

THE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE ENROLLMENT PROJECTIONS

Gregg A. Pane, MD, MPA, Chief Policy and Planning Officer, Mary E. (Beth) Martindale, DrPH, Randall J. Remmel, PhD, MBA, Don Stockford, MA, Health Policy Analysis Group, Office of Policy and Planning, Veterans Health Administration, U.S. Department of Veterans Affairs

Abstract

The passage of the “Veterans’ Health Care Eligibility Reform Act of 1996” (P.L. 101-262) changed the way the Department of Veteran Affairs (VA) delivers health care to veterans. To receive care under this law, most veterans must be enrolled. This paper describes the Department’s projections of health care enrollment, utilization, and expenditures that are utilized each year for important policy decisions such as who the Department can continue to serve under its appropriation and other resources. An example of what the impact of internal or external changes in policies and other factors might be upon projections of one type of VA service, prescription drugs, is illustrated.

Background

For over 60 years, VA has been providing quality healthcare to America’s veterans through the Veterans Health Administration (VHA), the nation’s largest integrated health care delivery system. However, it is supported by a congressionally appropriated budget and is not an entitlement. Thus, the available resources have always determined to a large degree who the system will serve, what it will provide (or supply) to whom, how the delivery system is structured, and continues to do so today. The system began as a hospital system with very little outpatient care provided initially. Complex eligibility rules determined which veterans could be treated, where and how they could be treated, and for what condition. These developed over time into a patchwork maze of eligibilities, difficult for both clinicians and veterans to understand and navigate through to access needed care. In October 1996, Congress passed Public Law 104-262, the “Veterans’ Health Care Eligibility Reform Act of 1996”. For the first time in its history, once enrolled into the VA health care system, VA could provide the care to an enrollee that is needed to promote, preserve, or restore the health of the individual through a very comprehensive medical benefits package—the right care, at the right time, in the right place. The Law emphasized preventive medicine and primary care, as well as the specialty care, for service-connected disabled and special populations. It included most inpatient and outpatient care in accord with generally accepted standards of medical practice. Because of resource constraints, the law also mandated a system of enrollment as a tool to help VHA balance the demand for care with the resources available. After the passage of the “Veterans’ Health Care Reform Act of 1996”, VHA’s Office of Policy and Planning (OPP) developed an actuarial health care services demand projection model through a contract with Condor Technology Solutions, Inc., and Milliman USA, Inc., an actuarial firm. This is the fifth year this model has been used to make enrollment-related projections and analyses.¹

General Approach

This model projects enrollees, utilization and expenditures, and patients for the next Fiscal Year (FY) and future years based upon the accrual of actual health care enrollment before the annual projection model update is begun each year. Actual enrollment experience is tracked and reported monthly, with an enrollment-related database that is created and disseminated by OPP to all individuals and offices for their own business functions. OPP receives monthly updates of enrollment from VHA’s Health Eligibility Center, which is responsible for the business operation of veteran enrollment. OPP merges the enrollment data with various measures of enrollee utilization and costs that are provided by VHA’s Office of Finance and the Veterans Integrated Service Networks (VISN) Support Services Center. For the projection model, a master file of every enrollee and all the events about the veteran’s

¹ Department of Veterans Affairs, Enrollment, Utilization, and Expenditure Analyses, Fiscal Years 2002 – 2010, Contract #GS – 23F – 8025H, Task Order #1, Modification #9, September, 2001, Condor Technology Solutions, Inc., Milliman USA, Inc., Kathi S. Patterson, FSA, MAAA, Merideth A. Randles, John P. Cookson, FSA, MAAA, Michael J. Dekker, ASA, John W. Leo, Ph.D., Gary W. Massingill, FSA, MAAA, Stanley A. Roberts, FSA, MAAA.

enrollment and health care utilization has been created and is updated at least annually before the projection model is run.

The actuary applies the private sector's current experience of providing the services included in the VA Medical Benefits Package (MBP)² to the projected enrollee population. Private sector utilization norms are adjusted to the VA enrollee population by age, gender, morbidity, and reliance upon VA. This utilization is also adjusted by the degree of management within the VA system compared to the community private sector's degree of management. Projected enrollee expenditures are calculated by multiplying VA unit costs by the adjusted private sector utilization norms for VA enrollees. Unique patients are also projected based upon the enrollee and utilization projections.

