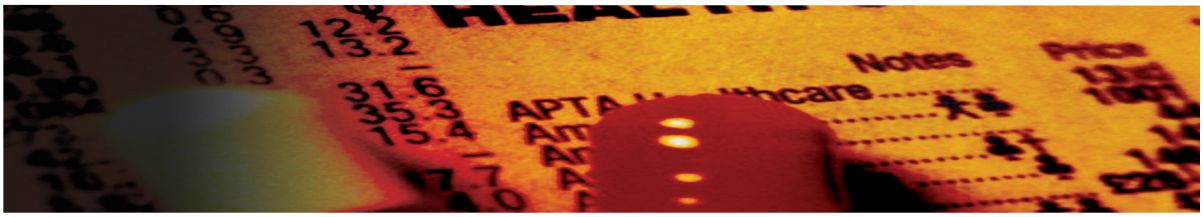
Vo.2 Issue 2



HEALTH POLICY research

James A. Baker III Institute for Public Policy-Baylor College of Medicine
Joint Program in Health Policy Research

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IN THIS ISSUE

The study, "Use of VA Pharmacy Services by Medicare Managed Care Enrolled Veterans" was presented in February 2006 at the annual Department of Veterans Affairs (VA) Health Services Research & Development Service Meeting in Washington, D.C. The authors are: Morgan, R.O.; Hasche, J.; Sundaravaradan, R.; Wei, I.I.; Petersen, L.; Davila, J.; Johnson, M. (all from the Houston Center for Quality of Care and Utilization Studies); Osemene, N. (Texas Southern University); and Byrne, M. (Miller School of Medicine, University of Miami).

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Could Medicare Part D Reduce Demand for VA Pharmacy Services?

"Yes," says Robert Morgan, Ph.D., associate professor of medicine at Baylor College of Medicine and research scientist at the Michael E. DeBakey VA Medical Center's Center of Excellence for Health Services Research. "Increased enrollment in Medicare prescription drug plans by VA-Medicare dual enrollees may have profound and immediate implications for the VA pharmacy service."

The Department of Veterans Affairs (VA) is the largest single purchaser of pharmaceuticals in the United States, and the VA has historically been an attractive source of pharmacy care for veterans. Approximately 90% of VA users over the age of 65 are enrolled in Medicare, with Medicare-enrolled veterans accounting for almost two-thirds of VA pharmacy expenditures. In turn, the VA provides pharmacy care to more than 10% of all Medicare-enrolled males. Under Medicare Part D, prescription drug plans (PDPs) have greatly increased the availability of non-VA pharmacy services for Medicare-enrolled veterans. The Government Accountability Office (GAO) originally estimated that few VA pharmacy users would migrate to the new Medicare PDPs. However, in spite of the extensive co-use of the VA and Medicare systems by older veterans, there is surprisingly little information on how Medicare plan benefits affect veterans' use of VA pharmacy services.

Morgan and his colleagues used national VA and Medicare data from 2002 to analyze the relationship between Medicare managed care benefit levels and VA use among more than 3 million veterans, adjusting for health status and other characteristics that affect the use of pharmacy care. Compared to veterans with no Medicare pharmacy benefits, veterans who were enrolled in Medicare managed care plans with the highest level of pharmacy benefits were only about half as likely to use any VA pharmacy care. VA pharmacy use was especially unlikely for veterans who had higher VA copayments or annual incomes exceeding $35,000. Modest levels of Medicare pharmacy benefits were associated with a slightly lower likelihood of VA pharmacy use.

Veterans with the highest Medicare managed care benefit levels were not only less likely to use VA pharmacy services at all, but also tended to use fewer VA resources when they did seek VA pharmacy care. Among VA pharmacy users, veterans concurrently enrolled in Medicare managed care plans with the highest pharmacy benefit levels had modestly lower average annual costs than veterans in managed care plans with no pharmacy benefits, veterans enrolled in traditional fee-for-service Medicare, and veterans living in counties not served by Medicare managed care plans.

Contrary to the GAO's predictions, PDPs may significantly reduce the demand for VA pharmacy services among current VA users, particularly in areas previously underserved by Medicare managed care plans. However, the interaction between Medicare and the VA will continue to be complex. A substantial percentage of veterans who do enroll in Medicare PDPs are likely to exceed the "cap" on the initial standard pharmacy benefit and will have a strong incentive to then turn to the VA for these pharmacy services. Alternatively, these veterans may split their pharmacy care, obtaining some medications from the VA and the rest from their Medicare PDP, in order to avoid exceeding their cap. In either case, the potential for disjointed continuity of care is substantial.

HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by the James A. Baker III Institute for Public Policy's Health Economics Program in collaboration with the Baylor College of Medicine's Health Policy and Quality Division.

This publication is provided to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of the Baylor College of Medicine.

The Baker Institute and the Baylor College of Medicine's Health Policy and Quality Division work with scholars from across Rice University and the Baylor College of Medicine to address issues of health care—access, financing, organization, delivery, and outcomes. Special emphasis is given to issues of health care quality and cost.

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