best non-governmental hospitals, clinics, and physicians' offices available. HIGPA members are the ones doing the negotiating on behalf of these facilities. We do not understand why the government should be allowed to usurp these significant parts of our business without even considering that this significant injection of the government into our markets would require Congress to at least have public hearings and consider legislation.

I have included in my full testimony for the record an overview of the abundant evidence showing that when a discount that is voluntarily given by a seller to a specific buyer based on unique terms and conditions of purchase, and other business advantages to the seller, is required to be given to a sizable group that does not share those same characteristics, a rational seller will eliminate or reduce those discounts.

We've heard today about the Medicaid best-price law. The Medicaid rebate requirement established in 1990 provides the clearest model, the clearest example, because it was the first to be enacted, and it came about, I believe, quite suddenly. In the wake of the

law's requirement that manufacturers' best price to any customer be extended to all Medicaid programs, the discounts available to HMOs and hospitals were reduced or discontinued completely, as were those to VA, DOD. And a new significant benchmark for prices now hangs over the entire commercial industry, the private sector.

Congress rather quickly passed a law to exempt VA prices from Medicaid best price requirements, for which the rest of the market today bears the burden. Implementation of the SAMBA demonstration project creates even more explicit baggage for VA negotiations by ensuring that the full cost of providing the discount to all FEHBP plans will hang over VA's FSS negotiations with vendors.

I must call your attention to the fact that Congress has already spoken on this issue of expanded access to FSS pricing on several occasions, most importantly of which was the congressional repeal in 1997 of Section 1555 of the Federal Acquisition Streamlining Act, known as FASA, of the cooperative purchasing program.

Let me just close, Mr. Chairman, asking if my full statement could be included in the record. We at HIGPA think that the evidence is clear: expansion of access to FSS takes away a potentially significant segment of HIGPA's market; it is likely to have a significant adverse impact on VA's continued ability to get good prices for FSS. We strongly oppose this demonstration project that they propose to implement through the VA.

Thank you, Mr. Chairman and the members of the Subcommittee.

[The prepared statement of Dr. Betz appears on p. 60.]

Mr. STEARNS. Thank you, Dr. Betz, and by unanimous consent your entire opening statement will be made part of the record, so ordered.

Mr. Wannemacher, as I understand it, Secretary Jesse Brown, who was the Secretary of Veterans' Affairs for this administration, expressed some concern about this proposal. Did you know about them, and if so, did you agree or disagree with his concerns?

Mr. WANNEMACHER. I wasn't part of those meetings that he had in the past, and I haven't had the opportunity to be briefed by the former Secretary, so I have no comment.

Mr. STEARNS. Okay. Dr. Betz, do you know about them at all? Secretary Jesse Brown?

Mr. BETZ. All I know is a report that I received that he has expressed concerns about this, sir.

Mr. STEARNS. Dr. Betz, in 1997, during the debate on expanding access to the FSS schedules, your organization evidently commissioned a study on the potential impact of FSS expansion on health care costs. What were the findings of this study? And would you furnish the Subcommittee a copy of your study for the hearing record?

Mr. BETZ. Mr. Chairman, I would be pleased to. Let me go to the heart of the findings.

Assuming similar behavior by FSS suppliers—and that is, using, as I said in my opening comments, the Medicaid best price program as your economic model—Federal Government costs could increase at a minimum by as little as $500 million in the first year, and $3 billion over a 5-year period, congressional scoring period, or as

much as $700 million in the first year and $4.3 billion over a 5-year period, as a consequence of expanding FSS access to additional health care providers.

Now, in that scenario that we were looking at, the discussion was opening up the Federal Supply Schedule to state and local governments, those facilities—nursing homes, et cetera--that could meet that "public" definition.

Mr. STEARNS. You implied in your opening statement that Congress has already spoken on this. And you sort of indicated that the administration, by going ahead on this, is being—with unilateral action—is going ahead. Do you want to comment on that any further?

Mr. BETZ. Mr. Chairman, it's part of a mosaic that we in the private sector see. It goes back to the reinventing government initiative early in the Clinton administration, that I believe Vice President Gore headed up, in which federal agencies were asked to act more like private business. And in theory, I think that's a wonderful goal for federal agencies.

But I think it has been interpreted in some quarters as going into competition with the private sector. Many of us—and not just in our industry, the health care industry, but in several other industries—came together and were concerned early on when the proposal came forward for the General Services Administration to expand the Federal Supply Schedules that they control, including the VA pricing for pharmaceutical products, to state, county and municipalities.

Congress in its wisdom did repeal that Section 1555. But there, very shortly, quickly came bouncing back up, as sometimes ugly things will, a program that was designed for drug interdiction. But it's called, I believe, the 1122 program. It was an act—a section that was included in an Act for the Department of Defense, as I recall, that allows drug interdiction equipment available on the Federal Supply Schedule. That, we were told, included ten schedules. When it was finally published, it included 90 schedules, including furniture, medical equipment—no pharmaceutical products were included.

We look at that, and we see that section of that law is still in effect today. Congress has again acted, through, I believe, a conference committee report instructing the General Services Administration and the Department of Defense to reduce those schedules back to the original numbers.

And indeed, we see the SAMBA program as another example of the administration's interest in opening up the federal supply schedules. And that's why I say it's part of a mosaic.

Mr. STEARNS. Well, Dr. Betz, sometimes you hear members say, well, you know, you can go to Mexico, you can go to Canada, you can go to France and buy these drugs a lot cheaper. And so why don't we have the cheaper drugs here? But isn't it true that the governments of these countries subsidize the purchase of these medicines?

Mr. BETZ. They are subject to price controls. It's kind of a strange fact, in Europe, according to my studies, you can buy name-brand pharmaceutical products cheaper than you can in the United States. And that gets a lot of hype in the media.

But go there and try to buy a generic product, and you'll see that their products are much higher than we pay here in the United States. In general.

Mr. STEARNS. So what we have in these other countries is price controls?

Mr. BETZ. Absolutely.

Mr. STEARNS. And what we have—here, we don't have price controls. So the question is, if we move towards opening up the FEHBP to these, if we went further than just the special agents here, it would be pushing on the pharmaceutical industry these 10 million additional Americans at a discounted price further. And so this is a form of price control, which would mean that this price control would come out with costs shifting somewhere else.

Mr. BETZ. Mr. Chairman, I've been in health care for 30 years, in Washington for the last 22. The subject of my dissertation was pharmaceutical pricing. So I have spent some time thinking about this.

These are profit-maximizing firms. They're going to respond to this demonstration project as a businessperson would, as a threat, because I think it's very clear from the testimony that has been given that this is an idea that will be expanded to FEHBP, which I believe has about 9 million folks in it. This is a sizable market.

Again, just look to the Medicaid best price law. We saw prices go up. And today, when you and your family go into a drug store, as do I, we're paying higher prices for it, you as a federal employee and me as a private sector employee. And I am convinced that they are going to see this as a threat and they are going to respond. And it's going to affect my membership's ability to provide quality health care at an affordable cost. And all across this country, in every district, every state, every township, I am very concerned about the government's intervention in this area.

I also quite frankly think that VA is going to suffer from this. I think their prices are going to go up, and that's going to mean that many more dollars that are not going to be available to take care of some veteran somewhere that deserves it.

Mr. STEARNS. I thank you, Dr. Betz. I have a competing commitment this morning at the Commerce Committee, and that will necessitate my absence. I will turn the questions over to Mr. Gutierrez, ranking member.

Mr. GUTIERREZ. Mr. Wannemacher, let me ask, is there anything the Office of Management and Budget could do to persuade you to—or to alleviate your concerns about the pilot program?

Mr. WANNEMACHER. Well, we believe that they should withdraw the proposal for the pilot.

Mr. GUTIERREZ. You just think they should withdraw it, not consider it whatsoever? So there's nothing they can do?

Mr. WANNEMACHER. As Mr. Bilirakis mentioned previously, when Medicaid was expanded, there were—and I think if we look back in history, we thought that—it was thought that there were going to be protections, protections, protections. And look what happened to Medicaid. It required 102-585 to be enacted.

Veterans' health care, now, is too important to be, you know, changing policy mid-stream. We just don't think that the expansion

of the Federal supply schedule would benefit at all sick and disabled veterans.

Mr. GUTIERREZ. I understand that. And I thank you for being here this morning. I thank you for the work that you do. It certainly would be nice, however—of course, and I understand your concern, because if they were to raise the prices, then we would have to go back to this Congress. And since you're not in the top percentile of wage-earners in America, and I don't think there are a lot of veterans that die that you're concerned with that have $2 million or more when they die and therefore have an inheritance tax—that's probably not a big issue for you guys. But the Congress, this Congress, thinks that's a very important thing, to make sure that people who have over $2 million, make sure they don't pay any inheritance tax.

So I know you would be concerned, because we, in this committee, when we tried to support a budget that you supported, to guarantee that we would increase it to $3 billion, which is nothing compared to the death penalty tax we just eliminated, which would help—which is actually something like $70, $80 billion. We couldn't get $3 billion. So I understand your concern. And given the Congress of the United States and its penchant for helping some and not others, and specifically the veterans, we have some little things over here from that day. I mean, maybe you weren't here——

Mr. WANNEMACHER. I was here.

Mr. GUTIERREZ. You were here. Well, this is Filner's thing, and this is Gutierrez's thing over here—simply because we wanted to have a vote on whether or not we could have a budget to increase $3 billion. So you can see how it is that—I can see how it is you would be concerned.

I think that given—and I'm going to be here—that given where the veterans are at, I think you have a real concern. On the other hand, I have a lot of veterans who have wives and children and families, and they say to me, you know, we fought to make this the greatest country in the world, and we want to guarantee health care for our wives, our children, our families, our daughters. But they, indeed, sacrificed so that I could be here, so that we could all be here having this discussion, although some days it isn't quite as democratic as I'm sure we would like to have it.

And so that's what I think we're trying to do, is to look. And I know Dr. Betz is here, and he's concerned about what it could do. Well, I'm also concerned, because I have a congressional district in which people don't even get to negotiate anything. They just don't get medicine. There's no schedule for them. There's no negotiating for them. And in part due to the fact that—no, it's true. They don't have health care insurance. I have lots of people who don't have health care insurance, most of whom—actually, the irony of it all? They work. It's not like they're unemployed. They actually work.

I have a wonderful congressional district in Chicago. It's the poorest congressional district in the state of Illinois, in per capital income. You would think, well, it must have the highest unemployment. Wrong. It has the lowest unemployment, right? Because actually, immigrants do the work that no one else wants in this country, so they'll take the $5.25 an hour job that no one else wants. But it doesn't come with health care insurance. So I'm concerned

about health care insurance for those people. So that's my particular point of view.

I'm not particularly afraid of the pharmaceutical companies. I think the pharmaceutical companies need to be taken to task. And I know that—how would you say this?—I know that the pharmaceutical companies—I'm sorry. I just don't believe—since they're only there to maximize their profits, that's what pharmaceutical companies were created, to maximize their profits, that's their goal—that they sit there and say, oh my God, let's give them a break; these are veterans of the United States of America. I just don't believe that they do it. And given corporate history and what we've seen from the cigarette industry and other industries in this country, and what they're willing to do in cost management, they're out to make a buck. I know that sounds like a screaming liberal proposal of big corporate America, but we've seen it time and time again.

So I don't really believe that that's what they're doing. I think they're going to continue to increase prices to the extent they can, and really don't give a darn about veterans. And I think it's probably—one of the reasons they really like this medical benefit is because, you see, as in Chicago, we have all these wonderful teaching hospitals: with Hines, with Loyola, with the Northwestern University. I think they like this schedule in part because they get all these wonderful young doctors, and they give them all these wonderful prescriptions at this given rate, so that when they go to the private sector, they take this wonderful memory of these drugs with them to the private sector, and continue to promote their product.

Mr. BILIRAKIS (presiding). The gentleman's time has expired.

Mr. GUTIERREZ. I understand. I would ask unanimous consent for one additional minute.

Mr. BILIRAKIS. No, let's just—we'll go back around.

Mr. GUTIERREZ. I ask unanimous consent for one additional minute. I'm the ranking member, I can ask an additional——

Mr. BILIRAKIS. All right. The gentleman has one additional minute.

Mr. GUTIERREZ. Thank you. That wasn't so difficult.

See, I really think that what it's really about is that they like getting these young doctors. And so I don't know that we can attribute—and I know you, and I respect your point of view; maybe you've met with them and they've told you, Doctor, that they really care and they've convinced you that that's why they're giving these great prices, FSS prices. Maybe that's where—I really don't believe that. I've been there. I've seen it. It's a great place.

It's almost as though if I sold Coca-Cola, I'd probably sell it cheaper too if I thought these people were going to then promote my product everywhere they went in the future. And not only that, they were going to be the authorities on soda. Every time somebody would say, well, you know, I don't know what soda to drink, I'm going to an authority—as doctors are seen in our country. I never argue with my doctor. He's kind of an authority and an expert, and somebody that I rely on to give me good information.

And I know people think, and I know the Chairman will probably think, Gutierrez is editorializing again. Well, for some people it's

editorializing; for others, advocacy. And I listened to the panelists, and I thank them for being here. And I appreciate the additional minute that I got. And I think we should take as many turns as possible.

Thank you so much, Mr. Chairman. And now, to your delight, Mr. Chairman, I'll leave.

Mr. BILIRAKIS. Mr. Wannemacher, taking into consideration, of course, the effort here is to lower the prescription drugs for those particular employees, you know, that's in question here, these SAMBA people, could DAV support—I mean, what you know about it, and I understand you may not know that much about it. But could DAV support the pilot project if you did not think, or if you had 100 percent assurance, that veterans would not be affected at all by the pilot project?

Mr. WANNEMACHER. Well, let me tell you, when I came in this morning, I didn't think so. The discussion that I heard from Ed Powell and Mr. Flynn, they seemed to want to agree that they would make sure that veterans weren't impacted, negatively impacted at all.

Mr. BILIRAKIS. How about if there were legislation or something of that nature?

Mr. WANNEMACHER. If there was legislation or some kind of statement, a memorandum of understanding, then we wouldn't be so concerned.

Mr. BILIRAKIS. So you would not really oppose it as such?

Mr. WANNEMACHER. Yes, sir.

Mr. BILIRAKIS. Dr. Betz, you've heard me express my interest in how the negotiations take place.

Mr. BETZ. Yes, sir.

Mr. BILIRAKIS. I appreciate the fact that you were in the room at that time. How do those—the negotiations at the VA, do each of these four agencies do their own negotiating?

Mr. BETZ. Not for pharmaceutical prices——

Mr. BILIRAKIS. In other words, the FSS list is a list for all four of those agencies that have access to it? Is that right?

Mr. BETZ. That's my understanding.

Mr. BILIRAKIS. So the negotiation takes place by who? Representatives from each one of those agencies, would you say? Or is there a key negotiator?

Mr. BETZ. The VA is the key negotiator, sir.

Mr. BILIRAKIS. The VA is the key negotiator for the entire list?

Mr. BETZ. Yes, sir.