The enrollee, workload, expenditure, and patient projections have been projected at the national, VISN, and the parent preferred facility level. Enrollees, utilization, and expenditures have been projected by county of residence and zip codes for some applications. In addition, enrollment-related projections have been made through the current year, and for future years, *e.g.*, through FY 2022. Applications include:

- The Secretary's Enrollment Level Decisions
- The Capital Asset Realignment for Enhanced Services (CARES)
- Enrollee Cost Sharing Analyses
- Budget Formulations
- Market and Unmet Demand Analyses
- Planning Model for VISNs
- Scenario Testing
- Policy Decision Analyses
- Private Sector Contracting

Policy Issues and Implications

VA Senior Management considers the following:

Demand--Whom do we serve?

Financial--Where are we going?

Services/Supply—What services do we provide and how?

Whom do we serve?

VA has traditionally served veterans with service-connected disabilities, VA pensioners, populations with special rehabilitation needs and specialty care, the low income veterans as a safety net, and other veterans as resources permit. With the "Veterans' Health Care Eligibility Reform Act of 1996", Congress established priorities for enrollment. The priorities listed below are being updated and proposed for regulatory action this year. Because of budgetary constraints and continuing increases in demand, VA may have to consider policies that might limit whom we serve.

² Each year VHA verifies with VA's Office of the General Counsel whether any changes have been made in the interpretation of what benefits are covered or not covered in the Medical Benefits Package as described in the current enrollment regulations: Department of Veterans Affairs, 38 CFR Part 17, RIN 2900-AJ18, Enrollment-Provision of Hospital and Outpatient Care to Veterans, Final Rule, Federal Register/Vol.64, No.193/Wednesday, October 6, 1999/ Rules and Regulations, 54207-54218.

Figure 1. VA Enrollment Priorities, FY 2001

Priority	Description
1	Veterans with service-connected conditions rated 50 percent or more disabling.
2	Veterans with service-connected conditions rated 30 to 49 percent disabling.
3	Veterans who are former POWs Veterans with service-connected conditions rated 10 to 29 percent disabling. Veterans discharged from active duty for a disability incurred or aggravated in the line of duty. Veterans awarded special eligibility classification under 38 U.S.C., Section 1151. Purple Heart Veterans.
4	Veterans who are receiving aid and attendance or housebound benefits. Veterans who have been determined by VA to be catastrophically disabled.
5	Non-service-connected veterans and service-connected veterans rated 0 – 9 percent disabled, whose income and net worth are below the established dollar thresholds.
6	All other eligible veterans who are not required to make co-payments for their care, including: World War I and Mexican Border War veterans. Veterans solely seeking care for disorder associated with exposure to a toxic substance, radiation, or for disorders associated with service in the Persian Gulf. Compensable zero percent service-connected veterans.
7	The following Priority Level 7 subgroups have been considered: Priority Level 7a Zero percent non-compensable service-connected veterans enrolling prior to a specified date with income above the statutory threshold; who agree to pay specified co-payments. Priority Level 7b Zero percent non-compensable service-connected veterans enrolling after a specified date with income above the statutory threshold; who agree to pay specified co-payments. Priority Level 7c Non-service-connected veterans enrolling prior to a specified date with income above the statutory threshold, who agree to pay specified co-payments. Priority Level 7d Non-service-connected veterans enrolling after a specified date with income above the statutory threshold; who agree to pay specified co-payments.

For the Secretary’s enrollment level decision concerning whom we can serve in the coming fiscal year, OPP analyzes the expenditures needed to make the MBP available to all the next fiscal year’s projected enrollees. For example, last Fall the projected demand for enrollment, utilization and expenditures resulted in the following information.

Table 1. FY 2002 Enrollment-Related Projections

Priority	Projected Live End-of-Year Enrollees	Projected Average Enrollment	Projected Total Unique Enrollees	Projected Unique Patients	Projected Medical Benefits Package Expenditures	Cumulative Projected MBP Expenditures
1	519,686	521,840	540,660	431,137	\$3,680,025	\$3,680,025
2	396,302	391,741	410,149	279,089	\$1,217,133	\$4,897,158
3	819,210	798,902	846,837	525,220	\$1,992,862	\$6,890,020
4	168,349	168,051	180,610	158,101	\$2,600,802	\$9,490,822
5	2,322,426	2,263,640	2,416,167	1,787,627	\$7,735,314	\$17,226,136
6	138,335	128,845	141,024	75,471	\$160,049	\$17,386,185
7a & 7b	88,636	85,535	91,691	49,603	\$117,627	\$17,503,812
7c	1,607,478	1,640,430	1,673,824	854,295	\$1,732,099	\$19,235,910
7d	320,544	143,039	326,955	156,584	\$141,720	\$19,377,630
Total	6,380,966	6,142,023	6,627,916	4,317,127	\$19,377,630	

Since the projected MBP expenditures above (\$19.378 billion) were greater than the estimated resources initially available for supporting the MBP reported below in Table 2 (\$18.937 billion), VA assessed through what priority VA could continue to enroll veterans. After all resources and efficiencies were considered, there was a final MBP difference of \$142 million (Tables 1 and 2).

