

GAO

Report to the Ranking Member,
Committee on Homeland Security and
Governmental Affairs, U.S. Senate

April 2013

PRESCRIPTION DRUGS

Comparison of DOD and VA Direct Purchase Prices



G A O

Accountability * Integrity * Reliability

Highlights of [GAO-13-358](#), a report to the Ranking Member, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

In fiscal year 2012, DOD and VA spent a combined \$11.8 billion to purchase drugs on behalf of about 18.5 million beneficiaries. Both agencies purchase drugs directly from manufacturers via prime vendors—intermediaries that provide the drugs at a discount off the lowest price that would otherwise be available. The agencies dispense these drugs to beneficiaries through their medical facilities and pharmacies, including their mail order pharmacies.

GAO was asked to compare prices paid for prescription drugs across federal programs. This report describes direct purchase prices paid by DOD and VA for a sample of prescription drugs. GAO will compare drug prices paid using other approaches and by other federal programs in future work. Using prime vendor data provided by these agencies for the first quarter of 2012, GAO selected a sample of high-utilization and high-expenditure drugs important to both DOD and VA and compared average unit prices paid by these agencies for those drugs. The sample contained 43 brand-name and 40 generic drugs and accounted for 37 percent of DOD utilization, 32 percent of DOD expenditures, 28 percent of VA utilization, and 35 percent of VA expenditures for directly purchased drugs in that quarter. GAO calculated average unit prices by dividing total expenditures by total utilization for each drug, the entire sample, and the subsets of brand-name and generic drugs. GAO also compared DOD and VA average unit prices to the FSS and Big Four prices for each drug. GAO interviewed DOD and VA officials about their drug purchasing approaches and factors affecting the prices they are able to obtain.

View [GAO-13-358](#). For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

April 2013

PRESCRIPTION DRUGS

Comparison of DOD and VA Direct Purchase Prices

What GAO Found

When GAO compared prices paid by the Department of Defense (DOD) and the Department of Veterans Affairs (VA) for a sample of 83 drugs purchased in the first calendar quarter of 2012, DOD's average unit price for the entire sample was 31.8 percent (\$0.11 per unit) higher than VA's average price, and DOD's average unit price for the subset of 40 generic drugs was 66.6 percent (\$0.04 per unit) higher than VA's average price. However, VA's average unit price for the subset of 43 brand-name drugs was 136.9 percent (\$1.01 per unit) higher than DOD's average price. These results were consistent with each agency obtaining better prices on the type of drugs that made up the majority of its utilization: generic drugs accounted for 83 percent of VA's utilization of the sample drugs and brand-name drugs accounted for 54 percent of DOD's utilization of the sample drugs. DOD officials told GAO that in certain circumstances they are able to obtain competitive prices for brand-name drugs—even below the prices for generic equivalents—and therefore will often preferentially purchase brand-name drugs.

At the individual drug level, DOD paid higher average unit prices than VA for 32 of the 40 generic drugs and for 23 of the 43 brand-name drugs in the sample, while VA paid higher average unit prices for the remaining 8 generic drugs and 20 brand-name drugs. In nearly every case, substantially higher prices paid by one agency were correlated with substantially lower utilization by that agency. Specifically, for 10 of the 11 drugs for which one agency paid more than 100 percent above the price paid by the other agency, the agency that paid a substantially higher price also had substantially lower utilization. However, even when one agency paid a substantially higher price than the other, in all 11 cases both agencies paid less than the highest of the Federal Supply Schedule (FSS) prices available to all direct federal purchasers or the Big Four prices available to the four largest government purchasers. Additionally, in most cases (9 out of 11 drugs) both agencies paid less than the lowest of these prices. The lower prices obtained by one agency may be due to factors such as differences in the agencies' formulary design and prescription practices, price and rebate negotiations with manufacturers that may not be available more broadly to the other agency, and differences in utilization practices between the agencies based on differences in their beneficiary populations.

DOD and VA face continued challenges in controlling drug costs. While the prescription drug market is complex and there are many factors affecting the prices DOD and VA are able to obtain for directly purchased drugs, differences in prices paid for specific drugs may provide insights into opportunities for each agency to obtain additional savings on at least some of the drugs they purchase.