Mr. BILIRAKIS. All right, how do those negotiations compare, in your opinion, if you know, sir, with the negotiations that take place by the OPM regarding the FEHBP, the prices there, managed care, HMOs in general, managed care, Blue Cross/Blue Shield, et cetera. Do you have an opinion regarding that, sir?

Mr. BETZ. It is an opinion, sir, based on my research. I think it's actually some things that are very similar to what's done in the private sector. You heard the previous witness talk about the ability to aggregate a market share. When you go into negotiations with a seller, that's one of the things you like to bring to the table. You also like to talk about committed volume. The ability to move

a market share and committed volume are things that are very important in those negotiations.

But there are other things as well. Mr. Gutierrez was exactly correct—and if he was here, I would agree with him—about why pharmaceutical companies give special pricing to VA. It is because they do teach a great deal of the medical doctors in this country. But quite frankly, that benefits the VA, in terms of their pricing. Strangely enough, it also benefits some of the Medicaid population, because now, because the Medicaid best price law, they get access to that VA FSS pricing.

Mr. BILIRAKIS. Do those pharmaceutical companies make money, do they make a profit on the prices that they give the VA—I mean, on the FSS list?

Mr. BETZ. Absolutely. They are private sector companies. I assume if they weren't making profits on some of the drugs, people wouldn't be buying their stock. But there are other things that go into that. Their use of drug formularies—but there's another factor, too. These firms are in absolutely a death grip of competition with one another. That's something that the VA and we in the private sector play off of each other. The ability to knock a competitor's product out of the market for a short period of time—a short period of time being 3 to 5 years, depending on the length of the contract for that specific drug—is of enormous economic value to these manufacturers. And quite frankly, my organizations that get up every day and worry about the high cost of health care in this country, those supply-chain costs that is the purview of our responsibility, we use these things to our advantages, just like the VA does in their negotiations.

But there is one other thing that the VA has—two things, I think, that they have that we do not. Number one is, is that they have access to information that is unavailable to the private sector. Through the Medicaid best price law of 1990, all the best prices of the private sector are reported to the VA, and there is—it's the largest repository of best price information in the country.

And then finally, where I might disagree with the ranking Democratic member in his most recent statement just a moment ago, you can ignore the data if you wish, but I believe the data will show, if you take out all the other variables, that indeed at times—and I'm not saying it's the primary driving force—but at times, pharmaceutical companies do give a break for the veterans in their pricing policy. I can find no other variable that would indicate——

Mr. BILIRAKIS. Well, I also know, and I understand, too, that though it's not a public record, some folks who really can't afford some very, very necessary, very expensive drugs, also receive some sort of breaks there.

Well, let me ask you, are you telling this committee that insofar as the FSS, as it exists, and the fact that those four agencies have access to it, that you're supportive of that, but you don't want to see it go any further?

Mr. BETZ. I—we could kill an afternoon——

Mr. BILIRAKIS. Yes. And I don't want to do that.

Mr. BETZ (continuing). With the—I could get out the economic charts and we could talk about how the private sector might, could add some benefit to that. But I think that there are some very

dedicated, talented people working in the Veterans' Administration that are adopting—and even more so—some of the private sector techniques, and doing a good job——

Mr. BILIRAKIS. But you haven't answered my question yet. Anyway, the red light is on, and—I know we can learn an awful lot from you, sir, and I appreciate that very much. I don't mean to cut you off, but I mean—would your organization have been against the FSS concept that now exists, that only four agencies have access to, when it first initiated?

Mr. BETZ. You mean to go back to the creation of the FSS?

Mr. BILIRAKIS. Yes.

Mr. BETZ. Mr. Chairman, I think that my members at the end of the day would agree that we believe that the private sector could add some benefit——

Mr. BILIRAKIS. Could do a better job than——

Mr. BETZ. Yes, sir. And we have had—our members have gone to the VA and tried to work with them on demonstration projects in the past, and have not met with much success in those discussions. But nevertheless.

Mr. BILIRAKIS. Well, you know, one thing about prescription drugs—and forgive me, I'm taking more than the requisite time here.

Dr. SNYDER. Unanimous consent. (Laughter.)

Mr. BILIRAKIS. But you know, we all—one thing about health care, you know, we're in an ivory tower here, the Congress. And we pass an awful lot of laws and don't have any idea of the unintended consequences, and don't really have that much knowledge of a lot of the things that we pass legislation on. But when it comes to health care, we all experience it: our families, ourselves, et cetera. And we have seen with our experience the cost of drugs. I know I've gone, in January, before my deductible has been fulfilled, and purchased a particular drug that cost, if I remember correctly, something like $55, and then that same drug, I've gone back after my deductible has been fulfilled, and it's something like 20 percent of that $55, something of that nature. So we've kind of all experienced these things.

Well, Dr. Snyder to inquire.

Dr. SNYDER. Thank you, Mr. Chairman. Dr. Betz, if I can just play devil's advocate a minute here, in your statement you state the great concern to your organization that "OPM feels free to disregard the almost certain adverse impact on veterans without any new data" that shows benefits that outweigh the harm to veterans. But I mean, now you're saying you're in opposition to a study that would show new data. I mean, this is a lose-lose situation for the federal employees and the VA. You say you want new data, but here we—it seems to me to be a very controlled study, not at all similar to what happened in 1990. I think they're completely different situations.

But how are we ever going to get new data if every time somebody steps forward to do a study, you all say, no, we can't do it?

Mr. BETZ. Well, Mr. Chairman—pardon me, Congressman, I believe that our opposition to the study is based upon what they have said they want to use it for. And my experience, I am here as a witness to tell you what I think the pharmaceutical industry is

going to do in response to that, based on the experience of our membership.

Dr. SNYDER. Well, if I can interrupt, your statement says you object to it because there's no new data. But I'm just inquiring, how are they ever going to get any new data without doing a controlled study?

I want to ask if you could help me—and I may have some misinformation, because I was scrambling around this morning trying to get the legislative history of this 1997 repeal of Section 1555. Was that repealed? I was thinking that the act the Congress passed was—part of it was language inserted into a supplemental that was vetoed by the President.

Mr. BETZ. No, sir, we're very happy to report to you that President Clinton did sign it into law.

Dr. SNYDER. That did get repealed?

Mr. BETZ. Yes, sir.

Dr. SNYDER. Okay. You made some comments about—I think in response to Mr. Stearns's question about the study that you all funded. But as you know, we refer to that around here as an industry-funded study, just like when I release poll data in my campaign, it'll be, oh, that's, you know, a partisan poll. GAO's statement is that the story is not in on this topic.

Mr. BETZ. I find that very interesting. I've looked at that study. As a matter of fact, it was the subject of my dissertation—I used it in my dissertation research. And quite frankly, that's kind of a half-empty/half-full kind of analysis.

I think you can read it another way. They say it was inconclusive if prices would rise. Well, you can look at it one way and it says that that's a definitive statement that they don't know, but I think you can also look at it as being there's no way for them to really understand it, because you're looking at proprietary data, which I think gets to the earlier comments that you said.

We have only governmental sources, for the most part, to look at pricing data. We certainly don't have access to FSS pricing, best prices, or how these companies make their determination——

Dr. SNYDER. But again, it seems—I'm sorry, sir, but my time's almost up—it seems to me that if we've got—you know, we have to work on the information we have as policy makers, just like you all do, too. And I mean, I think—this seems to me to be it could be helpful to have some information. But—anyway, it seemed to me that's what this study's about.

The issue of—I'm trying to figure out who the players are. You represent—you don't—there's been some statements, some written statements here to talk about how the pharmaceutical industry is opposed to this study. I've not seen any statements from what I consider the pharmaceutical industry, which is the drug manufacturers. Have you seen any statements, or has the committee received—we haven't received any statements. So I think—you don't represent drug manufacturers. You represent people who put out and manage drug plans.

Mr. BETZ. I do—in fairness, sir, I do have drug companies that are members of the association, along with the not-for-profit hospitals and others that are interested in reducing supply chain costs. So I believe less than 20 percent of our membership is made up of

pharmaceutical manufacturers. And of those, several of those are international companies.

Dr. SNYDER. The last comment I want to make and have you respond to, you make some references to—I think you talk about government bureaucrats, and how the private sector can do a better job and those kind of things. But this seems to me to be a peculiar situation here. I mean, we're talking about government employees and veterans, both of which are clearly a federal responsibility to take care of. And whatever solution we come out with is going to be some kind of blend between the private and the public sector.

Mr. BETZ. Yes, sir.

Dr. SNYDER. For example, I mean, one option to provide drugs to federal employees would be to say, we're going to open a chain of federally owned pharmacies all across the country, and you'll take your prescriptions there and get your drugs for free. Well, obviously the country's not doing that, and doesn't have anybody doing that. We use private pharmacies. But it's always going to be a blend of things. And I think that we're on a little thin ice when we say, well it's, you know, bureaucrats doing this stuff. This is clearly a federal responsibility, to deal with federal employees and their health care.

I would point out that SAMBA is a private entity that has stepped forward. They apparently think it's in their commercial interest to try to work in partnership with the government, which I think, whatever solution we have at any stage in our history of caring for both veterans and caring for federal employees in their health care, is going to be a blend of the private and the public by the very nature of these two groups. So I would not be too quick to refer to folks you're opposed to as "bureaucrats." We refer to them as voters here, but that's——

Mr. BETZ. Yes, sir.

Dr. SNYDER. Thank you.

Mr. BILIRAKIS. I thank the gentleman. The gentleman from Pennsylvania, Mr. Doyle, who would be my congressman if I still lived where I was raised.

Mr. DOYLE. And I'd be honored to represent you, Mr. Chairman. Thank you for the time.

Mr. Wannemacher, welcome.

Mr. WANNEMACHER. Thank you.

Mr. DOYLE. My dad was a 100 percent service-connected disabled veteran, World War II, who passed away at the ripe old age of 61 years old due to those disabilities. So let me just say at the beginning, we appreciate everything DAV does for veterans. And you've done an awful lot for my family, and we appreciate it.

I guess, if I hear you correctly—and we won't belabor this—is that your concern obviously is that this pilot program not adversely impact the veterans community. And some of what you've heard here today maybe makes you a little less concerned than maybe you were when you prepared your testimony. And I want to assure you that all of us here on the committee want to be certain that that's not the case, too. I don't believe personally that three-tenths of 1 percent is going to adversely impact veterans. I think the fear is more of what happens after the study. So be assured that we share your concern, and that those of us on the committee are

going to be watching this pilot with great interest. And I just wanted to make that comment.

I actually want to speak to Dr. Betz more. Dr. Betz, Chairman Bilirakis was, at the end of his questioning, I think, attempting to ascertain whether or not your industry organization would have been supportive of the 1992 law. And I think you were sort of diplomatically saying that, like this pilot project, that you're fearful of what that could expand into, and become a competitor, that the whole idea of getting VA into this FSS would probably not have been something you might have embraced when it was going on.

And you also suggested that perhaps the private sector could have done a better job. I'm just curious: are you saying that had the 1992 law not been passed——

Mr. BETZ. Absolutely not.

Mr. DOYLE (continuing). That you'd be giving veterans a cheaper price than they're getting today? In the private sector?

Mr. BETZ. No, sir. I am——

Mr. DOYLE. So that was a pretty good deal for veterans, then.

Mr. BETZ. Oh, absolutely. The power of the Federal Government behind you, and access to all the information, you've even got an army behind you. I think that's a pretty good deal.

Mr. DOYLE. Yes. It's sort of—I mean, I understand it, you know, we want government to act like a business, but then when we start competing with other businesses, and we sort of have some advantages over you guys, then you guys scream bloody murder. And you probably wish we didn't try to operate like a business, that we went back to some of the ways prior to that.

I think—you know, what I'm hearing from the people at OPM is that we're struggling as we're trying to get a handle on these increases. And it's not just happening here with the federal work force; it's happening all over the country. And people are trying to think out of the box, so to speak. And you know, how can we get a handle on what's going on? And so the study, on the surface—you know, to do this demonstration project and see what we can learn from that, in and of itself, to me doesn't—seems like a good idea, seems like something we shouldn't be fearful of.

I can understand, based on—I was reading about your organization on your web page to get a little more understanding about who you represent—I understand your concerns as somebody that would be potentially disadvantaged. I just think we want to assure the veterans' groups, especially the DAV, that we're going to keep a pretty close eye on that. And I guess, you know, they could potentially be a help to you, an ally to you in this thing you fear, if they also would fear that they would be adversely impacted. And that's the—I don't want to call it an unholy alliance, but the strange bedfellows that we see up here on the panel today.

So we understand what's going on with that part of it. And I don't really have any direct questions here, Mr. Chairman. But I think we both understand from whence the organization Dr. Betz comes from, and their concerns, and they're obvious. And if I were sitting in your seat, I would have those same concerns. And also to tell our good friend from the DAV that we understand yours, and we're going to be keeping a close eye on things.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Wannemacher, it's always great, of course, to see you, sir. And you do have our assurances that we're not going to just drop this, this particular matter.

Dr. Betz, you know, we all wish we had your knowledge up here. You've got a tough job, obviously. But in the climate that we have today, where the concerns are—you know, there's very escalating health care costs, prescription costs, and prescription drug things and whatnot. I know it's caused me an awful lot of sleepless nights as Chair of the Health and Environment Subcommittee. So you've got a pretty darn tough job. But you do have an awful lot of knowledge that I wish, often times, we had here.

As per custom, you will both be receptive to any written questions that the staff or any members might send to you, and you would respond to them? Is that correct?

Mr. WANNEMACHER. Yes.

Mr. BETZ. Happy to, Mr. Chairman.

Mr. BILIRAKIS. Okay, thank you very much. Well, I want to thank you again for being here. I think that sort of takes care of things today. Meeting is adjourned.

[Whereupon, the subcommittee was adjourned.]

APPENDIX

COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, March 15, 2000.

Hon. TOGO D. WEST, JR.
Secretary of Veterans Affairs,
Washington, DC.

DEAR MR. SECRETARY: It has come to my attention that the Office of Personnel Management (OPM) has advised the Department of Veterans Affairs (DVA) that, in OPM's opinion, the Special Agents' Mutual Benefits Association (SAMBA) should be allowed to access the Federal Supply Schedule Class 65, Drugs, *Pharmaceuticals and Hematology Related Products*, because SAMBA contracts with OPM (under Contract No. CS 1074) as a fee for service health benefits plan participating in the Federal Employee Health Benefits Program (FEHBP).

Based on my initial review of this matter, I have grave reservations about the legitimacy of OPM's position. It appears that there are significant legal, regulatory, administrative and policy issues, all of which OPM has resolved in favor of allowing SAMBA to access the FSS, that I believe require further analysis and review. Indeed, the actions suggested by OPM could be contrary not only to the governing statutes and regulations, but also to the spirit and intent of the relevant Schedule.