Tables 1 and 2 revealed that VA could continue to enroll all priorities of veterans except those non-service-connected (NSC) veterans in Priority 7d, who were not already enrolled prior to December 1, 2001. This was the date determined to divide proposed subpriorities 7c and 7d (referred to as *7iii* and *7iv* in the proposed subpriority regulation RIN 2900-AK50) if enrollment were stopped for Subpriority 7d.

Table 2. FY 2002 Estimated MBP Resources Available vs. Projected MBP Expenditures

Resources and Expenditures	(Billions \$)
Estimated Medical Care Appropriation	\$21.331
Collections for Copayments, Deductibles, Third-Party Reimbursements, Other Revenue, and Carry-Over Funds	1.606
Subtotal, Resources for All MBP and non-MBP Services	22.937
Less Resources for Non-MBP Services ³	(4.001)
Subtotal, Resources for the MBP	18.937
Projected MBP Expenditures	19.378
Subtotal, Initial Difference (Projected MBP \$ and Resources Available)	(0.441)
Less Projected Policy and Management Efficiencies ⁴	0.299
Final Difference, Projected MBP \$ and Adjusted Resources Available	(\$0.142)

³ Certain types of services for specified veterans are not included in the MBP, but are provided under other authorities, e.g., long-term care, domiciliary care, dental care, per diem payments for State Homes, emergency care, CHAMPVA, readjustment counseling, certain prosthetic services, and counseling treatment for sexual trauma.

⁴ Management savings through improved standardization policies and compliance in the procurement of supplies, pharmaceuticals, equipment and other capital purchases; adherence to national criteria established to promote operational efficiencies in current and new Community-Based Outpatient Clinics (CBOCs); and improved guidance and control of centrally managed programs.

Last Fall, VHA's total FY 2002 medical care appropriation was estimated to be \$21.3 billion. This is supplemented by additional funds from collections for copayments, third-party reimbursements for services, and other revenue, including the effect of new outpatient copayments. The sum of these resources is \$22.9 billion. These resources include \$4.0 billion for services provided that are not included in the medical benefits package.⁵ This leaves \$18.9 billion available for the medical benefits package. When these available resources for the medical benefits package are subtracted from the projected expenditures (\$19.4 billion), there is a resulting shortage of over \$441 million. VA believes that this difference within the medical-benefit package can be lessened, but not eliminated, by taking additional management actions that are estimated to be \$299 million. VA expects the Office of Management and Budget (OMB) to approve a supplemental request to Congress for funding to allow for continuation of full enrollment. Thus, the Secretary announced his decision on November 30, 2001, to continue to enroll all priorities of veterans in FY 2002. However, if supplemental funding is not received, additional enrollment action may be necessary during FY 2002.

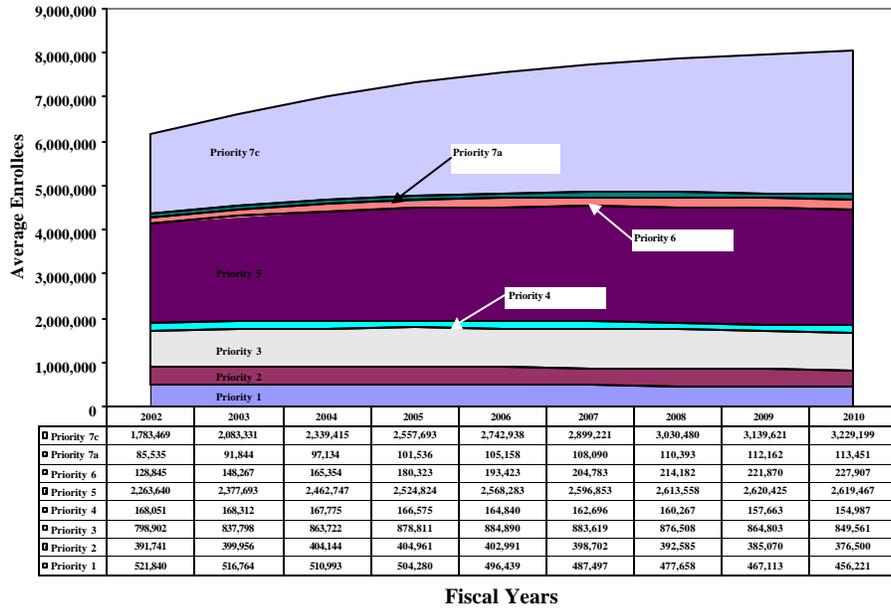
Longer-Range Projections

It is impossible to determine how world events will unfold. Those events that impact our economy and the use of our military may have a profound impact on VA's long-range enrollment and expenditure projections. Nevertheless, long-range projections are given below, with the caveat that actual results will differ from those projected here for many reasons. It is important that actual enrollment and expenditures be monitored and the projections updated regularly.