In commenting on a draft of this report, DOD generally agreed with GAO's findings and described additional factors that may contribute to differences in prices paid by DOD and VA. VA expressed concerns with the content of the report. VA suggested additional analyses and highlighted the impact of program design on each agency's use of prescription drugs. GAO maintains that its analyses have value in identifying opportunities for savings and the report acknowledges the limitations involved with estimating potential cost savings in this complex area. DOD and VA also provided technical comments that GAO incorporated as appropriate.

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Abbreviations

CMOP	Consolidated Mail Outpatient Pharmacy
DOD	Department of Defense
FSS	Federal Supply Schedule
HCPCS	Healthcare Common Procedure Coding System
MTF	military treatment facility
NCPDP	National Council for Prescription Drug Programs
NDA	new drug application
NDC	national drug code
TMOP	TRICARE Mail Order Pharmacy
VA	Department of Veterans Affairs

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

April 19, 2013

The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

Dear Dr. Coburn:

The Department of Defense (DOD) and Department of Veterans Affairs (VA) are major federal purchasers of prescription drugs. In fiscal year 2012, the departments spent a combined \$11.8 billion to purchase drugs on behalf of approximately 18.5 million beneficiaries.¹ In fiscal year 2011, the departments' expenditures—totaling about \$11.3 billion—amounted to about 13 percent of all federal drug expenditures.² As we previously reported, DOD and VA face continued challenges in controlling drug costs and need to make drug savings a priority.³

One method used by DOD and VA to pay for prescription drugs on behalf of their beneficiaries is the direct purchase approach. In this approach, the program purchases drugs directly from manufacturers—through intermediaries known as prime vendors⁴—and dispenses them to

¹Total DOD and VA spending includes all VA drug expenditures plus DOD's expenditures for drugs dispensed at DOD inpatient and clinic facilities as well as all outpatient prescriptions filled at the TRICARE Mail Order Pharmacy (TMOP), DOD pharmacies, and non-DOD retail pharmacies. DOD officials told us they are unable to provide spending totals for inpatient drugs in non-DOD facilities because costs for these drugs are usually bundled with other services for payment.

²Total federal prescription drug expenditures for 2011 were obtained from the National Health Expenditures data for 2011 (the most recent comprehensive federal data available at the time of our analysis) and include spending for DOD, VA, Medicare, Medicaid, the Children's Health Insurance Program, Indian Health Services, and Maternal/Child Health. See Centers for Medicare & Medicaid Services, Office of the Actuary, Division of Health Statistics, *NHE Web Tables*, accessed January 17, 2013, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

³See GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: March 1, 2011), pp. 82-87.

⁴Both DOD and VA use a competitive bidding process to award contracts to one or more prime vendors for the purchase and delivery of drugs to the agencies' facilities.

beneficiaries through their own medical facilities and pharmacies.⁵ DOD and VA have access to certain federal pricing arrangements for these direct purchases, including Federal Supply Schedule (FSS) prices—prices available to all direct federal purchasers—and Big Four prices—prices available to the four largest federal purchasers.⁶ In addition, the prime vendors used by DOD and VA for these purchases provide a fixed percentage discount off the lowest price (e.g., the FSS or Big Four price) otherwise available for each drug. Direct purchase drug prices are generally not subject to intermediary markups from a wholesaler or other distributor.

You requested that we compare prices paid for prescription drugs across federal programs. In this report, we describe direct purchase prices paid by DOD and VA for a sample of prescription drugs. We will compare drug prices paid using other approaches and by other federal programs including Medicare and Medicaid in future work.

In order to compare direct purchase prices paid by DOD and VA for a sample of prescription drugs, we selected a sample of drugs important to both agencies and compared unit prices paid by each agency for those drugs. The sample included the top 50 brand-name and top 50 generic drugs based on combined utilization ranks and combined expenditure ranks for DOD and VA in the first calendar quarter of 2012.⁷ After accounting for overlap between the high-utilization and high-expenditure drugs, the final sample contained 43 brand-name drugs and 40 generic drugs and included 37.0 percent of DOD utilization, 31.7 percent of DOD expenditures, 27.7 percent of VA utilization, and 34.8 percent of VA

⁵Other purchasing approaches include retail reimbursement, in which DOD allows its beneficiaries to fill prescriptions in non-DOD retail pharmacies and then reimburses the pharmacies for the cost of the drugs. In some cases, VA beneficiaries can obtain drugs on a fee-for-service basis through non-VA facilities. The retail reimbursement and fee-for-service payment approaches are outside the scope of this report.