It is my further understanding that under Federal Acquisition Regulation 51.102(c)(3), your office must provide specific approval for SAMBA to access the relevant Schedule. In light of the concerns addressed above, I request that your office withhold any such approval until such time as all relevant issues related to SAMBA's request—and OMB's apparent decision to approve it—have been resolved satisfactorily, and all parties who have an interest in the resolution of this matter have had the opportunity to present their views to all concerned. Indeed, this may be the type of issue that would be appropriately addressed through the notice and comment procedure typically followed under the Administrative Procedure Act.

Please advise at your earliest convenience, how you intend to proceed on this matter.

Sincerely,

CLIFF STEARNS, *Chairman,*
Subcommittee on Health.

COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, July 14, 2000.

Hon. JACOB LEW,
Director, Office of Management and Budget,
Washington, DC.

DEAR MR. LEW: On Tuesday, July 25, 2000 the VA Subcommittee Health will hold a hearing to examine VA pharmaceutical procurement policy. We are specifically interested in recent testimony by Mr. William Flynn of the Office of Personnel Management, before the Subcommittee on Civil Service, Committee on Government Reform and Oversight, concerning a current effort within the Administration to add a new participant from the Federal Employee Health Benefits Plan, the Special Agents Mutual Benefit Association, to the Federal Supply Schedule drug pricing program, administered by VA. The Subcommittee needs to understand the rationale for this proposal, its legal basis, and any policy implications for future price increases for drugs procured by VA for care of its own patients. You or your designee are invited to testify on these matters and your role in this proposal. The hearing is scheduled for 10 a.m. in room 334 of the Cannon House Office Building. You will be permitted up to five minutes for your opening statement.

You are requested to furnish 150 copies of written testimony to Angela Jeansome at 338 Cannon House Office Building by noon on Friday, July 21. Committee rules provide for the timely receipt of written testimony, and witnesses failing to submit written testimony by the deadline may not be called to testify. To reduce costs and to facilitate the inclusion of the written testimony in the printed record of the hearing and on the Committee's web page, please be in accordance with the enclosed submission requirements.

Sincerely,

CLIFF STEARNS, *Chairman,*
Subcommittee on Health.

Statement of Congressman Luis Gutierrez
House Committee on Veterans' Affairs
Subcommittee on Health:
VA Pharmaceutical Procurement Policy
July 25, 2000

Thank you, Mr. Chairman. I am pleased that we are here today to discuss the issue of pharmaceutical procurement and I thank the witnesses for appearing here today.

As we know, the Department of Veterans Affairs currently purchases pharmaceutical drugs and medical supplies for VA patients through the Federal Supply Schedule, a program for volume buying that allows VA to receive these goods at a below-average price per item. VA medical centers are the most significant federal purchasers of pharmaceuticals through the Federal Supply Schedule. By buying in bulk and negotiating the Federal Supply Schedule with drug companies, this procedure keeps costs to a minimum for veterans who rely on VA facilities for their health care needs.

Recently, the Office of Personnel Management authorized the Special Agents Mutual Benefit Association, a Federal Employee Health Benefits Plan provider, access to the Federal Supply Schedule for pharmaceuticals. By doing so, OPM instructed the Department of Veterans Affairs to permit approximately 16,000 federal employees, under certain restrictions, access to pharmaceuticals at reduced cost. The goal of this pilot program is to determine if a prescription drug prices similar to those specified in the Federal Supply Schedule can be established to provide pharmacy benefits to millions of federal employees. I strongly support the goal of this endeavor.

I am deeply concerned about the rising costs of pharmaceuticals in recent years. For example, prescription drug premiums for federal employees have increased by thirty percent in the past three years. Some Americans, most of them senior citizens, are now traveling to Canada to purchase their medications because they can buy prescription drugs there for a price that, on average, is forty percent lower than what they are charged in the United States.

I fear that our veterans population will be among the hardest hit by the increasing costs of drugs. We must remember that the vast majority of veterans who rely on the VA for their health care do so because they have nowhere else to turn, and these men and women will face great hardship if they are forced to pay more for the medicines they need.

I strongly support efforts to ensure that our nation's veterans continue to have access to pharmaceuticals at affordable prices.

However, I believe that all of us on this committee, while we work to assure that veterans continue to receive affordable prescription drugs, must commit ourselves to the critical goal that every American has access to affordable prescription drugs. The rising cost of drugs, and the unwillingness of this Congress to take real, credible action to give the American people life-saving or life-sustaining drugs at reasonable prices, constitutes a national crisis. I urge my colleagues, all advocates for veterans and-- most importantly--the pharmaceutical industry, to take action to protect our veterans' ability to receive these drugs, while assuring that every other American has this right.

Thank you, Mr. Chairman.

Statement of Representative Helen Chenoweth-Hage
Veterans' Subcommittee on Health
Hearing on VA Pharmaceutical Procurement Policy
334 Cannon House Office Building
July 24, 2000

I'd like to thank Chairman Stearns for holding today's important hearing. I am glad that my good friend from Florida is taking the lead in protecting the integrity of our health care system, both for our veterans and for the general public.

As you know, the Office of Personnel Management (OPM) recently launched a two-year demonstration pilot program. Mr. William Flynn, who is one of our panelists today, testified before the Government Reform Subcommittee on Civil Service on June 13 about the demonstration program. Mr. Flynn testified that a framework of agreement was reached under which the Special Agents Mutual Benefits Association (SAMBA) -- a health plan for law enforcement agents and their dependents -- would have access to the Federal Supply Schedule (FSS) for prescription drug coverage. It is the position of OPM -- according to Mr. Flynn -- to "get maximum savings on the drugs that we purchase on behalf of our members."

Mr. Chairman, while I applaud OPM for making an attempt to address the very serious concern of the tremendous growth in prescription drug prices, I believe that this particular program is short sighted and could lead to unintended consequences. Allowing special opportunities for drug benefits to one federal constituency represented by SAMBA over another would create an incentive for pharmaceutical producers to adjust by raising drug prices for other constituencies that do not have the same beneficial coverage. This is evidenced by previous experience. For instance, in 1990, Congress passed the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) to expand the Medicaid best price program. Instead of lowering prices, pharmaceutical companies responded to the tactic by either eliminating their discounts or *raising* their rates to other market segments.

Mr. Chairman, this program raises a number of serious questions about what could happen to drug prices for our veterans. The agency which procures prescription drugs for our veterans, the Veteran's Administration, is the same agency which procures prescription drugs for this pilot program for SAMBA. If pharmaceutical companies respond to this program by eliminating discounts, or raising prices, then our veterans as well as many other groups covered by the FEHBP could suffer serious cost increases for their drugs.

Mr. Chairman, I do believe that we need to address the massive increase in drug prices, and the potential costs that this creates for the average consumer as well as the taxpayer. I do believe that pharmaceutical companies are unfairly taking advantage of the American consumer -- by drastically increasing the costs of drugs in the United States while at the same time severely discounting those same drugs in other countries. We need to address this problem in a reasonable and workable manner.

Mr. Chairman, rather than implementing an uncertain and experimental pilot program to

deal with escalating drug prices, perhaps the best way to address this problem is to apply the trade principles and laws that have worked within the United States for over fifty years. If we were to apply the principles of the Clayton Act internationally to prescription drug pricing, insurance companies could obtain drugs at virtually the same cost that other countries' insurance plans obtain them at. In other words, drug producers could not charge more for their drugs inside the United States than outside the United States. Thus, the price of a particular drug will be the same no matter who is purchasing it, thus eliminating the harmful practice of price discrimination. To accomplish this end, I have introduced a bill that would do precisely this, H.R. 4869, the Prescription Drug Fairness Act. I urge the Members of this Committee to take a look at this legislation and strongly consider becoming a cosponsor.

Mr Chairman, again, I thank you for holding this important hearing today. We have duty to ensure that our veterans receive the benefits that they duly deserve for serving our country, and that they not be potentially harmed by untested pilot programs.

Again, thank you for giving me this opportunity Chairman Stearns. I look forward to hearing from our panelists.

STATEMENT OF
THE HONORABLE EDWARD A. POWELL, JR.
ASSISTANT SECRETARY
FOR FINANCIAL MANAGEMENT
DEPARTMENT OF VETERANS AFFAIRS
ON VA PHARMACEUTICAL PROCUREMENT POLICY
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

JULY 25, 2000

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs (VA) pharmaceutical procurement policy and to address your concerns regarding the pilot project of the Office of Personnel Management (OPM) to authorize the Special Agents Mutual Benefit Association (SAMBA), which is a Federal Employee Health Benefits Plan (FEHBP) provider, access to the Federal Supply Schedule (FSS) for pharmaceuticals. I am accompanied today by Gary J. Krump, Deputy Assistant Secretary for Acquisition and Materiel Management.

The OPM pilot program to allow a FEHBP contract holder access to the FSS for pharmaceuticals acquisition appears to be a reasonable exercise of management diligence. The goal of the pilot is to determine if a schedule similar to the FSS can be established to provide pharmacy benefits to the FEHBP community. This goal is consistent with the President's desire to improve the operating efficiency of Government. VA has not objected to, and will participate

in, this pilot because of the potential overall benefit to the Federal Government. While our focus for this experiment is overall good governance, we are acutely aware our foremost mission is service to our Nation's veterans.

Background

VA is delegated by the General Services Administration (GSA) the responsibility for establishing and administering the FSS contracts for health care related commodities for the Federal Government. The FSS Program is a multiple award schedule (MAS), with indefinite delivery-indefinite quantity (IDIQ) type contracts. These contracts are national in scope and available for use by all Federal agencies. Prices are negotiated with the goal of obtaining equal to or better than Most Favored Commercial Customer (MFC) prices. The contract establishes, at the time of award, a price monitoring methodology whereby "best pricing" is ensured for the life of the multi-year contract through monitoring commercial market pricing trends. When using an FSS, the customer evaluates price lists and identifies the contractors which appear to offer the best overall value. An FSS contractor has a duty to provide the schedule goods and services to a Federal executive department customer. The contractor has the option to refuse any order from non-executive department customers within 5 days of receipt. Under the terms of our FSS, cost-reimbursement contractors for executive agencies are non-executive department FSS customers when they are granted FSS access under Federal Acquisition Regulation (FAR) Part 51.

VA also administers Section 603 of the Veterans Health Care Act of 1992 (P.L. 102-585), which prescribes Master Agreements and Pharmaceutical Pricing

Agreements with covered drug manufacturers. These agreements set Federal Ceiling Prices (FCP) for the four major Federal agencies that procure pharmaceuticals (VA, DoD, portions of the Department of Health and Human Services, and the Coast Guard, i.e., the "Big Four"). Section 603 requires that the price of a "covered drug" not be more than 76 percent of the Non-Federal Average Manufacturer Price (Non-FAMP). In some instances, VA obtains statutory pricing lower than 76 percent of Non-FAMP. Covered drugs include single source drugs, innovator multiple source drugs, and biological products (e.g., vaccines).

SAMBA will not be entitled by law to Federal Ceiling Prices. At this time, however, FSS pricing and P.L. 102-585 pricing are often the same because most manufacturers do not choose to establish separate price schedules. Thus, Government agencies other than the "Big Four" are frequently receiving the benefit of P.L. 102-585 pricing by voluntary choice of most manufacturers. Contractors would be within their legal rights to insist that dual pricing (separate FSS price lists) be negotiated for other than "Big Four" entities. If dual pricing occurs, then higher prices for other eligible users could result.

Understandably, OPM has looked for innovative ways to cut taxpayer costs. Pursuant to FAR Part 51, OPM granted SAMBA, an FEHBP experience-rated contract holder, immediate access to the FSS for pharmaceuticals.

Presently, SAMBA consists of approximately 16,000 enrollees and their beneficiaries, and the use of the VA FSS would apply only to the mail-out pharmacy.

OPM and VA officials have met to discuss the use of the FSS pharmaceutical schedule by an FEHBP contractor as a possible pilot program. A pilot program would give OPM a basis for developing strategies that would reduce pharmaceutical pricing for other FEHBP experience-rated contract holders.

OPM has determined SAMBA's experience-rated FEHBP contracts are of a cost-reimbursement nature, and, therefore, the holder is entitled to access VA FSS for pharmaceuticals pursuant to FAR Part 51. The VA OGC has deferred to the determination of OPM's OGC.

We are entering into this pilot, based on the following principles: (1) the pilot will not exceed 2 years; (2) access to FSS by SAMBA will be for their mail-out program only; (3) access to the FSS for pharmaceuticals by health insurance carriers within the FEHBP will not be extended beyond the SAMBA Health Plan Pilot; (4) OPM and VA will continuously evaluate the financial and program impact of the pilot throughout its 2-year existence; and (5) a process for the quick resolution of problems by OPM and VA is incorporated into an agreement between VA and OPM.

The last point is worth reiterating: because VA is concerned about any significant cost impact to its program resulting from the pilot, a Memorandum of Agreement (MOA) between OPM and VA will be developed describing how the agencies will work together to oversee the pilot. We will include language in the MOA that provides a mechanism for bringing our concerns to OMB and OPM for

quick resolution, including potentially terminating the pilot. The administration is committed to ensuring VA's ability to provide appropriate pharmaceutical care for veterans. In addition, the MOA will also contain language for the joint evaluation of the pilot program.

The evaluation plan will compute the net cost savings to the Government; analyze the administrative implementation issues, especially the operational procedures implemented by SAMBA and its Prescription Benefit Manager, to assure that there is no diversion of drugs. In addition, the feasibility of negotiating and establishing a separate pricing schedule for the FEHBP will be investigated.

VA and OPM will arrange for pharmaceutical companies to meet with representatives from VA and OPM.

Summary

VA remains committed to assist the continued improvements of OPM's programs and those of every other Federal entity. The efficiency of every agency and conservation of taxpayer dollars are important concerns. We stand prepared to extend our expertise to accomplish this pilot and the eventual establishment of a separate pharmaceutical schedule for OPM. We will not, however, compromise our duty to serve those who have served this country.

This concludes my statement. I will be pleased to answer any questions members of the Subcommittee may have.

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
OFFICE OF PERSONNEL MANAGEMENT

at an oversight hearing of the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

VA PHARMACEUTICAL PROCUREMENT POLICY

July 25, 2000

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR CONVENING THIS HEARING TODAY. IN YOUR INVITATION LETTER, YOU INDICATED YOU WANTED TO DISCUSS THE DEPARTMENT OF VETERANS AFFAIRS PHARMACEUTICAL PROCUREMENT POLICY IN THE CONTEXT OF THE SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION HEALTH PLAN'S ABILITY TO PURCHASE SOME OF ITS PRESCRIPTION DRUGS THROUGH A SUPPLY SCHEDULE ADMINISTERED BY THE DEPARTMENT. I AM PLEASED TO BE HERE.

YOU ASKED ME TO ADDRESS SEVERAL ISSUES REGARDING AN OFFICE OF PERSONNEL MANAGEMENT (OPM) DECISION TO AUTHORIZE THE SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION (SAMBA) ACCESS TO THE FEDERAL SUPPLY SCHEDULE FOR DRUGS ON A 2-YEAR PILOT BASIS.