Politically, VA and the legislative and executive branches of government found it difficult at this time to restrict care to veterans when a war on terrorism was being waged. It is expected that Congress will appropriate the funds to cover the unexpected high demand for enrollment this year. But VA continues to wrestle with the tension between demand for services and resources available in its budget planning processes for FY 2003 and 2004. As a response to these pressures, the Secretary of VA has consulted its leaders and constituents in several focused policy discussions about whom VA should serve and how. The projected demand for enrollment and services suggest this will be a continuing problem.

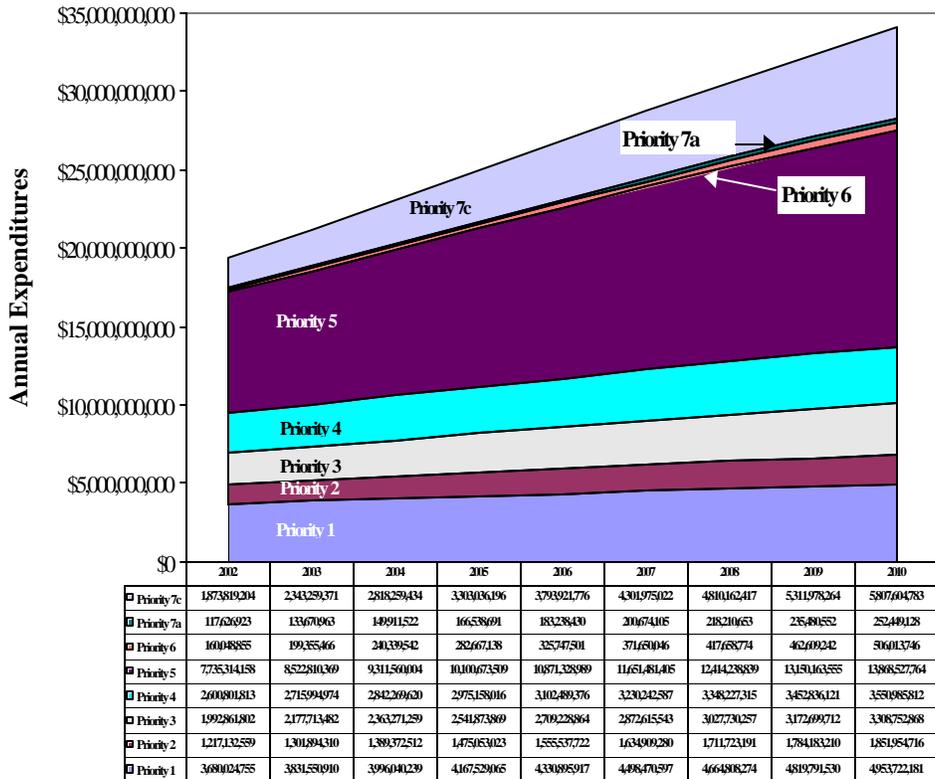
⁵ Op. Cit. (3).

Chart 1. Average Projected Enrollment



Fiscal Years

Chart 2. Projected Annual Expenditures



Fiscal Years

General Model Description

The following outline provides a general description of the methodology used to develop the Veteran Enrollment, Health Care Utilization And Expenditure Projection Models (the model). These models were created by Condor Technology Solutions, Inc., and Milliman USA to support VA's Enrollment Level Decision, and later enhanced to support CARES analyses, VHA's budget formulation, and other policy decisions.

Enrollment Projections

1. Obtain baseline actual enrollment by scrambled Social Security Number (SSN)
2. Develop enrollment rates using historical enrollment and historical veteran population projections (VETPOP)
3. Develop projections of new enrollees using the rates developed in Step 2, the baseline from Step 1 and VETPOP projections
4. Apply mortality rates to enrollment projections

Workload Projections

1. Summarize private sector health care utilization averages by geographic area
2. Adjust utilization to reflect Medical Benefit Package and Millennium Bill health care services
3. Adjust utilization to reflect age and gender characteristics of the projected veteran enrollee populations
4. Adjust utilization to reflect the morbidity of the projected veteran enrollee populations relative to the underlying private sector populations (VA patient diagnosis data used to assess relative morbidity levels)
5. Adjust utilization to reflect the estimated degree of health care management observed within the VA health care system relative to the loosely managed level observed in the local community (VA inpatient diagnosis and workload data used to assess degree of health care management)
6. Adjust utilization to reflect the estimated veteran enrollee reliance on VHA for their health care needs (Veteran enrollee survey data and CMS⁶ match data used to assess reliance)
7. Adjust utilization to reflect the residual differences between modeled and actual historical VA workload (estimates of unmeasured morbidity, reliance and degree of health care management differences)