⁶Big Four prices are available to DOD, VA, the Public Health Service, and the U.S. Coast Guard.

⁷A brand-name drug is a drug marketed under a proprietary, trademark-protected name. After any patent and market exclusivity for the brand-name drug expires, other drug companies may develop a generic equivalent—a similar drug that has the same active ingredient, strength, dosage form, route of administration, and intended use. We excluded physician-administered outpatient prescription drugs and over-the-counter drugs from our sample. We also excluded items that are not traditionally considered drugs such as bandages, syringes, needles, diabetes test strips, saline, and water for irrigation.

expenditures for directly purchased prescription drugs. We calculated average unit prices paid by DOD and VA by dividing total expenditures by total utilization for: each drug; the entire sample; the subset of brand-name drugs; and the subset of generic drugs. In order to maintain the confidentiality of prices for individual drugs, in each case we converted from absolute prices to relative prices by assigning 100.0 to the lowest price and determining the higher price as a percentage above the lowest price. We compared the average unit prices paid by DOD and VA to the FSS and Big Four prices available to these agencies. Finally, we determined the maximum potential savings that might have been obtained if each agency had been able to obtain the lower of the DOD and VA average unit prices for each of the 83 drugs in the sample. The results of our analyses are limited to the 83 high-utilization and high-expenditure drugs in our sample for the first calendar quarter of 2012 and are not necessarily applicable across all drugs. We also interviewed DOD and VA officials about drug purchasing approaches they use and factors affecting the prices they are able to obtain. See appendix I for additional details on our methodology and a list of the drugs in the sample. See the Related GAO Products list for other GAO work on DOD and VA drug programs.

Data were received from DOD in June 2012 and from VA in July 2012. We reviewed agency data for reasonableness and consistency, including screening for outlier prices and examining possible reasons for inconsistencies between the data sources. We also reviewed documentation and talked to data providers about steps they take to ensure data reliability, but did not confirm the accuracy of the underlying data. We conducted this performance audit from April 2012 through April 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In fiscal year 2012, VA provided prescription drug coverage to about 8.8 million eligible veterans primarily through its medical centers and

Consolidated Mail Outpatient Pharmacy (CMOP).⁸ VA primarily uses the direct purchase approach to acquire drugs directly from manufacturers for distribution through its facilities. These purchases are usually made under contract with a prime vendor that provides the drugs at a fixed percentage discount off the lowest price otherwise available for each drug. VA's drug prices are generally below wholesale prices provided to commercial buyers and do not include costs for storage, overhead, or dispensing. VA also has access to federal pricing arrangements and other discounts to help control drug spending, including the following:

- *Federal Supply Schedule (FSS) prices:* These prices are available to all direct federal purchasers and are intended to be no more than the prices manufacturers charge their most-favored nonfederal customers under comparable terms and conditions.
- *Big Four prices:* These prices are available to DOD, VA, the Public Health Service, and the U.S. Coast Guard. By law, these prices are 24 percent lower than nonfederal average manufacturer prices.⁹
- *VA national contracts:* These contracts provide additional pricing concessions in return for commitment to potential vendors, resulting in pricing lower than FSS. The VA national contracts program is a separate contract vehicle from the FSS contract program.¹⁰

In fiscal year 2012, VA's prescription drug spending totaled about \$4.2 billion, according to VA officials.¹¹

⁸Veterans who served in active military duty and who were discharged or released under conditions other than dishonorable are generally eligible for VA health care. Reservists, National Guard members, and certain others may also be eligible for VA health care under certain conditions. In some cases, VA beneficiaries can obtain drugs on a fee-for-service basis through non-VA facilities. These make up a very small proportion of VA drug expenditures (less than 1 percent in fiscal year 2010) and are outside the scope of this report.

⁹See 38 U.S.C. § 8126(a)(2). The nonfederal average manufacturer price is the weighted average price of a single form and dosage unit paid by wholesalers to a manufacturer, taking into account cash discounts or similar price reductions. Big Four prices, in general, do not apply to generic drugs.

¹⁰In fiscal year 2012, VA's national contract purchases totaled \$296.8 million, or about 6 percent of total drug expenditures.

¹¹Spending is net of beneficiary copayments.