THESE ISSUES INCLUDE: THE RATIONALE FOR THE PILOT, ITS LEGAL BASIS, AND THE IMPLICATIONS FOR THE FUTURE PRICES OF DRUGS PROCURED BY THE DEPARTMENT OF VETERANS AFFAIRS THROUGH THE SCHEDULE.

AS YOU MAY KNOW, OPM ADMINISTERS THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, THE LARGEST EMPLOYER-SPONSORED

HEALTH INSURANCE PROGRAM IN THE NATION. LIKE OTHER HEALTH INSURANCE SPONSORS, WE HAVE WITNESSED RISING PREMIUMS FOR OUR MEMBERS OVER THE PAST SEVERAL YEARS. AMONG THE FACTORS CAUSING THESE INCREASES, PRESCRIPTION DRUG COSTS ARE, BY FAR, THE MOST IMPORTANT. DRUG COSTS CURRENTLY ARE INCREASING AT A RATE OF 20 PERCENT A YEAR, AND IN 1999 THEY ACCOUNTED FOR 26 PERCENT OF BENEFIT COSTS, OR $4.66 BILLION. TAKEN ALONE, PRESCRIPTION DRUGS TODAY CAN ACCOUNT FOR UP TO A FIVE-PERCENTAGE POINT INCREASE IN A HEALTH PLAN'S ANNUAL PREMIUM.

IN AN EFFORT TO MAINTAIN THE AFFORDABILITY OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, WE HAVE TAKEN A NUMBER OF ACTIONS TO MITIGATE RAPID RISES IN PREMIUMS ACROSS THE PROGRAM. WE HAVE ALSO ENCOURAGED ALL OF OUR HEALTH PLANS TO DEVELOP AND IMPLEMENT TECHNIQUES THAT HELP CONTROL COSTS WHILE MAINTAINING COMPREHENSIVE AND AFFORDABLE CARE FOR THE 9 MILLION FEDERAL EMPLOYEES, RETIREES AND MEMBERS OF THEIR FAMILIES WHO DEPEND ON THE PROGRAM FOR THEIR HEALTH NEEDS.

IN LINE WITH THIS PRACTICE, THE SAMBA HEALTH PLAN REQUESTED ACCESS TO FEDERAL SUPPLY SCHEDULE PRICING FOR ITS MAIL ORDER PRESCRIPTION DRUG PROGRAM IN 2000.

SAMBA IS A RELATIVELY SMALL EMPLOYEE ORGANIZATION PLAN THAT IS ONLY AVAILABLE TO FBI AGENTS AND OTHER LAW ENFORCEMENT PERSONNEL OF THE JUSTICE DEPARTMENT AND A FEW OTHER FEDERAL AGENCIES. THE PLAN HAS 16,000 ENROLLEES. ITS MAIL ORDER PHARMACEUTICAL BENEFIT COSTS TOTALED $11 MILLION LAST YEAR. ON THE ASSUMPTION THAT SUPPLY SCHEDULE ACCESS WOULD BE AUTHORIZED IN 2000, SAMBA REDUCED ITS YEAR 2000 PREMIUM INCREASE BY THREE PERCENTAGE POINTS.

IN RESPONSE TO SAMBA'S REQUEST, OPM DETERMINED THAT SAMBA MET THE REQUIREMENTS FOR ACCESS TO THE FEDERAL SUPPLY SCHEDULE. OUR AUTHORITY TO GRANT SAMBA ACCESS TO THE SCHEDULE WAS DECIDED FOLLOWING EXTENSIVE PROGRAMMATIC AND LEGAL ANALYSIS.

THE AUTHORITY FOR SAMBA TO ACCESS THE SCHEDULE STEMS FROM PART 51 OF THE FEDERAL ACQUISITION REGULATION. THE PERTINENT SECTION OF THE REGULATION PROVIDES:

- "IF IT IS IN THE GOVERNMENT'S INTEREST, ... CONTRACTING OFFICERS MAY AUTHORIZE CONTRACTORS TO USE THESE SOURCES IN PERFORMING – ...

  - ... OTHER TYPES OF NEGOTIATED CONTRACTS WHEN THE AGENCY DETERMINES THAT A SUBSTANTIAL DOLLAR PORTION OF THE CONTRACTOR'S CONTRACTS ARE OF A GOVERNMENT COST-REIMBURSEMENT NATURE..."

OPM'S CONTRACT WITH SAMBA MEETS THE REQUIREMENT OF BEING "OF A GOVERNMENT COST-REIMBURSEMENT NATURE." THE REGULATION DESCRIBES COST-REIMBURSEMENT TYPE CONTRACTS AS FOLLOWS:

- "COST REIMBURSEMENT TYPE CONTRACTS PROVIDE FOR PAYMENT OF ALLOWABLE INCURRED COSTS TO THE EXTENT PRESCRIBED IN THE CONTRACT. THESE CONTRACTS ESTABLISH AN ESTIMATE OF TOTAL COST FOR THE PURPOSE OF OBLIGATING FUNDS AND ESTABLISHING A CEILING THAT THE CONTRACTOR MAY NOT EXCEED (EXCEPT AT ITS OWN RISK) WITHOUT THE APPROVAL OF THE CONTRACTING OFFICER."

SAMBA'S CONTRACT WITH OPM MEETS THESE REQUIREMENTS. FIRST, THE CONTRACT LIMITS SAMBA TO CHARGING ACTUAL AND ALLOWABLE BENEFIT AND ADMINISTRATIVE EXPENSES UNDER A LETTER OF CREDIT ARRANGEMENT. SECOND, SAMBA'S PROFIT IS LIMITED TO A NEGOTIATED PERCENTAGE OF ALLOWABLE EXPENSES. CONSEQUENTLY, SAMBA DOES NOT PROFIT FROM OPM'S AUTHORIZATION TO ACCESS THE SCHEDULE FOR PHARMACEUTICALS.

IN ADDITION, SAMBA'S CONTRACT PLACES A CEILING ON ADMINISTRATIVE EXPENSES THAT MAY BE CHARGED TO THE CONTRACT. FINALLY, SAMBA UNDERTAKES THE CONTRACTUAL RISK OF PAYING BENEFITS COVERED UNDER THE PLAN IF THE PLAN'S PREMIUMS AND RESERVES ARE INSUFFICIENT TO PAY THE COST OF BENEFITS.

IF THIS OCCURS, THEN THE CARRIER PAYS BENEFITS AND ADMINISTRATIVE EXPENSES FROM ITS OWN FUNDS. SUCH OCCURRENCES ARE RARE, HOWEVER. HEALTH CARRIERS THAT CONTINUE THEIR PARTICIPATION IN THE PROGRAM FROM ONE YEAR TO ANOTHER USUALLY RECOUP LOSSES BY ADJUSTING PREMIUMS FOR THE FOLLOWING YEAR.

WE ARE ENTERING INTO THIS PILOT BASED ON THE FOLLOWING PRINCIPLES:

- ACCESS TO THE FEDERAL SUPPLY SCHEDULE BY SAMBA, FOR TWO YEARS, WILL BE FOR THEIR MAIL ORDER PROGRAM ONLY.
- ACCESS TO THE FSS FOR PHARMACEUTICALS BY HEALTH INSURANCE CARRIERS WITHIN THE FEHBP WILL NOT BE EXTENDED BEYOND THE SAMBA HEALTH PLAN PILOT.
- A MEMORANDUM OF AGREEMENT BETWEEN OPM AND THE DEPARTMENT OF VETERANS AFFAIRS WILL DESCRIBE HOW THE

TWO AGENCIES WILL OVERSEE AND EVALUATE THE PILOT. THE MEMORANDUM WILL PROVIDE A MECHANISM FOR QUICK RESOLUTION OF CONCERNS AND POTENTIALLY, THE TERMINATION OF THE PILOT.

- OPM AND THE DEPARTMENT OF VETERANS AFFAIRS WILL EVALUATE THE FINANCIAL AND PROGRAM IMPACT OF THE PILOT. WE WILL LOOK AT THE NET COST SAVINGS TO THE GOVERNMENT AND ADMINISTRATIVE IMPLEMENTATION ISSUES, SUCH AS ENSURING NO DIVERSION OF DRUGS TO NON-AUTHORIZED USES. WE WILL INVESTIGATE THE FEASIBILITY OF ESTABLISHING A SEPARATE PRICING SCHEDULE FOR THE FEDERAL EMPLOYEE PROGRAM.
- THE DEPARTMENT OF VETERANS AFFAIRS AND OPM WILL ARRANGE FOR PHARMACEUTICAL COMPANIES TO MEET WITH REPRESENTATIVES FROM VA AND OPM.

AS THE LARGEST EMPLOYER-SPONSOR OF ANY HEALTH BENEFITS PROGRAM IN THE NATION, OPM HAS A DUTY TO BOTH TAXPAYERS AND OUR PARTICIPANTS TO ENSURE THAT THE PROGRAM IS AS COST EFFICIENT AS POSSIBLE WHILE PRESERVING THE OPEN COMPETITION AMONG PLANS ON WHICH THE PROGRAM IS BASED. ACCESS TO PRICE SCHEDULE DISCOUNTS FOR PRESCRIPTION DRUGS HAS THE POTENTIAL TO REDUCE PREMIUM INCREASES AND FOCUS COMPETITION ON OTHER AREAS OF PLAN PERFORMANCE SUCH AS QUALITY AND SERVICE LEVELS. USING THE FEDERAL SUPPLY SCHEDULE TO EVALUATE THE POTENTIAL OF EXTENDING SAVINGS TO OTHER FEDERAL EMPLOYEES HEALTH BENEFITS PLANS THROUGH A SEPARATE SCHEDULE IS A SMART BUSINESS DECISION.

AS PART OF OUR DECISION-MAKING AND CONSULTATION, WE ALSO EXAMINED THE IMPLICATIONS THAT SAMBA'S ACCESS MIGHT HAVE ON

EXISTING FEDERAL AGENCY PARTICIPANTS THAT PURCHASE DRUGS FOR THEIR MEMBERS. FOUR AGENCIES, THE DEPARTMENT OF VETERANS AFFAIRS, THE DEPARTMENT OF DEFENSE, THE COAST GUARD, AND THE PUBLIC HEALTH SERVICE, HAVE STATUTORY ENTITLEMENT TO PHARMACEUTICAL DISCOUNTS AND CONSUME 95% OF THE DRUGS SOLD THROUGH THE FEDERAL SUPPLY SCHEDULE.

OTHER AGENCIES THAT PURCHASE DRUGS, SUCH AS THE BUREAU OF PRISONS, SOMETIMES BENEFIT FROM THESE STATUTORY DISCOUNTS AND SOMETIMES PAY A HIGHER PRICE. THE PRICE PAID BY THESE OTHER AGENCIES DEPENDS ON WHETHER THE SUPPLIER OF DRUGS CHOOSES TO ESTABLISH A SECOND PRICING TIER FOR BUYERS NOT OTHERWISE ENTITLED TO THE STATUTORY DISCOUNT. MANY SUPPLIERS HAVE NOT ESTABLISHED A SECOND TIER OF PRICES SINCE THE VOLUME FOR OTHER BUYERS IS SO LOW – ONLY ABOUT FIVE PERCENT.

SAMBA IS NOT ENTITLED TO THE STATUTORY DISCOUNTS. LIKE THE BUREAU OF PRISONS, IT IS REQUIRED TO PAY THE SECOND TIER PRICE FOR DRUGS WHERE ONE EXISTS. SAMBA'S VOLUME OF PHARMACEUTICAL PURCHASES AMOUNTS TO THREE-TENTHS OF ONE PERCENT OF THE TOTAL VOLUME OF DRUGS CURRENTLY PURCHASED FROM THE SCHEDULE.

THE SAMBA PILOT WILL BE USED SIMPLY AND EXCLUSIVELY TO ESTABLISH A BASE LINE AND EXPERIENCE AGAINST WHICH TO ASSESS THE DESIRABILITY OF ESTABLISHING A SEPARATE SCHEDULE FOR THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND WHAT THAT SCHEDULE MIGHT LOOK LIKE AND HOW IT MIGHT BE IMPLEMENTED.

THIS CONCLUDES MY OVERVIEW OF THE 2-YEAR PILOT PROGRAM GRANTING SAMBA ACCESS TO THE FEDERAL SUPPLY SCHEDULE.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE AT THIS TIME.

STATEMENT OF
RICHARD A. WANNEMACHER, JR.
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
JULY 25, 2000

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

We are pleased to present the views of the Disabled American Veterans (DAV) to the Subcommittee to assist in the examination of the Department of Veterans Affairs (VA) pharmaceutical procurement policy.

DAV was founded in 1920 and chartered by Congress in 1932 as the primary advocate for America's service-connected disabled veterans, their dependents and survivors. Since its inception, DAV has been dedicated to one, single purpose: building better lives for our nation's disabled veterans, their dependents and survivors.

As an organization of more than one million service-connected disabled veterans and an auxiliary, DAV ensures that disabled veterans and their families are adequately cared for by using the voice of our membership to participate in the governmental and political processes that affect the well-being of veterans. We work closely with the Congress to aid in the formulation of legislation that will best serve veterans; and we work in partnership with the VA to find optimum ways to serve the needs of America's veterans.

DAV's National Legislative Department in Washington, D.C. promotes reasonable, responsible legislation to assist disabled veterans, their families, their widowed spouses, and orphans. As the principle advocate for America's 2.3 million disabled veterans—a role we take very seriously—it is not only our policy to seek reasonable, responsible legislation, but to help disabled veterans keep the benefits they have earned by spilled blood, prolonged illness, and loss of mental well-being as a result of their military service.

While serving in our country's armed forces, veterans not only temporarily relinquish their liberty to allow the rest of us to continue to enjoy ours, they lose income and other civilian economic and educational opportunities, endure the rigors and hardships of military service, risk the hazards of war and other dangerous military missions, and suffer injury and death. Of course, the heaviest burdens are borne by those who are disabled—those who sacrifice their health—during service. However, all who put aside civilian education and career opportunities to serve in our nation's defense make noble sacrifices.

Our nation's commitment to its veterans has endured periods of economic crisis and has evolved through various military conflicts to the existing integrated system of veterans' programs. Together, these programs form a benefit system that provides support and addresses the needs of veterans and their dependents in a comprehensive manner.

The breadth of support among the citizens of this country for veterans is fully demonstrated by public opinion data. As our government makes decisions about the future of its programs, it must keep in mind the special nature of veterans' benefits and pay attention to the desires of the American people to honor the nation's pledge to care for its veterans.

Despite this strong commitment to veterans, it sometimes fades from the consciousness of some of our elected officials. In recent years, veterans' champions in the government have been fewer, and veterans themselves have had to fight to secure their programs. Over the last two decades, veterans' programs and services have been cut by more than $27 billion (including spending cuts to be realized through fiscal year 2004). These spending cuts have taken place even though the cost of veterans' benefits has been held to a virtual straight line, while expenditures for certain other federal programs were increasing at an extraordinary pace. Veterans' programs are not a cause of this country's fiscal problems; nor are veterans a major

cause of the backlogs in the VA's claims processing system. Yet veterans' benefits and health care services are being attacked from every direction—the Administration, Congress, the VA, commissions, and so-called think tanks.