Unit Cost Projections

1. Obtain baseline Cost Distribution Report (CDR)-based VA unit cost data
2. Unit cost data adjusted for health care service mix inherent in data
3. Adjust VA -based unit costs to residual differences between modeled and actual historical VA expenditures

Expenditure Projections

1. Enrollment, Workload and Unit Cost Projections are combined to produce Expenditure Projections

⁶ Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration (HCFA)

VA Enrollee Health Care Projection Model



In most of the applications, enrollees are assigned to a preferred facility, where the veteran's care is managed by a VA health care provider. The cost models reflect the projected health care demands of the enrollees by preferred facility. It is not anticipated that all of the enrollees' VA demanded health care will necessarily be obtained from that preferred facility; consequently, most of the cost model applications are enrollee-based, not facility-based.

Costs were projected for providing the health care benefits defined in the Medical Benefits Package as well as other VA non-medical services to the Enrollees. Expected utilization by Facility, Enrollee Type (Enrollee Pre and Enrollee Post), Age Group (Under Age 45, Ages 45 to 64 and Ages 65 and Over), and Priority Level were developed using private sector utilization adjusted to reflect the veteran enrollment populations and an appropriate level of managed care for the VA. This health care utilization is detailed by several Inpatient and Ambulatory medical service categories. Estimated VA unit costs based on VA's Cost Distribution Report (CDR) and related data sources were applied to the expected utilization by medical service category. From the utilization and VA unit cost data, expected per member per month (PMPM) costs were calculated for each combination of Facility, Enrollee Type, Age Group, and Priority Level veteran Enrollees. The PMPM cost is the cost of providing health care to each member, in this case veteran Enrollees, for a one-month period of time.

Each cost model has been adjusted to reflect relative veteran morbidity and reliance on VA for obtaining health care services. These adjustments vary by VISN, Enrollee Type, Age Group, Priority Level, and service category.

The partial reliance adjustments reflect the fact that the majority of veterans (particularly those who qualify for Medicare) have another choice for health care services. Consequently, veterans can utilize health care from facilities both inside and outside VA concurrently. The partial veteran reliance in these models reflects estimated current veteran reliance on the VA health care system.

The relative morbidity adjustments reflect the relative health status of veteran Enrollees compared to the private sector populations underlying the utilization benchmarks. These adjustments are based on a diagnosis-based risk adjustment methodology which incorporates the responses to the OPP's 1999 Survey of Enrolled Veterans performed by Computer Hardware Maintenance Corporation (a division of Condor), and its 2000 Survey of Enrolled Veterans performed by Shugoll Research (through a contract with Condor) and the 1999 Health Survey of Veterans (Veterans SF-36 & Health Behaviors) supported and funded by VHA's Office of Quality and Performance.