In fiscal year 2012, DOD provided prescription drug coverage to about 9.7 million active-duty and retired military personnel, their dependents, and others through its military treatment facilities (MTF), the TRICARE Mail Order Pharmacy (TMOP), and retail pharmacies.¹² As with VA, DOD has access to FSS and Big Four prices and uses the direct purchase approach to buy drugs at a discount through a prime vendor for distribution through its MTFs and TMOP. Therefore, DOD's direct purchase drug prices are also generally below wholesale prices provided to commercial buyers and do not include costs for storage, overhead, or dispensing.¹³ In fiscal year 2012, DOD's prescription drug spending totaled about \$7.6 billion, according to DOD officials.¹⁴

Both DOD and VA use prescription drug formularies to help control prescription drug costs.¹⁵ In our November 2012 report on DOD and VA health care, agency officials told us that some of the differences in the agencies' formularies are due to differences in the structure of their health care systems.¹⁶ For example, DOD covers prescriptions written by both military and civilian providers, and DOD officials previously reported that, as a result, the department needs to have a broad formulary to account for differences in prescribing practices among different providers.¹⁷ In

¹²Other beneficiaries include National Guard and Reserve members, their families, survivors, and certain former spouses worldwide. TRICARE is a regionally structured program that uses contractors to maintain provider networks to complement health care provided at MTFs. Prescriptions filled by DOD beneficiaries at retail pharmacies are excluded from this report because they are not directly purchased by DOD.

¹³However, DOD officials told us that direct purchase prices for drugs shipped to DOD facilities overseas include a shipping charge and therefore the prime vendor prices for these purchases will be slightly above the actual cost of the drug.

¹⁴Spending is net of beneficiary copayments and postpurchase refunds and includes drugs dispensed at DOD inpatient and clinic facilities as well as all outpatient prescriptions filled through TMOP, DOD pharmacies, and non-DOD retail pharmacies. Of the \$7.6 billion, about \$3.9 billion (51 percent) was for directly purchased drugs.

¹⁵See GAO, *Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs*, [GAO-09-819T](#) (Washington, D.C.: June 24, 2009), p. 9. A formulary is a list of medications, grouped by therapeutic class, that a health care system's providers are expected to use when prescribing medications.

¹⁶See GAO, *DOD and VA Health Care: Medication Needs during Transitions May Not Be Managed for All Servicemembers*, [GAO-13-26](#) (Washington, D.C.: Nov. 2, 2012), p. 36.

¹⁷With the exception of several classes such as smoking-cessation and weight-loss medications, DOD makes all Food and Drug Administration–approved medications available.

contrast, VA primarily covers medications for eligible beneficiaries through prescriptions written by its own providers. As VA officials reported, this allows VA to have more direct control over the medications that are prescribed to its patient population. Both agencies provide access to nonformulary medications determined by a physician to be clinically necessary.

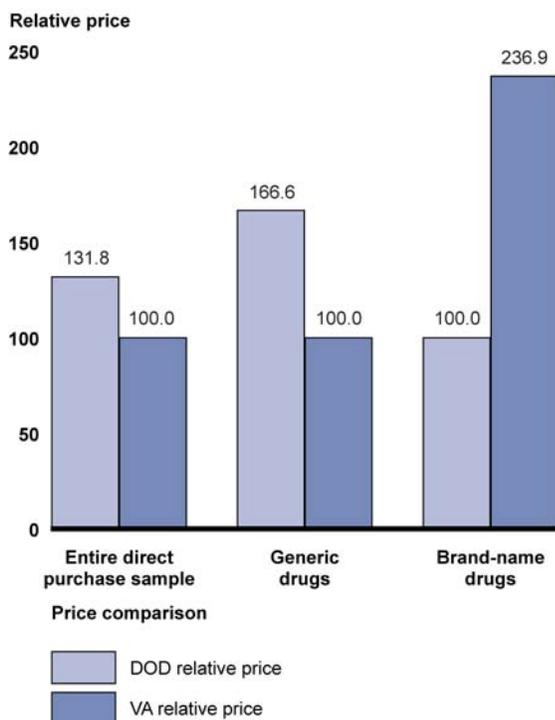
DOD Paid a Higher Average Direct Purchase Price Than VA across the Entire Sample but Paid Less Than VA for Brand-Name Drugs