In May of 1992, former Congressman Sonny Montgomery introduced H.R. 5193. The intent of the bill was to improve the delivery of health-care services to eligible veterans and to clarify the authority of the Secretary of Veterans Affairs. H.R. 5193 became Public Law 102-585, enacted on November 4, 1992. This bipartisan bill improved the manner by which the VA could obtain best price pharmaceuticals under the Federal Supply Schedule (FSS).

Under Title VI: drug pricing agreements –P.L. 102-585 amended Title XIX (Medicaid) of the Social Security Act to exclude the prices charged on or after October 1, 1992, for prescription drugs purchased by the VA, the Department of Defense, a State Veterans' Home receiving certain grant funds, the Indian and public health services, or certain federally funded clinics and public or private nonprofit hospitals from the calculation of best price procurement for purposes of application of Medicaid rebate agreements.

In order to receive reduced prices, the law requires covered entities to:

- Take certain steps to avoid duplicative discounts or rebates;
- Refrain from reselling such purchased drug to a person who is not a patient of such entity; and
- Permit audits of records to determine agreement compliance.
- Make covered entities liable to the manufacturer for the full amount of any reduced price if the Health and Human Services (HHS) Secretary determines agreement noncompliance on the entity's part.

Public Law 102-585 also amended Title 38, United States Code, to require agreements between the VA Secretary and covered drug manufacturers limiting the purchase price of drugs procured by the VA and certain other federal agencies. The statute provides for additional discounts for covered drugs purchased under the depot contracting system or listed on the FSS. It requires certain manufacturer reports to the secretary on drug prices. The measure authorizes the VA Secretary to audit relevant manufacturer or wholesaler records. It requires the VA Secretary to supply to the HHS Secretary the name of the manufacturer upon the execution or termination of any master agreement and, on a quarterly basis, a list of manufacturers who have entered into such agreements.

As we understand the purpose of the proposed pilot, it would determine if a schedule comparable to the FSS should be established to expand discounts to provide pharmacy benefits to the federal employee health benefit program community.

Mr. Chairman, the DAV is concerned that by expansion of the FSS, the VA would have to bear increased costs that could require either an increased appropriation of billions of dollars from Congress or the reduction of health care services to hundreds of thousands of sick and disabled veterans who rely on the VA as their sole source of health care.

As VA officials have stated on numerous occasions in the last decade, anything which increases the volume of drugs sold under FSS and subject to Public Law 102-585 pricing policy has potential to adversely affect VA pricing for pharmaceuticals. The issue here is not the provision of one FEHBP plan with access to the FSS. The perception that such an action is the beginning of a course of events that could possibly lead to all of FEHBP, Medicare and Medicaid pharmaceutical pricing being linked to FSS/Public Law 102-585 is the key issue. Simplistically, market share/outlays for these programs are already circulating in the economy. If outlays for pharmaceuticals to these programs are lowered through extension of FSS pricing, it is clear the pharmaceutical industry will move to retain profit margin through pricing strategy modifications, i.e. they will raise prices in other venues to maintain profit margins.

Years of inadequate funding—less than current service budgets and below inflation levels—combined with rising demands and fewer employees, have resulted in services that are delayed or withheld. Many veterans die before they are able to access health care.

And what is and has been the Administration's response to all of this? "The Office of Management and Budget (OMB) will maintain sufficient oversight of the pilot to ensure that the initiative does not adversely affect the Department of Veterans Affairs and the federal budget."

I suggest a more accurate statement would be, "without the sacrifices made by veterans, we would not have the level of peace and prosperity we are enjoying today." Few citizens serve and sacrifice for the nation, but all citizens benefit from the efforts of our citizen-soldiers.

Fifty-six years ago, plans were underway for the largest allied air and sea invasion of Europe. Two years ago, the release of the blockbuster hit *Saving Private Ryan* graphically depicted the horrors and loss of life and limb experienced by America's citizen-soldiers as they overcame virtually insurmountable obstacles to successfully complete their mission—to breach the beachhead defenses of a well-fortified enemy. Many who saw the movie were horrified by the images on the large screen. They left the theater praising the efforts of those brave men who stormed ashore at Normandy on June 6, 1944. More than any other movie, *Saving Private Ryan* has made the public aware of the horrors of war and the sacrifices made by those who served this great nation.

On June 25th, America marked the 50th anniversary of the beginning of the Korean War. On Thursday, July 27, we will mark the 47th anniversary of the end of America's "forgotten war." Yet, our government's commitment to care for those who have served in the armed forces continues to be eroded—veterans are no longer a national priority. The now famous words of President Lincoln, inscribed on the VA central office building—"to care for him who shall have borne the battle and for his widow and his orphan"—no longer retain their true meaning. The bottom line is that service-connected disabled veterans, including 100% service-connected disabled combat veterans, are not receiving the medical care, services and benefits they are eligible for.

We are concerned that this pilot will increase the cost of pharmaceuticals purchased by the VA and will result in diminished health care for sick and disabled veterans. We are not satisfied with the Administration's statement that OMB will provide sufficient oversight to ensure that the VA is not adversely impacted. Sick and disabled veterans must not be held hostage to the whims of the Administration and pharmaceutical companies. They must not experience further diminution of health care services.

This concludes my statement. Thank you for permitting us to present our views regarding this most important issue and its effects on health care for the nation's wartime disabled veterans and their families.

HEALTH INDUSTRY GROUP PURCHASING ASSOCIATION

TESTIMONY

Robert B. Betz, Ph.D.
Executive Director

DEPARTMENT OF VETERANS' AFFAIRS
PHARMACEUTICAL PROCUREMENT INITIATIVE
ADDING FEDERAL EMPLOYEE HEALTH BENEFIT PLAN PARTICIPANTS TO THE FEDERAL SUPPLY SCHEDULE DRUG PRICING PROGRAM

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

July 25, 2000

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Summary of Written Statement Submitted For the Record

Mr. Chairman and Members of the Subcommittee, I am Dr. Robert Betz, Executive Director of the Health Industry Group Purchasing Association (HIGPA), the only nationally chartered trade association of health care purchasing and supply chain organizations. HIGPA's membership includes over 160 organizational members who service nearly all of the acute care hospitals in the country as well as a growing portion of the long term care, home care and medical group practice markets. These organizations are engaged in cost containment services, such as group purchasing, for health care providers around the country. HIGPA's Industry Members include for-profit and not-for-profit corporations, purchasing groups, associations, multi-hospital systems, and health care provider alliances. HIGPA's Trading Partner members include many of the nation's leading health care product and medical supply manufacturers, distributors, wholesalers and related suppliers.

Mr. Chairman, I am here today because, according to testimony by the Office of Personnel Management (OPM) before the Civil Service Subcommittee of the House Committee on Government Reform on June 13, 2000, OPM has instructed the Department of Veteran's Affairs (VA) to implement a "demonstration project" under which pharmaceutical prices available for federal agencies' procurements under the Federal Supply Schedule (FSS) will be available to the Federal Employees' Health Benefit Plan (FEHBP) for the Secret Service. This plan, known as the Special Agents Mutual Benefit Association (SAMBA), is a private entity and accordingly, does not have access to FSS pricing for pharmaceutical products under any existing federal law.

It may not be obvious, but the Federal Supply Schedules (FSS) serve the same role for federal agency procurements as the prices negotiated by HIGPA's members for the entities that we serve. At some level, a hospital uses its group purchasing organization (GPO) contract much like a VA medical center uses the FSS schedules when it needs to replenish the inventory of pharmaceuticals and medical supplies it uses in caring for veterans. If the FSS were available to non-government hospitals, clinics and health plans, the VA, as the agency that administers the FSS, would be a direct competitor of HIGPA's members. In such a competition, the VA could enjoy a significant advantage over HIGPA members. The full power of the Federal government under the federal acquisition laws and regulations requiring bidders to disclose and regularly report on the prices given to other purchasers, and the government's authority to enforce these requirements through the False Claims Act and other Federal statutes give VA negotiating leverage that is remarkably unlike the "give and take" that characterizes the arms-length bargaining between vendors and GPOs.

Currently, the VA also enjoys another unique advantage – it is negotiating on behalf of entities that serve our Nation's veterans. Although the General Services Administration is responsible for administering the FSS, it has delegated responsibility for administering the pharmaceuticals and medical supply schedules to VA because, among other things, VA medical centers are by far the most significant federal procurements of pharmaceuticals through the FSS. This means that in administering the FSS, VA can act in the interest of veterans; in its negotiations, VA does not have to be distracted by the differing requirements for payment terms, delivery arrangements, and inventory management that characterize a more diverse group of purchasers. Perhaps

equally important, in negotiating with VA, vendors know that the concessions they make are going to the benefit of veterans. Although commercial realities clearly are a factor in arriving at FSS prices for those items that are not already established by statute, veterans are not just another slice of the market that is indistinguishable from any randomly selected HMO. This committee may be well aware of the importance of this distinction, but it is an advantage that the OPM's SAMBA "demonstration" proposes to destroy in one fell swoop.

Currently the SAMBA program covers approximately 18,000 beneficiaries while the entire FEHBP plans cover 9 million beneficiaries. According to OPM's June 13 testimony, the SAMBA demonstration effort will be used as a foundation for expanding FSS pricing to all of the FEHBP plans. Mr. Chairman and Members of the Subcommittee, you know better than I that the use of health plans instead of government bureaucrats to provide health benefits to government employees has made FEHBP an important model in discussions of how to modernize government-run health programs such as Medicare and Medicaid. It is more than ironic, therefore, that OPM's FSS proposal and "demonstration" have, by administrative fiat, turned the whole structure of FEHBP on its head: It would convert a significant segment of the pharmaceutical market where prices currently are negotiated by HIGPA members into a government-run system administered by employees of the VA.

If this OPM FEHBP/FSS proposal comes to fruition, when the Veterans Committees appropriate funds that they think will pay for VA employees, they in fact would be appropriating funds for staff to establish pharmaceutical prices for all of the commercial health plans that choose to participate in FEHBP. As participants in the FEHB program, the Members of the committee are aware that FEHB plans include the very best commercial health plans available today -- Aetna U.S. Healthcare, Blue Cross/Blue Shield, CIGNA, Humana, Kaiser Permanente, and Prudential Healthcare, for example -- and health care in the best non-government hospitals, clinics, and physician offices. HIGPA members do not understand why the government should be allowed to usurp these significant parts of our business without even considering that this significant injection of the government into our market would require Congress to have public hearings and consider legislation.

Giving SAMBA, and ultimately all FEHBP plans, access to federal drug prices under the FSS not only will dismantle our pharmaceutical market, it promises to damage the VA and its ability to provide cost effective care to veterans. I have included in my full statement for the record an overview of the abundant evidence showing that when a discount that is voluntarily given by a seller to a specific buyer, based on unique terms and conditions of purchase and other business advantages to the seller, is required to be given to a sizable group that does not share those characteristics, a rational seller will eliminate or reduce the discount. We have seen this pattern time and again in pharmaceutical manufacturers' adjustments to the requirements of a whole series of federal pharmaceutical pricing laws. The Medicaid rebate requirement established in 1990 provides the clearest example because it was the first to be enacted, and it came about quite suddenly. In the wake of the law's requirement that the manufacturer's best price to any customer be extended to all Medicaid programs, the discounts available to HMOs and hospitals were reduced or discontinued completely, as were those to VA and DoD, and a new, significant benchmark hung over all commercial negotiations. Every negotiation was overhung with a new

cost cloud -- the dollar value of the rebates that the company would be required to pay Medicaid based on the price it agreed to give a customer.

Congress rather quickly passed a law to exempt VA prices from the Medicaid best price requirement for which the rest of the market must bear the burden. Implementation of this SAMBA demonstration project creates even more explicit baggage for VA negotiations by ensuring that the full cost of providing the discount to all FEHB plans will hang over VA's FSS negotiations with vendors. Perhaps it should go without saying, but I must call your attention to the fact that Congress already has spoken on the issue of expanded access to FSS pricing on several previous occasions. In fact, I am aware of at least four separate laws over the past 10 years enacted purely to correct the unintended adverse consequences on VA of changes in federal pharmaceutical pricing laws. In each of these cases, the unintended consequences were the result of a law passed by Congress to achieve some other purpose, and VA was an injured bystander. Most recently, in 1997, Congress acted to repeal Section 1555 of the Federal Acquisition Streamlining Act of 1994 (FASA) (P.L. 103-355), also known as "cooperative purchasing," which would have expanded access to the FSS. With its "demonstration," OPM is explicitly attempting to do for a different set of purchasers precisely the same type of FSS expansion that Congress has rejected. It is entirely unclear to me why this agency is free to disregard Congress' definitive statement in 1997 regarding FSS expansion. It is of great concern to HIGPA that OPM feels free to disregard the almost certain adverse impact on veterans without any new data showing benefits that outweigh the harm to veterans, or even an airing of the issues in public hearings or opportunity for public debate before the project is implemented.

Mr. Chairman, I ask that my full statement be included in the record. I have included a more complete account of my concerns regarding FSS expansion in my prepared statement. I have tried to pull together what HIGPA's members know about price negotiations in the pharmaceuticals market and about the various special pricing laws that have affected price negotiations over the past decade or so. We think the evidence is clear: expansion of access to the FSS takes away a potentially significant segment of HIGPA's market, and is likely to have a significant adverse impact on the VA's continued ability to obtain good prices for the FSS. The Health Industry Group Purchasing Association (HIGPA) strongly opposes the SAMBA FSS initiative OPM has implemented through VA.

Thank you Mr. Chairman and members of the Subcommittee.

STATEMENT

Mr. Chairman and Members of the Subcommittee, I am Dr. Robert Betz, Executive Director of the Health Industry Group Purchasing Association (HIGPA), the only nationally chartered trade association of health care purchasing and supply chain organizations. On behalf of HIGPA, I appreciate this opportunity to submit testimony on the matter of the proposed expansion of the Federal Supply Schedule (FSS) drug pricing program administered by the Department of Veterans' Affairs (VA) to Federal Employee Health Benefit Plans (FEHBP). HIGPA's membership includes over 160 organizational members who service nearly all of the acute care hospitals in the country as well as a growing portion of the long term care, home care and medical group practice markets. These organizations are engaged in cost containment services, such as group purchasing, for health care providers around the country. HIGPA's Industry Members include for-profit and not-for-profit corporations, purchasing groups, associations, multi-hospital systems, and health care provider alliances. HIGPA's Trading Partner members include many of the nation's leading health care product and medical supply manufacturers, distributors, wholesalers and related suppliers.

THE VETERANS HEALTH CARE PROGRAM THAT OPM PROPOSES TO DISRUPT

As modified over the years by the Veterans Health Care Act of 1992 and other statutes shaping the GSA schedules and regulations to fit the needs of VA and veterans, the FSS contracting program for pharmaceuticals works to provide veterans with access to discounts that are available in no other market.