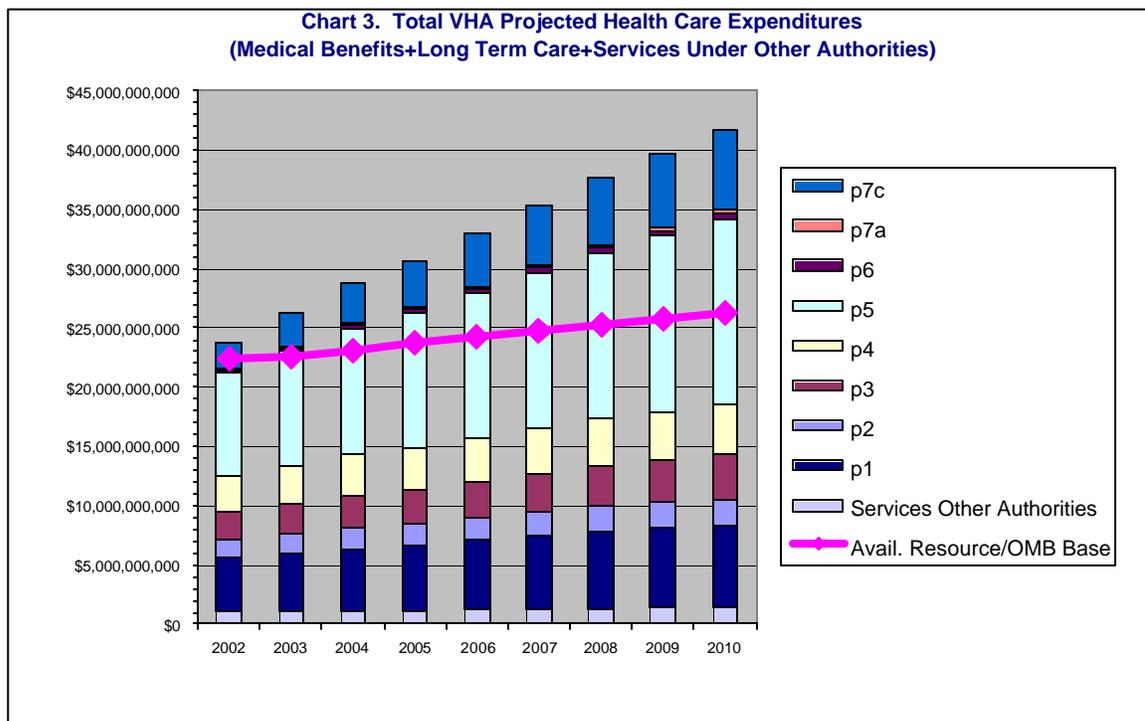
Enrollment Trends

Short-and Long-Term Considerations

The total veteran population is declining over the next 10 years, but older age groups are increasing, *e.g.*, the age 85 and over more than doubles (113% increase) in actual numbers. If there are no interventions, enrollee demand shows no sign of decreasing, with a 31% increase in the number of enrollees from 6.1 million in 2002 to 8.0 million in 2010. Most of the increase is due to increases in both the mandatory low-income Priority 5 veterans and the higher income Priority 7 veterans. Since both are the largest priorities of veterans, with a relatively small current market share, there is considerable potential for an expanding demand for enrollment from these two population subgroups. VA already has a large market share of the veterans in the other service-connected and pensioner sub-populations who need specialized care, aid and attendance, or other complex care (Priorities 1-4).

A concomitant increase in enrollee utilization results in an increase in MBP expenditures of 76% from \$19.4 billion in FY 2002 to \$34.1 billion in FY 2010, an average of \$1.8 billion per year. Priorities 1-6 (mandatory populations) account for \$10.7 billion or 72.8% of this increase, 60% due to Priority 5.

These same long-term trends are exacerbated if the total, not just the MBP, expenditures are considered. These total VHA health care expenditures increase \$17.9 billion or 75% from \$23.8 billion in 2002 to \$41.7 billion in 2010, an average increase of \$2.2 billion per year. Priorities 1-6 increases account for \$13.2 billion or 74% of these increases from 2002 – 2010. The \$17.9 billion increase over time can be contrasted with the fact that OMB has projected increases for the same time period of \$3.8 billion that is primarily only inflation of \$0.5 billion per year.



The “Veterans’ Health Care Eligibility Reform Act of 1996” assured every enrollee of receiving a comprehensive package of high quality inpatient and outpatient care in a timely manner. Because of mounting financial pressures, VHA is considering the development of several different policies for modifying either whom we serve, what services are provided, or what out-of-pocket costs may be required. One of the more perplexing trends in service utilization is that for the pharmacy benefit. An example is given below of some of the actual and projected experience with this service and how such projections may shape major policy decision-making within this government agency. Many endogenous, as well as exogenous, factors have influenced our projections and the policies associated with the pharmacy benefit.

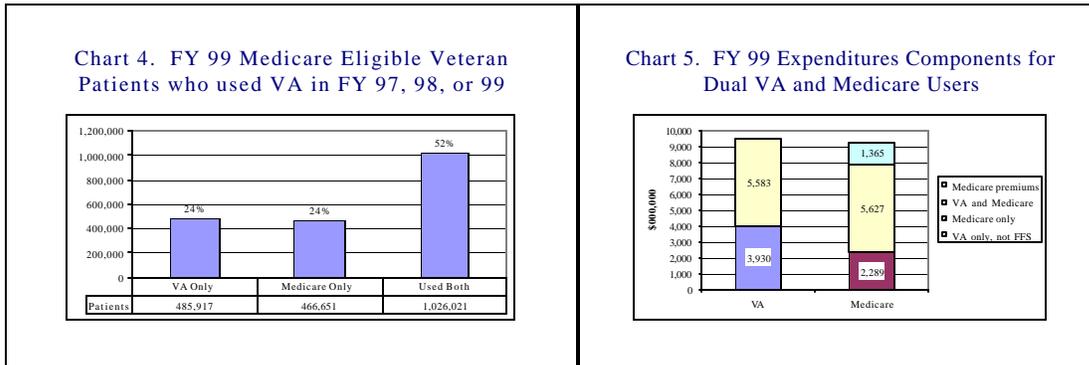
VHA Pharmacy Benefit

The demand for enrollment often reflects the personal economic decisions of veterans who seek to cover gaps in their insurance or other resources such as Medicare, or to reduce their out-of-pocket expenses for selected services. Many Medicare HMO’s are dropping their coverage of the elderly and disabled in some geographic markets or are scaling back their coverage of drug costs, a service currently not mandated in the Medicare benefits package, but which was offered in some Medicare HMO’s as an incentive to enroll with that type of Medicare provider. Medicare eligible veterans may be turning to the VA health care system at a time when its financial resources are also constrained.