DOD paid a higher average unit price than VA across the entire sample of 83 drugs and for the subset of generic drugs, but paid a lower average price than VA for the subset of brand-name drugs. Specifically, DOD's average unit price for the entire sample was 31.8 percent higher than VA's average price, and DOD's average unit price for the subset of 40 generic drugs was 66.6 percent higher than VA's average price. However, VA's average unit price for the subset of 43 brand-name drugs was 136.9 percent higher than DOD's average price. (See fig. 1.) DOD paid an average of \$0.11 per unit more than VA across the entire sample of 83 drugs and an average of \$0.04 per unit more than VA for the generic drugs in our sample, while VA paid an average of \$1.01 per unit more than DOD for the brand-name drugs in our sample.¹⁸ These results were consistent with each agency obtaining better prices on the type of drugs that made up the majority of its utilization: generic drugs accounted for the majority (83 percent) of VA's utilization of drugs in the sample for the first quarter of 2012, and brand-name drugs accounted for the majority (54 percent) of DOD's utilization of the sample drugs during the same period. DOD officials told us that in certain circumstances they are able to obtain competitive prices for brand-name drugs—even below the prices

¹⁸DOD's average unit price (e.g., price per tablet, capsule, or milliliter) for the entire sample of 83 drugs was \$0.45 while VA's corresponding unit price was \$0.34. For the subset of generic drugs, DOD's average unit price was \$0.10 while VA's corresponding unit price was \$0.06. DOD's average unit price for the subset of brand-name drugs was \$0.74 while VA's corresponding unit price was \$1.75.

for generic equivalents—and therefore will often preferentially purchase brand-name drugs.¹⁹

Figure 1: DOD and VA Relative Average Unit Prices for Drugs in the Sample, First Quarter of 2012



Source: GAO analysis of Department of Defense (DOD), Department of Veterans Affairs (VA), and Truven Health Analytics data.

Note: The Truven Health Analytics data used were Red Book data.

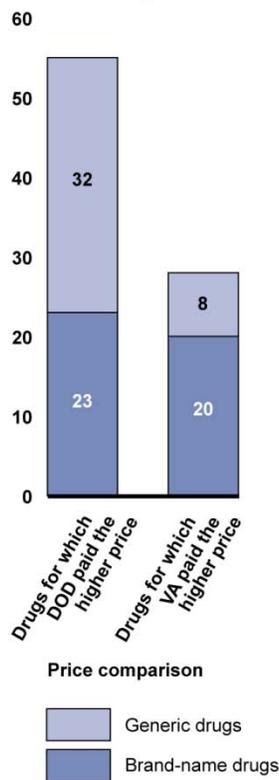
When we examined the prices paid for the individual brand-name drugs in our sample, DOD paid higher average unit prices than VA for 23 of the

¹⁹For example, DOD is often able to obtain competitive prices for brand-name drugs during the period when the generic equivalents are beginning to come to market. This was the case for Lipitor, which DOD was able to obtain at a price below its generic equivalent for several months after the first generic equivalent came on the market. In other instances, DOD is able to obtain significant price reductions for single-source brand-name drugs (i.e., drugs for which there is no generic equivalent) within a therapeutic class that includes other generic competitors. For example, DOD was able to obtain significant price reductions for Nexium because this drug is in a therapeutic class containing several other brand-name and generic drugs.

43 drugs (see fig. 2).²⁰ VA paid higher average unit prices for the remaining 20 brand-name drugs. DOD also paid a higher average price than VA for a majority of the generic drugs in our sample. Specifically, DOD paid a higher price for 32 of the 40 generic drugs in our sample, while VA paid a higher average price for the remaining 8 generic drugs. (See app. II for details on the relative prices paid by DOD and VA for the 83 individual drugs in our sample.)

Figure 2: Number of Drugs in the Sample for Which DOD or VA Paid the Higher Average Unit Price, First Quarter of 2012

Number of drugs for which each agency paid the higher price



Source: GAO analysis of Department of Defense (DOD), Department of Veterans Affairs (VA), and Truven Health Analytics data.

Notes: Of the 23 brand-name drugs for which DOD paid a higher price, 8 were different strengths of the same brand-name drug (Synthroid). The Truven Health Analytics data used were Red Book data.

²⁰However, 8 of these 23 drugs were different strengths of the same brand-name drug: Synthroid, a thyroid supplement.