Prior to 1990 the VA negotiated FSS contracts with manufacturers pursuant to a well-established statutory and regulatory framework. Pricing for all FSS contracts was determined on the basis of negotiations between the Government and individual manufacturers that were subject to the Federal Acquisition Regulation and other GSA and VA policy directives. The Government's FSS negotiation policy was to obtain FSS pricing equal to or better than the manufacturer's most favorable non-Federal pricing, taking into account differences between the Government and other customers regarding contract terms and conditions, purchase volumes, and other factors.

The Veterans Health Care Act of 1992 (VHCA) changed the FSS ground rules dramatically for certain drugs. The VHCA in effect now *requires* pharmaceutical manufacturers to make available for procurement on FSS contracts all of their "covered drugs" (including single source and innovator multisource drugs). Companies that do not comply cannot obtain *any* Medicaid funding for their products. Because Medicaid purchases constitute approximately 15-20% of the outpatient prescription drug market, most manufacturers have no choice but to make their covered drugs available on FSS contracts. The VHCA also sets a ceiling on the price of covered drugs offered to certain federal agencies (including the VA and the Department of Defense) at 76% of the manufacturer's weighted average commercial price (referred to as the non-federal average manufacturer's price ("non-FAMP")).

Some of the drugs that are subject to this ceiling price (e.g., innovator multiple source drugs that have generic competitors) may be discounted further below the ceiling in the negotiation process

as competitors vie for access to veterans and their caregivers. Negotiations for non-innovator multisource drugs and over-the-counter medications are still conducted under the basic rules, and manufacturers are not required to include them on FSS contracts. The discounts on these products are at special risk under the SAMBA/FEHBP proposal, for the reasons discussed below.

THE LESSONS OF HISTORY AND ECONOMICS

At a June 13, 2000 hearing of the Civil Service Subcommittee of the House Government Reform Committee, the Office of Personnel Management (OPM) made known its intentions to work with the VA to initiate a two-year demonstration program under which the SAMBA will have access to the VA FSS program for prescription drugs. Advocates of the SAMBA initiative contend that this part of the FEHBP will realize savings as a result of the availability of more extensively discounted pharmaceutical prices. They also contend that the SAMBA beneficiary population is so small that the impact of the pricing decision of pharmaceutical manufacturers in response to the demonstration project will be de minimis. Further, advocates argue that a pilot project is necessary in order to set the stage for implementation of expanding such a program to the entire FEHBP. The impact of such a vast expansion clearly would not be de minimis for either HIGPA members or veterans, but ***no lawful policy rationale has been demonstrated or asserted for the SAMBA demonstration apart from laying the groundwork for the proposed full FEHBP expansion.***

Opponents of FSS expansion question the legality and the appropriateness of expanding FSS pricing to what is not a federal agency, but is a private entity that provides services to employees of the federal government. They also contend that consumers and federal taxpayers will suffer adverse economic consequences resulting from higher procurement costs as a result of expanded access to FSS pricing. ***Based on historical experience and economic models, it is reasonable to conclude that if the demonstration project goes forward and is expanded to include all FEHBP beneficiaries, VA drug discounts will be reduced and products removed from the FSS, resulting in higher expenditures for pharmaceutical products needed by veterans.*** Or, to put the economic result in the context of VA's fixed appropriations for health care, VA will have reduced ability to meet the needs of veterans with the available appropriated funds.

Prior Congresses have taken steps similar to OPM's proposed FSS expansion with the intent to provide "lower priced" pharmaceuticals to targeted groups of beneficiaries. These efforts include the 1990 Medicaid rebate requirements, the 1992 Federal Ceiling Price on single source and innovator drugs required by veterans, the 1992 ceiling on prices to be charged certain recipients of federal grants, and the "Cooperative Purchasing Program" enacted as part of the Federal Acquisition Streamlining Act of 1994 (which was subsequently repealed).

The Cooperative Purchasing Program

We learn a great deal about the dangers of the FEHBP expansion program by considering the most recent proposal to expand "Federal pricing" to a population outside of the Federal government – the "Cooperative Purchasing" provision included in the "Federal Acquisition

Streamlining Act" (FASA) (P.L. 103-355, Oct. 13, 1994). This law, enacted by the 103rd Congress, included provisions authorizing the General Services Administration (GSA) to extend access to FSS contracts to procure goods and services. (GSA is the agency that administers FSS contracts; DVA administers FSS contracts for pharmaceuticals under a delegation of authority from GSA.) As enacted, the cooperative purchasing provision would have allowed GSA to expand access not only to the schedules negotiated by GSA, but also to the pharmaceuticals and medical supply schedules negotiated by VA.

Unfortunately, there was no discussion – neither hearings nor debate – relating to the "Cooperative Purchasing" FSS expansion authority in FASA. If there had been, Congress would have learned of a whole range of laws designed to protect VA's FSS prices that would interact in unfair and inappropriate ways with the proposed expansion. Congress also would have learned of the untoward impact of the proposal as the government proposed to displace critical players in the commercial market.

When GSA announced in the *Federal Register* a "Notice and Request for Comments" on its proposed plan for implementing a Cooperative Purchasing program the following Spring, it received 300 or so comments that strongly criticized the plan. (*See* 60 Fed. Reg. 17764, April 7, 1995; Congressional Research Service Rep't No. 97-964 GOV (Oct. 24, 1997).) Opposition from a diverse array of large and small manufacturers, purchasers, wholesaler-distributors and dealers culminated in Congress' enactment of a moratorium delaying implementation of the program. (*See, e.g.*, Conference Report for FY '96 Treasury, Postal Service, and General Government Appropriations Act (H. Rep. No. 104-291, 104th Cong. (1995); the "Federal Acquisition Reform Act" (the "Clinger-Cohen Act") (P.L. 104-106, Feb. 10, 1996)). There followed additional legislation establishing successive moratoriums and requiring further study before implementation. (*See* S. 672, 105th Cong.; P.L. 105-18; S. 1023, 105th Cong.). Legislation repealing the Cooperative Purchasing program ultimately was signed into law on October 10, 1997. (*See* P.L. 105-61).

During the initial moratorium, the General Accounting Office (GAO) conducted a study required by that Act which culminated in a report assessing the effects of an FSS expansion to non-federal public agencies on industry, including the impact on small business and local dealers, on the state and local governments entities that would be eligible to use the schedules; and on costs to federal agencies.

The GAO report, ***COOPERATIVE PURCHASING: Effects Are Likely to Vary Among Different Governments and Businesses*** (GAO/GGD-97-33, February 1997), was transmitted to the Congress on February 10, 1997. The findings by the GAO were inconclusive.

Basic Health Care Economics

Other studies of the effects of non-federal public entity access to the FSS have arrived at clearer conclusions than the GAO. Economists Incorporated was retained by the Health Industry Manufacturers Association (HIMA) to look at the effect of non-federal public agency access to

the FSS on the medical device industry. This study concluded:

> "...the inclusion of state and local customers as qualified buyers from the federal supply schedule would require manufacturers of health products to charge higher prices than are currently being offered on the supply schedule. These higher prices would be necessitated by the substantial increases in costs of the program and the inclusion of so many customers that are substantially higher cost to serve than current federal customers. In addition, the uncertainty in predicting the implications of discounts for revenues with so many hundreds of additional buyers, would either lead to higher costs (and thus, higher prices) or withdrawal from the schedule. Even if administrative costs did not increase...the other factors would lead to a reduction in discounting from current levels."

HIGPA commissioned Muse & Associates in October 1996 to analyze the impact on health care costs of expanded access to the FSS by non-federal public entities. According to the HIGPA study, purchasers currently benefiting from discounts will receive reduced discounts as the share of the market receiving discounts expands. In fact, *the study found that federal government costs would increase by as much as $4.3 billion over a five-year period, and costs to non-public hospitals and other health care providers could increase by as much as $320 billion over a similar period of time.*

Testimony of the VA on July 10, 1997 before the House Committee on Veterans Affairs underscores the case made in the HIMA and HIGPA studies with respect to the likely impact on veterans:

> "(A)ny additional increases in prices paid for pharmaceuticals caused by the potential cumulative effects of opening the Federal Supply Schedule to state and local governments could interfere with our ability to care for eligible veterans...The collective concern of VA officials involved in the management of the pharmacy benefit is that *opening the FSS for pharmaceuticals to non-federal entities could adversely affect the expenditures for pharmaceuticals for not only VA and other Federal buyers, but also the groups this action is intended to assist."*

VA's concern was not based on idle speculation but on its direct experience as a result of the fall out from previous laws that implicated VA pricing mechanisms. As VA stated:

> "This concern stems from the price increases we experienced following implementation of the Medicaid Rebate drug pricing provisions included in the Omnibus Reconciliation Act of 1990 (OBRA '90). Specifically, the highest increases were seen in items that were deleted from the FSS by pharmaceutical manufacturers after the enactment of OBRA '90. Prices for those deleted products increased, on average 80 percent. Prices of items remaining on the FSS increased 14 percent. The cost of items in VA depots

> increased in price by 12.4 percent...If similar tactics are employed in 1997 in response to opening FSS pharmaceutical contracts, just as new FSS contracts are being negotiated for the next five or more years, *VA alone could suffer an increase in pharmaceutical costs of as much as $250 million per year.*"

House of Representatives, Subcommittee on Health, Committee on Veterans' Affairs, "Pharmaceutical Prices, and Draft Legislation on Homeless Veterans' Programs and Issues Related to Persian Gulf War Illness," July 10, 1997 (testimony of John Ogden, Chief Consultant, Pharmacy Benefits Management Strategic Health Group, VA) (emphasis added).

This damage was projected in spite of the fact that Congress, in 1992, had established in statute a mandatory ceiling on prices VA can be charged for single source and innovator multiple source drugs as part of its remedy for the collateral damage suffered by VA as a result of the fall out from the Medicaid rebate statute.

The Medicaid Best Price Law: A Lesson Learned

Attempts by certain purchasers to use the power of the federal government to obtain mandatory discounts are not new. And forces on all sides have expressed concern about pharmaceutical prices for decades. In 1990, Congress enacted Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (P.L. 101-508) which required drug manufacturers to provide to state Medicaid programs rebates on drug purchases based on the "best price" that they offer any customer. The law was enacted to lower pharmaceutical costs to the Medicaid program. However, the Medicaid best price program is truly an example of good public policy intentions resulting in disastrous unintended consequences. States did save funds by receiving discounts from drug manufacturers, but the market place was altered in the process.

Since the VA was not exempted from the best price statute, drug manufacturers were quick to abandon deep discounts that they historically offered to the VA, leading to the Veterans Health Care Act of 1992. Although certainly the VA was not the only customer affected by the law. Immediately prior to and after the passage of the law, pharmaceutical manufacturers responded strategically to maintain profit levels by lowering their discounts to a number of customers -- GPOs, the Department of Defense, the VA, hospitals, HMOs, and others. Clearly, when faced with a mandatory extension of negotiated discounts to the Medicaid program, manufacturers raised or eliminated those discounts to other market segments.

In the case of SAMBA and FEHBP, OPM has gone beyond the usual negotiating pressures and has resorted to asserted technicalities and dubious contractual distinctions to insist that it, like veterans, is entitled to the special prices established for the FSS.

What we have clearly learned from the Medicaid best price law is that as the percentage of the market asserting a claim to the discount grows (whether using OPM's legal sleight of hand or more typical competitive pressures), ultimately a vicious cycle plays out where no one gets a discount, earned or otherwise, with everyone paying a higher price. Where this result occurs through the power of government agency, such a result is, as a practical matter, no different from

price controls. It is a world in which there is no role for the members of my organization in negotiating prices for providers and the patients they serve. Furthermore, if VA's process were to become this universal benchmark, it is entirely unclear whether VA's process, in the absence of private sector pricing for comparison, would set "good" prices. What is clear is that there would be higher prices than VA would be able to obtain if it were negotiating on behalf of veterans, and leaving the private sector plans to fend for themselves, as has been occurring in the commercial market since its inception.

DISCUSSION

Opening up the FSS to the SAMBA demonstration project raises an important matter of principle and a critical policy question: Should Federal law permit an agency to take the earned discounts on pharmaceutical products given to the VA and make them available to non-governmental entities?

The Congress is rightfully suspicious of the Administration's push to open access to FSS pricing. Congress should say to the Administration "We told you once to stop in repealing the cooperative purchasing provision. We're telling you a second time to stop." If you do not, OPM will have gotten away with thwarting the clear intent of Congress. Quibbling over the minor differences between SAMBA and FEHBP is a bureaucratic ploy that is more words than substance. The SAMBA demonstration feels like Section 1555 cooperative purchasing; it does virtually the same thing that cooperative purchasing would have done (but for a different group of non-governmental entities); it will have the same deleterious impact on veterans. Therefore, it should be subject to the same Congressional decision. Otherwise, the expressed will of Congress will have been twisted by clever wordsmiths to create a double standard. On the one hand, federal Cooperative Purchasing has been considered and rejected as a bad policy when the beneficiary is state and local government. On the other hand, the same type of plan would be OK when a federal agency plays favorites with certain of its contractors and calls the expansion a "demonstration project."

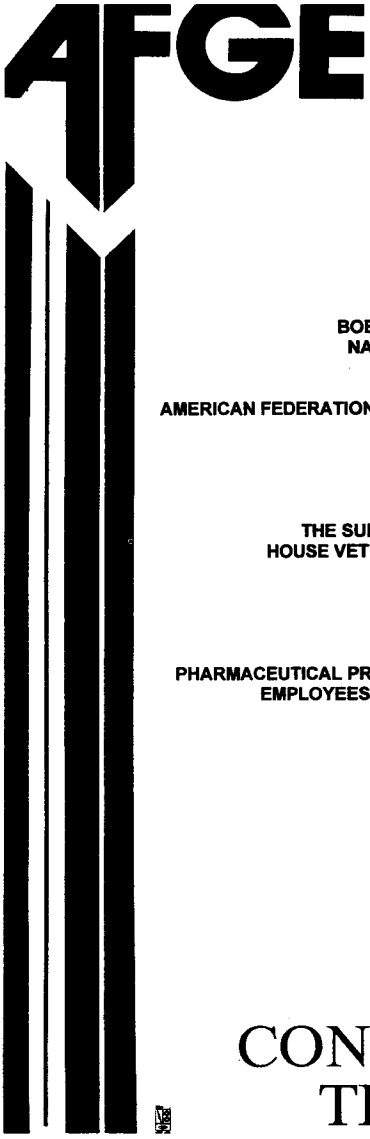
Further federal intrusion into the marketplace is neither necessary nor appropriate at this stage in the evolution of the private marketplace. The SAMBA initiative should be seen for what it is – a direct contravention of Congress' decision in repealing Section 1555.

CONCLUSION

The HIGPA and its member institutions appreciate this opportunity to share with you and Members of the Subcommittee our thoughts on Department of Veteran's Affairs (VA) initiative to provide drugs available under the Federal Supply Schedule (FSS) under the proposed demonstration project.

We respectfully request that as you contemplate the potential impact that the demonstration project can have that you give serious consideration to the impact on VA drug prices and the long term effect on overall pharmaceutical pricing if the program goes forward.