A number of various analyses have been initiated within VA that are looking at VHA’s actual historical experience to assess those who are using pharmacy services and to what degree. In addition, the VHA enrollee projection model generates long-range projections of pharmacy utilization and expenditures. Because of the influx of the Medicare eligible veterans who may be enrolling primarily for the pharmacy benefit, many of the analyses have focused on the Medicare eligible enrollee or the age 65 and over enrollee as a proxy for Medicare eligibility.

CMS/VA Dual Eligibles⁷

In FY1999, 52% of the veterans who had been VA patients in FY 1997, 1998, or 1999 (1,026,021), received care in both VA and Medicare systems. In FY 1999, the same percent (24%) used either VA only (not Medicare FFS) or Medicare only. In FY 1999, Medicare eligible veterans who had been VA patients in FY 1997, FY 1998, or FY 1999, received \$18.8 billion in care from either VA or Medicare. Of this total FY 1999 expenditure in both systems, half (\$9.5 billion) was borne by VA.



The more recent VA/Medicare dual user experience is not reflected in the older VA/Medicare matched data. In FY 1999 there were only 847,584 Priority 7 enrollees. By the end-of-year FY 2001 there were 1,747,591, a 106% increase. The increase in Priority 7 Medicare enrollees was even greater (138%), from 410,446 in FY 99 to 975,343 in FY 01. Total expenditures for enrollees age 65+ (a Medicare proxy) increased 121% from FY 99 to FY 01. This recent growth in total expenditures from FY 99 to FY 01 was almost entirely attributed to 'Post' enrollees who are new to the VA system after enrollment began (564% increase in total expenditures), *i.e.*, 'Post' enrollees are those enrollees who were not a VA user in FY 96, 97, or 98 prior to enrollment implementation. Priority 7 age 65+ enrollee total outpatient expenditures increased 170% from FY 99 to FY 01. Most of this growth occurred in the Post enrollees (714%) from FY 99 to FY 01.

Many dual VA/Medicare eligibles are coming to VA for services not covered by Medicare, *e.g.*, prescriptions. In just one VA network in Florida, VA's Inspector General found 43% of the P7 cases reviewed (949) indicated that since they had private sector primary and other specialty care, the sole purpose of their VA care was for prescriptions. These cases (949) represented an estimated \$11.9 million annually in direct prescription costs.⁸ In order for a veteran to currently receive prescriptions in VA, a VA clinician must exam the patient and prescribe the medication. Thus, duplication of services and poor coordination of care across systems and providers may occur with potential quality of care problems.

VA Pharmacy Projection Trends

It was projected last fall that VA pharmacy expenditures would increase 148% from \$3.2 billion in FY 2002 to \$7.8 billion in FY 2010. Pharmacy expenditures for the elderly were projected to increase 138% from \$1.8 billion in FY 2002 to \$4.3 billion in FY 2010. For the enrollees age 65 and over, Priority 7 pharmacy expenditures were expected to increase almost 257% from \$386 million to \$1.4 billion from FY 2002 to FY 2010. The projected pharmacy expenditure trend for enrollees age 65 and over by priority is illustrated in Chart 6. Chart 7 presents the projected total expenditure trend for enrollees age 65 and over by priority.

⁷ Dual utilization of VA and Medicare Systems: Expenditure Trends from FY 98 and FY 99, Management Sciences Group, VHA's Office of Policy and Planning, VHA Budget and Policy Roundtable, September 17, 2001.

⁸ Audit of VHA Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans, Report No. 99-00057-4, issues 12/20/0, VA Office of the Inspector General.