HIGPA looks forward to working with the Members of the Subcommittee and their staff on these very important matters. Thank you.



American Federation of
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STATEMENT BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTEE ON HEALTH
HOUSE VETERANS' AFFAIRS COMMITTEE

REGARDING

PHARMACEUTICAL PRICES FOR ENROLLEES IN THE FEDERAL
EMPLOYEES HEALTH BENEFITS PROGRAM

JULY 24, 2000

CONGRESSIONAL TESTIMONY

Mr. Chairman and Subcommittee Members:

My name is Bobby L. Harnage, Sr. and I am the National President of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 600,000 federal and District of Columbia employees our union represents, I am pleased to submit this testimony on the merits of allowing a contractor in the Federal Employees Health Benefits Program (FEHBP) to purchase prescription drugs at the discounted prices available to federal agencies through the Federal Supply Schedule (FSS).

The members of AFGE, and indeed all of the more than nine million Americans who purchase their health insurance through the FEHBP have a stake in the outcome of this debate. Federal employees and retirees pay on average 28 percent of premiums for health insurance coverage through the FEHBP, with the federal government paying the remaining 72 percent. Federal agencies, including the Department of Veterans Affairs (DVA) and their employees and retirees, have been forced to swallow FEHBP premium increases averaging more than 27 percent over the past three years. The Office of Personnel Management (OPM) has warned that 2001 will bring further increases of an additional eight to nine percent.

It is in this context that the pilot program allowing the Special Agents Mutual Benefits Association (SAMBA) plan to purchase mail-order prescription drugs at the discounted prices negotiated for the Federal Supply Schedule (FSS) should be considered. The actuaries who administer FEHBP at OPM have estimated the annual savings from this pilot program, which will affect a small fraction of the prescription drug costs (mail order only), for one small plan (17,000 people out of 9,000,000 or 0.2 percent of the total) will approach $2.4 million. More important, OPM estimates that this small change will lead to a 3 percent decline in SAMBA's premiums.

Prescription drug prices currently stand as the number one reason behind the escalation in the rate of increase in FEHBP premiums. According to OPM, drug charges now account for a fifth of all FEHBP claims, and because both prices and utilization of prescription drugs are rising faster than other health care costs, that percentage continues to rise. Up until now, OPM has done little to pursue strategies which restrain the growth of FEHBP premiums, advancing only proposals which would shift costs onto federal workers and retirees, who can ill afford any additional expenses. This year's initiative on the part of the Special Agents Mutual Benefits Association (SAMBA) is the first policy change, however small, that OPM has endorsed which will actually lower the rate of increase in FEHBP costs for *both* federal agencies and their employees and retirees.

AFGE testified before the House Government Reform Subcommittee on Civil Service two months ago regarding proposed changes to the FEHBP. At that time, the Office of Management and Budget (OMB) was still studying the SAMBA initiative from the perspective of federal procurement law. Since that time, OMB has concurred with the legal opinion of OPM's General Counsel that not only is the SAMBA initiative legally permissible, it is also entirely consistent with the federal government's procurement policy objective of encouraging contractors to minimize costs reimbursable to the government.

Opponents have resorted to specious legal arguments in an attempt to divert attention from the fact that this is a matter of price equity. We believe the question at hand is not whether an FEHBP contractor is allowed access to the FSS for certain reimbursable goods and services, but whether the government should capitulate to the pharmaceutical industry's demand that it be allowed to charge the federal government different prices for drugs, according to its own prerogatives.

AFGE believes strongly that when the federal government is paying directly for health care, including prescription drugs, it should not hesitate in pursuing all

opportunities to minimize its costs. In the area of prescription drugs, if the government has an existing agreement with vendors to pay $1.00 for a dose of a particular medication, why should it sometimes pay $1.00 and other times $5.00 for a dose of the same medication? For example, the popular allergy medication Claritin costs from $.77 to $1.20 a dose on the FSS; its average wholesale price is $2.31, and the retail price in the Washington, D.C. area averages $3.43. There is no good reason why the government should pay many different prices for the same drug.

The drug companies' insistence on the right to charge the government different prices according to its will takes the pernicious strategy of price discrimination to a new level. Price discrimination occurs when vendors charge customers different prices for the same good or service. The vendor maximizes profits by capturing any "consumer surplus" which might exist because of variation among consumers in terms of ability to pay, availability of alternatives, knowledge, race, gender, or national origin. While drug companies are notorious for their practice of price discrimination in terms of charging more domestically than they do abroad, it is an act of extreme arrogance and greed to charge the same consumer different prices for the same good. But that is exactly what the drug companies do to the federal government.

Only one serious question has been raised with regard to the SAMBA initiative. That is whether the drug companies will raise the prices they charge to the DVA (and other government payors with access to the Federal Supply Schedule (FSS) for prescription drugs such as the Department of Defense (DoD), the Public Health Service (including the Indian Health Service), the Bureau of Prisons, the Coast Guard, and certain D.C. institutions such as Howard University and St. Elizabeth's Hospital) through the FSS.

AFGE is submitting this testimony in the hope that Congress will treat this issue as a question rather than a foregone conclusion. It is clear that the pharmaceutical industry prefers that Congress consider it axiomatic that drug prices in the FSS will rise if access is granted to an FEHBP contractor. But prices will only rise if the drug companies raise those prices, and if the federal government allows it. Thus, the question of what will happen to the drug prices on the FSS if the SAMBA initiative goes forward is not like the question of what will happen to the weather next week. It's a question of what policy the U. S. government is prepared to pursue with regard to the pricing power of the drug industry.

In 1997, the General Accounting Office (GAO) conducted a thorough study of this question in the context of a proposal to open the FSS to some non-federal purchasers by establishing a cooperative purchasing program that would allow state, local, and Indian tribal governments and Puerto Rico to buy drugs through the FSS. The GAO investigation gathered information from three sides of the issue: those with access to the FSS who worried about price increases if access were broadened, those who wanted access to the FSS so that they could begin to pay lower prices for prescription drugs, and the associations representing drug stores and the drug companies themselves. Not surprisingly, GAO concluded that it was impossible to predict the outcome of expanding access to the FSS, noting that since the prices were set through negotiation, only time would tell.

Thus the question is really only one of the relative bargaining strength of the federal government and the pharmaceutical companies. It is somewhat akin to a parlor game to speculate on which party has more leverage or is a better negotiator. As GAO wrote, "although many factors would influence the negotiations between VA (for the federal government) and drug manufacturers, two primary ones are VA's negotiating ability and manufacturers' pricing strategies." As one who has faced the VA across the bargaining table in the

context of labor-management collective bargaining, I urge the Subcommittee not to underestimate the VA's abilities.

Why should the federal government of the United States of America cower in the corner rather than advance its interests in lowering the price one of its small contractors pays for prescription drugs? The prospect would be laughable if the reality were not so tragic. The SAMBA initiative merely confirms that under existing law, the federal government has the right to allow one type of contractor to purchase goods whose cost will be reimbursed from its own negotiated price schedule.

Because the issue of prescription drug prices is so highly politicized, perhaps it would be useful to consider an analogous situation. If the federal government were building a new structure, and needed to hire a builder to perform construction services, would it not be reasonable either to require or to allow that builder to purchase lumber at discounted prices the government had negotiated with the lumber yard rather than reimburse him at the higher rates the lumber yard might charge that small-time builder? Of course it would. And it is just as reasonable for the government to allow FEHBP contractors to purchase prescription drugs off the FSS.

It is difficult to address the fears of the DVA with regard to the pharmaceutical companies' implied threats to raise FSS prices in the future if an FEHBP plan is permitted to utilize the schedule. The U.S. government should always have the courage to stand up to threats, and do what it can to assuage the fears of any of its agencies. It is never good policy to give in to bullies; we all know that their power is not intrinsic, but rather derives from fear on the part of their victims.

In fact, AFGE believes that the drug companies are making empty threats. The prospect of pharmaceutical companies going on strike against the federal government for insisting that it not charge different prices to different government

programs for the same drugs is highly unlikely. As more questions are raised in the political sphere about their widespread price discrimination, especially with regard to the U.S. domestic market relative to foreign customers, it would be truly shocking to witness retaliatory price gouging to punish taxpayers and veterans.

GAO testified before the Subcommittee on Oversight and Investigations of the House Veterans' Affairs Committee in May of this year that the government could realize $300 million of savings per year if the Department of Defense and the VA were to join forces more often in the purchase and distribution of prescription drugs. According to GAO, the VA and DoD could maximize savings to the government by pursuing what it calls "the most cost-effective mechanism-national, committed-use contracting with a supplier," rather than the FSS. It appears that agency rivalries and a sentimental attachment to the FSS have led these agencies to put fiscal concerns aside.

The relevance of this GAO study and testimony to the subject of this hearing is clear. Evidence abounds that increasing the size of a purchasing pool allows the purchasers to extract larger discounts from sellers, not smaller discounts as the drug companies argue and the VA fears. Whether it is national governments negotiating on behalf of their entire domestic markets (as is the case in Mexico, Canada, and Western Europe), or the combined purchasing power of several federal government programs (as is the case for VA and DoD), bigger is better.

Conclusion

The SAMBA-FSS pilot combines two important public policy issues. The first is how seriously the government takes the problem of unchecked prescription drug price inflation and price discrimination. The second is how seriously the government takes the laws requiring federal agencies to scrutinize the costs of private contracts, and to utilize government sources where it is cost-effective to

do so. AFGE believes that the SAMBA pilot is a step in the right direction on both of these questions.

What is under consideration is implementation of a policy which has the potential to save taxpayers 3 percent each year from a $20 billion federal program of health insurance. The savings can be accomplished without reducing coverage, restricting benefits, or shifting a larger share of health care costs onto employees. The policy asks the pharmaceutical industry to absorb the savings, on the principle that it should not practice price discrimination against the federal government.

It is wrong for the pharmaceutical industry to threaten the federal government, in particular the DVA and by extension our nation's veterans, with price increases if they do not capitulate to their demands. The federal government should wherever possible endeavor to pay one price for prescription drugs, whether the beneficiary is a veteran, an active duty or retired member of the military, a member of the Coast Guard, a participant in the Indian Health Service, a prisoner in a federal penitentiary, or even a federal employee.

The government has assumed financial responsibility for the provision of health care to all these Americans, and AFGE does not see a reason why federal employees, even the tiny percentage who work for the Federal Bureau of Investigation and participate in SAMBA for health insurance, should be left behind. This concludes my testimony. I would be happy to answer any questions the members of the Subcommittee may have.

TESTIMONY

OF

COLLEEN M. KELLEY

NATIONAL PRESIDENT

NATIONAL TREASURY EMPLOYEES UNION

ON

VETERANS ADMINISTRATION PHARMACEUTICAL POLICIES

JULY 25, 2000

10:00 AM

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON VETERANS' AFFAIRS

334 CANNON HOUSE OFFICE BUILDING

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Chairman Stearns, Members of the Subcommittee:

I am Colleen Kelley, the National President of the National Treasury Employees Union (NTEU). As you may know, NTEU represents more than 155,000 federal employees and retirees across the federal government.

NTEU very much appreciates the opportunity to provide testimony for today's hearing examining Veterans Administration pharmaceutical policies. As the Chairman is no doubt aware, one of the fastest growing components of health insurance premiums nationwide is prescription drug coverage. This is no less true for the Federal Employees Health Benefits Program (FEHBP). Prescription drug costs currently account for $1 of every $4 FEHBP dollars - a ratio that has increased dramatically over the last few years.

NTEU's goal is to insure that the FEHBP provide the 9 million federal employees, retirees and their families who rely on it for their health insurance needs with the best coverage at the best rates. The average premium increase in FEHBP plans for 2000 was 9.3%. This was preceded by increases of 9.5% and 7.2% in 1999 and 1998. Prescription drugs account for a large portion of these increases. Thousands of federal employees - especially lower paid employees - are unable to afford even the least expensive FEHBP coverage. For these reasons, it is important that we explore more cost efficient ways to purchase drugs, ways that will both permit these individuals to afford FEHBP coverage for their families and that hold the promise of providing the federal government with the best possible prices for its health benefits plan.

Moreover, to the extent these lower paid public servants have to make the hard choice not to have health insurance, the government will continue to lose ground to the private sector as

the employer of choice. I am sure the fact that the federal government is experiencing an increasingly difficult time attracting and retaining the best employees in this full employment economy has not been lost on this, or any other committee of the Congress.

One avenue under consideration by the Office of Personnel Management is insuring that the FEHBP - the largest employer sponsored health insurance plan in the nation - better use its buying power to negotiate discount rates and bring down costs and premiums wherever possible. To this end, NTEU strongly supports the efforts of one small FEHBP plan, the Special Agents Mutual Benefit Association's (SAMBA) request for access to the Federal Supply Schedule (FSS) for its mail order prescription drug program.

SAMBA requested this approval from the Office of Personnel Management (OPM) late last year, announcing that this one move alone would reduce its plan's premiums - premiums that both the federal government and employees share - by 3% annually. Savings from this one effort are estimated to be $2.4 million annually.

Because the federal government, in its role as employer, pays almost 75% of FEHBP premiums, the savings to taxpayers inherent in this proposal are enormous. As I pointed out earlier, prescription drug costs currently account for an estimated $1 of every $4 FEHBP premium dollars. With the annual cost of the FEHBP reaching $20 billion dollars, the taxpayer savings that could result from the federal government adopting a prescription drug schedule similar to the FSS must be considered.

A patchwork of drug purchase arrangements currently exists in the FEHBP. The SAMBA proposal represents a forward thinking approach to controlling health care costs and OPM has worked to insure that SAMBA's request be approved, limiting it to a two year pilot, after which time, OPM would review the advisability

of establishing its own, separate, schedule from which FEHBP fee for service health plans with cost-reimbursement type contracts with the federal government would purchase prescription drugs for their health insurance plans.

FEHBP providers have long been permitted to purchase other goods and services, such as hotel and travel rate discounts, from the Federal Supply Schedule for use in operating their federal health plans. Nonetheless, the idea that one tiny FEHBP health plan with only 17,000 enrollees would be permitted to purchase drugs from the FSS has ignited a controversy that has at least, in part, led to this hearing today.

The most vocal opposition to this pilot going forward, which most agree has the potential to save the federal government, federal employees and retirees, and equally important, the American taxpayer millions of dollars, has come from the pharmaceutical industry. They have employed scare tactics and hired pricey Washington law firms to do their bidding. They have attempted to scare the Veterans Administration, the largest purchaser of prescription drugs from the Federal Supply Schedule, into believing that should this one little 17,000 member FEHBP plan be permitted to purchase drugs at the discounted FSS rate, the prices veterans hospitals will pay will rise.

Why? Because it might cut into pharmaceutical industry profits - profits that according to published reports, exceeded $26 billion dollars in 1998. It is difficult to muster much sympathy for an industry with profits that exceed the size of entire economies of some small countries.

According to the Health Care Financing Administration, prescription drug expenditures have grown dramatically in recent years. In 1997, for example, prescription drug expenditures grew 14% while the annual growth rate for all health care expenditures

was 5%. Unlike other segments of the economy, drugs always seem to be priced according to what people will pay. Those able to afford FEHBP coverage are lucky because they at least have medical coverage for prescription drugs, however, the elderly and others without prescription drug coverage must pay whatever drug companies demand. In 1998, the average price for a new drug (those coming onto the market in 1992 or later) was $71.49, a price more than double the average price of drugs previously on the market - $30.47. It is difficult not to view this as price gouging.

As this committee knows, the House has approved legislation allowing Americans to purchase prescription drugs abroad, legislation that for the first time would permit Americans access to the same drugs at discount prices that they pay dearly for in their own country. Furthermore, last week, the Senate approved similar legislation that will allow pharmacies and wholesalers to import low cost prescription drugs from foreign countries as long as they meet U.S. safety guidelines. This move would effectively allow pharmacies and wholesalers to negotiate for prices with drug manufacturers, because, for the first time, they would have the ability to purchase the identical drugs from foreign countries for less than they are available for in the United States!

NTEU hopes this body will thoroughly examine these issues and demand answers. Questions such as why are pharmaceutical companies providing prescription drugs to foreign countries at a lower cost than to America's own citizens need to be answered. And, why is the industry so opposed to the federal government saving millions of dollars by purchasing prescription drugs for its FEHBP program in a manner consistent with the size of its 9 million member pool?

In conclusion, NTEU hopes this committee will look beyond the shallow arguments the pharmaceutical industry has made for why the SAMBA pilot program should not go forward and throw its support behind OPM's efforts. OPM is a major purchaser of drugs through its workforce health benefits plans and the government has a responsibility to make its purchases in the most cost efficient manner possible. NTEU believes the SAMBA plan should have access to the Federal Supply Schedule in an effort to determine if this approach has merit for the entire FEHBP program. Thank you very much for your consideration of these views.

BlueCross BlueShield Association

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July 24, 2000

Honorable Cliff Stearns
Chairman
Subcommittee on Health
338 Cannon House Office Building
Veteran's Affairs Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Stearns:

It is my understanding that you are interested in knowing the views of the Blue Cross and Blue Shield Association on allowing the Federal Employees Health Benefit Program (FEHBP) plans access to the Department of Veteran Affairs (VA) Federal Supply Schedule for Prescription drugs. As you are aware, the Office of Personnel Management (OPM) and VA reached an agreement on July 14, 2000, to allow the Special Agents Mutual Benefit Association Plan (SAMBA) access to the FSS on a 2-year pilot basis. I would like to take this opportunity to discuss some of the reasons why we believe that FEHBP carriers should not have access to the FSS.

I. FEHBP contracts are not authorized to have access to the VA FSS

Authorizing FEHBP contractors access to the VA FSS for prescription drugs would be contrary to the Federal Acquisition Regulations (FAR). Under the FAR 51.101, contractors may be authorized to use Government sources of supply in performing either Government cost reimbursement contracts, or in performing other types of negotiated contracts when the agency determines that a substantial portion of the contractor's contracts are of a Government "cost-reimbursement nature." FEHBP contracts are neither cost reimbursement contracts nor of a "cost-reimbursement" nature.

The FAR defines cost reimbursement contracts as contracts that:

> Provide for payment of allowable incurred costs, to the extent prescribed in the contract. These contracts

> establish an estimate of total cost for the purpose of obligating funds and establishing a ceiling that the contractor may not exceed (except at its own risk) without the approval of the contracting officer (FAR 16.301-1).

In contrast, fixed price types of contracts are defined as those that

> Provide for a firm price or, in appropriate cases, an adjustable price (FAR 16.201).

Further the FAR notes that firm fixed-price contracts have a contract price that:

> Is not subject to any adjustment on the basis of the contractor's cost experience in performing the contract. This contract type places on the contractor maximum risk and full responsibility for all costs and resulting profit or loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties (FAR. 202-1).

FEHBP contracts are a combination of fixed priced contracts with provisions for a form of retroactive price redeterminination, and while they may not be an exact match for any of the contract types enumerated in the FAR, what is clear from their structure and operation is that they are *neither* cost reimbursement contracts *nor* of a "cost-reimbursement" nature. Each year the premium is set for the following year of insurance coverage for enrollees. The premium paid entitles the enrollee to payment by the carrier of all covered health services incurred by enrollees and dependents during the year. Once the premium is determined for the year, there is no retrospective change in the amount, regardless of the costs actually incurred by the Plans during the contract year. Underwriters of experienced-rated FEHB Plans, including the Service Benefit Plan, are bound by the FEHB contract to pay all claims incurred for the premium income received. If the accumulated premium income is insufficient, underwriters must pay remaining claims and expenses out of their own funds.

Unlike cost reimbursement contracts in which the contractor has a low risk of financial loss and the Government assumes a high risk of cost overruns, experience rated FEHBP plans always bear the risk that costs of performance will exceed both premium revenue and available reserves. Unlike cost reimbursement contracts where there is no limit on the amount of reimbursement that the contractor may receive, FEHBP contracts cannot receive reimbursements that exceed the amount of money in the reserve funds. OPM may for "good cause" authorize additional payment to the carrier from the contingency reserve; however, the contractor has no right to any additional payments beyond the residue of the contingency reserve regardless of the extent of unanticipated adverse experience during the contract period. Thus FEHBP contracts bear all the health care cost experience risk in excess of the reserve funds. In fact, there is a history of carriers losing large amounts of money on the Program. This would not happen if the FEHBP contracts were cost reimbursement contracts. For instance, in 1990, the House held a hearing on the FEHBP, in which a Vice-President of Mutual of Omaha testified that his company had lost approximately $70 million underwriting FEHBP plans. The Service Benefit Plan itself suffered $200 million in losses in 1981.

It is important to note that OPM itself prior to September 10, 1997 characterized its FEHBP contracts as "a combination of negotiated fixed price contracts with provisions for a form of retroactive price redetermination." (FEHBP Acquisition Regulation 1616.102(b)) and included in the Service Benefit Plan contract and other FEHBP contracts standard FAR clauses for fixed price contracts. Only in final regulations issued September 10, 1997 for the purpose of applying the Truth in Negotiations Act to community rated contracts did OPM change its description of experience rated contracts to "negotiated benefits contracts." Moreover, it wasn't until June of 1998 that we are aware of any OPM statement characterizing experience rated contracts as "cost type" contracts.

II. Allowing access to the VA FSS would have long term ramifications on the commercial health insurance sector

Not only is the Blue Cross and Blue Shield Service Benefit Plan the largest plan in the FEHPB, but the local BlueCross BlueShield plans are also the Nation's largest private insurer, covering one out of four Americans (or approximately 80 million lives). Given BCBSA's role in both the public and

private health insurance sector we must be cognizant of the economic impact that FEHBP access to the FSS will have on the private health insurance sector. Allowing plans access to the FSS is tantamount to extending government price controls to a dynamic, and critical, sector of our Nation's economy, which inevitably would shift the overall product costs to the private sector. Drug manufacturers, seeking to recoup losses would shift costs to the private payers; which not only includes health insurance carriers, but also retail purchasers who pay for Rx drugs with out-of-pocket funds. In particular, this group would include persons without prescription drug coverage, including about a third of all Medicare beneficiaries. This cost shift would make drug coverage that much less affordable in the private sector.

At a time when prescription drug cost trends continue to grow and the number of uninsured is increasing at a rate of 1 million per year, BCBSA has serious reservations about expanding access to additional entities because of the potential impact it might have on consumers.

Past evidence suggests that any attempt to provide access to the FSS for FEHBP prescription drug purchases is likely to lead to cost-shifting and higher prices for non-FEHBP purchasers. For example, the Medicaid Prescription Drug Rebate Program provides insight on the potential impact of requiring discounts through the FSS to the FEHBP market. Under the Omnibus Budget Reconciliation Act of 1990, a system for pharmaceutical manufacturers was established to grant states rebates for drugs dispensed and paid for by state Medicaid programs. States would receive discounts from the list price equal to the "best price" available to private sector volume purchasers for manufacturers' drugs. Not unexpectedly, drug manufacturers responded by reducing the volume discounts they had offered to reduce the size of the legislated rebates. In addition, some manufacturers responded by raising prices charged to other customers, such as hospitals and health insurance carriers, instead of lowering prices to state Medicaid programs. While up until 1991 VA enjoyed deep discounts, beginning in 1991, the VA reported significant price increases due partially to the implementation of the OBRA 1990.

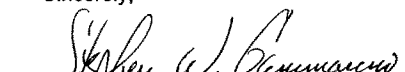
III. Allowing access to the VA FSS could undermine the FEHBP

The FEHBP, by statute, is a program of insurance in which competing private sector carriers offer benefit packages to federal enrollees. Key to

the success of the FEHBP is the essential role of the private sector. The proposal to allow SAMBA access to the FSS is tantamount to procuring prescription drugs from a governmental source. Separating the prescription drug benefit from the overall benefit package would set a bad precedent by eroding the original Congressional intent of a competitive insurance program in which each plan provides a comprehensive set of benefits to each member. If prescription drug benefits are carved out of the insurance product, what benefit is next? How will this affect the quality and accessibility of health care to our federal employees? Because the Blue Cross and Blue Shield Association believes quality of health care is equal in importance to cost of health care, the Blue Cross and Blue Shield Association cannot support any action that may negatively impact the FEHBP, and ultimately, the health of federal employees.

In conclusion, we believe that FEHBP plans should not be allowed access to the FSS not only because it is statutorily not permitted under the FAR, but also because it potentially would have long-term consequences on non-FEHBP purchasers and would undermine the FEHBP. Therefore, we do not believe that SAMBA, nor any other FEHBP carriers, should have access to the VA's Federal Supply Schedule.

Sincerely,



Stephen W. Gammarino
Senior Vice President
Federal Employee Program

SWG/clh

Post-Hearing Questions
Concerning the July 25, 2000, Hearing

for
The Department of Veterans Affairs

from
The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives

1. Please provide the drug inflation rates in VA for the past five years.

Over the past 5 years, the number of veterans receiving a pharmaceutical benefit has increased from approximately 2.7 million to 3.2 million. From Fiscal Year 1995 through Fiscal Year 1999, pharmaceutical expenditures have increased from approximately $1.1 billion to $1.8 billion. It is anticipated that expenditures for pharmaceuticals in Fiscal Year 2000 will exceed $2 billion. This increase is a reflection of a number of factors, including, but not limited to, utilization, new drugs, treatment modalities, and price increases. VA is in the process of quantifying the elements of the drug expense and the various factors for increased costs. The data VA has available at this time reflects inflationary increases for branded drugs only. The percentages are as follows:

FY 1995	FY 1996	FY1997	FY1998	FY 1999	FY 2000*
-0.04%	24.38%	-2.01%	11.99%	7.93%	1.23%

*FY is not complete.

These percentages reflect the variables of the Federal ceiling price calculation and the impact of new contract periods on price.

2. How does VA negotiate for drug prices under the FSS? Please provide information that details the negotiation process.

VA's National Acquisition Center (NAC) is responsible for awarding and administering the Pharmaceutical Federal Supply Schedule (FSS) program for Class 65, Drugs, Pharmaceuticals, and Hematology Related Products. The FSS is negotiated based on the pricing strategies utilized by vendors in relationship to their most favored commercial customers. The Government's starting point is to receive pricing equal to or better than the best commercial customer pricing for a product. The Government also reviews all negotiated points (i.e., annual rebates, quantity discounts, prompt payment discounts) to ensure that, in final

negotiations, the Government will receive terms and conditions, including prices, that are equal to or better than the vendor's most favored commercial customer.

In relationship to Public Law 102-585, the Veterans Health Care Act of 1992, proposed pricing is reviewed to ensure that the requirements of the Federal Ceiling Price Calculation (as outlined in the Public Law) are being met. If a vendor's best commercial customer price is better than the calculated price under the Public Law, the Government will target the best commercial customer price for negotiations. If the calculated price under the Public Law is better than a vendor's best commercial customer price, the calculated price will be accepted.

Additional discounts also are sought for one-time quantity purchases as well as under Blanket Purchase Agreements (BPA), a provision under the Federal Supply Schedule contract. BPAs allow for tiered pricing and other incentives based on the customer's or group of customers' commitment to buy a certain level/percentage of product over a specified period of time (more than one order) not to exceed the performance period of the Federal Supply Schedule contract. Under the Pharmaceutical Federal Supply Schedule program, these BPAs encompass additional tiered quantity discounts based on certain dollar or quantity levels, market share, or shared efficacy, and result in better overall pricing and/or free goods.

The NAC awards and administers pharmaceutical national contracts. To date, over $655,700,000 have been saved and reinvested in veterans health care as a result of these contracts. Although this cost savings is important, the procurement process is clinically driven to ensure that our patients receive appropriate care. The NAC works very closely with the Veterans Health Administration (VHA) Pharmacy Benefits Management Strategic Health Group (PBM) in the development of all national contracts.

The PBM identifies the drugs or drug class for potential standardization and thoroughly researches the efficacy, safety, and administration of the drugs. In addition to reviewing product literature and articles published in professional journals, the PBM solicits information from the manufacturers of the items being reviewed. A draft drug review is developed by the PBM that summarizes their findings and conclusions based on this research. The PBM consults with members of the VA Medical Advisory Panel (MAP) and Veterans Integrated Service Network (VISN) Formulary Leaders who review the draft drug review. The MAP is composed of clinicians and subject matter experts and the VISN formulary leaders group consists of representatives from each of VA's 22 VISN regions. This review process ensures that the drugs selected will meet VA's health-care goals.

The PBM identifies the drugs to be competed and outlines the agency's minimum requirements in the procurement request that is forwarded to the NAC. Whenever feasible, the NAC works with other Government agencies such as the

Department of Defense, Indian Health Service, and Bureau of Prisons, to combine their requirements into our National Contracts. This process allows the NAC to further leverage the requirement and drive down acquisition costs. The procurement request also identifies the source selection factors that will be used to evaluate offerors' proposals. There are three main types of evaluation factors that are used in VA's solicitations: price, past performance, and technical factors. The use of these factors is tailored to the procurement and is based on the conclusions of the drug class review. For example, price and past performance are usually considered most important when procuring generically equivalent drugs. However, when competing drugs that are not generically equivalent, but fall within the same drug class, technical factors are considered in addition to price and past performance. These technical factors are often considered more important than price. Some examples of technical factors used in procurements include efficacy, outcomes, safety, compliance, and VA patient needs. The use of technical factors, past performance, and price allows VA to select the product that represents the best overall value for our patients.

3. Please provide a copy of the memorandum of understanding that you have worked out with the Office of Personnel Management.

The Memorandum of Agreement (MOA) with the Office of Personnel Management has not been finalized. Because VA is concerned about any significant cost impact to its program resulting from the pilot, VA is carefully reviewing every detail of the MOA. Once all of the terms have been agreed upon, a copy will be forwarded to you. VA recognizes the need for the Federal Government to obtain better pharmaceutical pricing and conserve resources; however, protection of the veterans we serve is paramount.

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