Chart 6. Projected Pharmacy Expenditures for Age 65+ Enrollees, FY 2002-2010

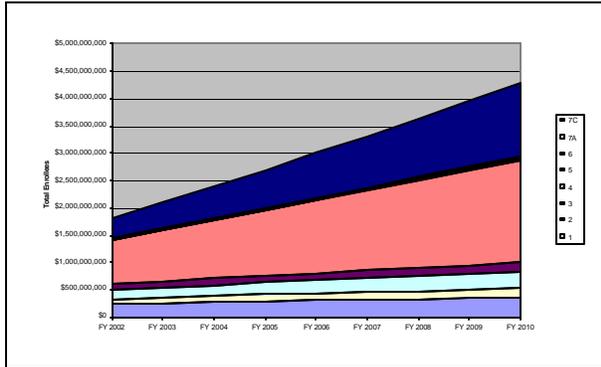
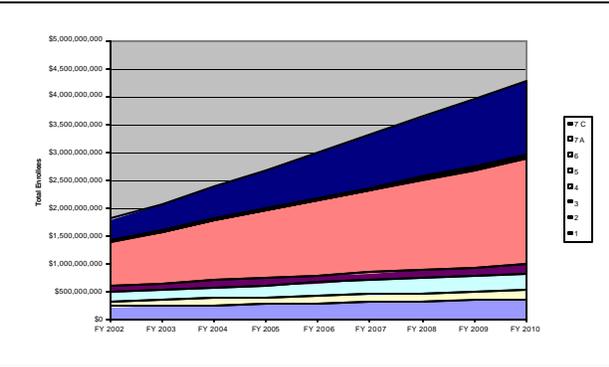


Chart 7. Total Projected Expenditures for Age 65+ Enrollees, FY 2002-2010



For the Medicare proxy (age 65 and over) enrollees, it was projected that non-service-connected Priority 7c enrollees would use more of its total health care expenditures for pharmacy services than any other priority. *i.e.*, expenditures in Chart 6 divided by expenditures in Chart 7. In FY 2002, 33.3% of all Priority 7c expenditures were consumed by pharmacy (Chart 8), with an average percentage of pharmacy to total expenditures across all priorities of 18.3%. This Priority 7c percentage of pharmacy to total expenditures grew to 41.1% by FY 2010 (Chart 8). Higher priority enrollees who had always had access to prescriptions in VA, *e.g.*, Priorities 1-6, had the lowest percentages of pharmacy to total expenditures. The service-connected Priority 7a enrollees had the second highest percentages of pharmacy to total expenditures. The spread or difference in VA pharmacy use by the elderly Priority 7's versus those who are under age 65 and the remaining priorities is illustrated in Charts 8 and 9.

There were much smaller differences by priority in the percentage of pharmacy to total expenditures for the under age 65 (Chart 9). For the younger age enrollees, Priority 7c continued to have the largest VA pharmacy to total VA expenditure percentage, 17.9% in FY 2002, while the average of all priorities for the younger enrollees was 14.2%. This pharmacy percentage grew to 23% in FY 2010 for Priority 7c. The younger groups that are employed may also have improved insurance coverage with a pharmacy benefit, unlike most elderly enrollees.

Chart 8. Pharmacy as Percent of Total Expenditures (Age 65+)

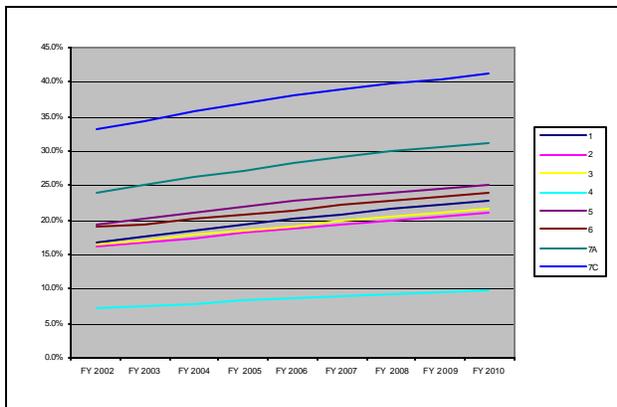
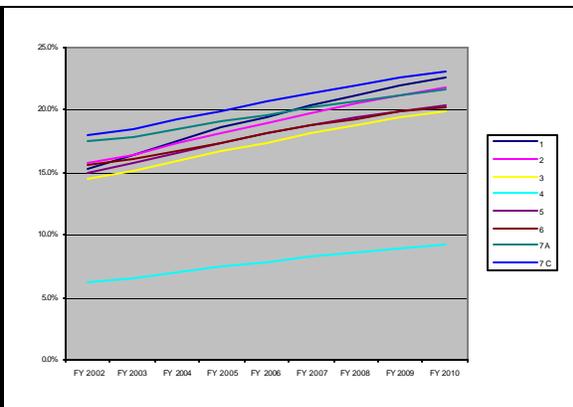


Chart 9. Pharmacy as Percent of Total Expenditures (Age <65)



Implications

Until Congress enacts a pharmacy benefit for the Medicare population or VA alters its current policies on enrollment, VA will continue to experience increasing demand for VA health care that includes increased prescription utilization, especially by the elderly, higher income veterans who have not previously been able to access VA care.