In nearly every case, substantially higher prices paid by one agency were correlated with substantially lower utilization by that agency. Specifically, we found 11 drugs for which one agency paid more than 100 percent above the price paid by the other agency. For 10 of these drugs, the agency that paid a substantially higher price also had substantially lower utilization.²¹ This may indicate that prices can vary based on the relative importance of a drug to a given agency. However, it is noteworthy that even when one agency paid a substantially higher price than the other, in all 11 cases both agencies paid less than the highest of the FSS or Big Four prices available to government purchasers of the drug, and in most cases (9 out of 11 drugs) both agencies paid less than the lowest of the FSS or Big Four prices.²²

If DOD and VA had each been able to obtain the lowest of DOD's or VA's average unit price for each of the 83 drugs in the sample, the maximum potential savings for DOD would have been about \$19.1 million (7.5 percent of DOD's spending for the drugs in the sample) in the first quarter of 2012 and the maximum potential savings for VA would have been about \$13.9 million (5.1 percent of VA's spending on the drugs in the sample) during that same period. However, it is unlikely that this magnitude of savings could be achieved in practice because of the complexity of the prescription drug market and factors that affect the prices DOD and VA are able to obtain for drugs. For example, these savings apply only to the 83 drugs in our sample in the quantities purchased during the first quarter of 2012 and may not be representative of the savings available across all drugs in various calendar quarters. If either agency had purchased different drugs or even different quantities of the same drugs, the maximum potential savings could have been markedly different. Additionally, the lower prices obtained by one agency may be due to factors such as

²¹For example, VA paid 502.5 percent more than DOD, on average, for 40 mg delayed release capsules of Nexium. This drug was the third highest utilization brand-name drug for DOD (which purchased more than 26 million capsules) but only the 97th highest utilization brand-name drug for VA (which purchased fewer than 1 million capsules).

²²A given drug corresponds to one or more national drug codes (NDC), each representing a different labeler or different package size. Each NDC may have an FSS price and a Big Four price available to government purchasers, so there may be many such prices corresponding to a given drug. We compared the average unit prices paid by DOD and VA for each drug to all FSS and Big Four prices corresponding to the drug.

-
- differences in the agencies' formulary designs and prescription practices—for example, DOD's broader formulary, designed to accommodate prescriptions written by non-DOD providers, and VA's greater control over prescribing, designed to allow it to steer utilization toward a limited number of drugs within a given therapeutic class;²³
 - differences in utilization practices between the agencies based on differences in their beneficiary populations;²⁴
 - price and rebate negotiations with manufacturers that may not be available more broadly to the other agency—as VA officials told us, these can include VA's national purchase contracts or temporary price reductions offered to VA by a manufacturer in order to increase a drug's market share;
 - differences between the discounts obtained from one agency's prime vendors through a competitive bidding process and potentially not available to the other agency;²⁵
 - drug shortages—DOD officials told us that insufficient quantities of less expensive versions of a drug may force an agency to purchase a more expensive version; or
 - other factors, such as differences in purchasing authority, that may limit the extent to which particular discounts provided to one agency are available to the other agency.

Concluding Observations

DOD and VA face continued challenges in controlling drug costs. Our findings suggest that there may be opportunities for savings with directly purchased drugs. DOD and VA paid different prices for the drugs in our sample; for 11 of the 83 drugs, one agency paid at least 100 percent more than the other agency. DOD paid a lower average price for the brand-name drugs in our sample while VA paid less, on average, for the

²³For additional information on DOD and VA formulary design, see [GAO-13-26](#).

²⁴See Congressional Budget Office, *The Department of Veterans Affairs' Pharmaceutical Prime Vendor Program* (Washington, D.C.: Feb. 25, 2009), p. 1.

²⁵For additional information on the DOD and VA prime vendor programs, see Congressional Budget Office, *The Prime Vendor Program*.

generic drugs and across the entire sample. Our past reports highlight the importance of DOD and VA controlling drug costs. While the prescription drug market is complex and there are many factors affecting the prices DOD and VA are able to obtain for directly purchased drugs, differences in prices paid for specific drugs may provide insights into opportunities for each agency to obtain additional savings on at least some of the drugs they purchase.

Agency Comments and Our Evaluation

DOD and VA reviewed a draft of this report and provided written comments, which are reprinted in appendixes III and IV, respectively.

DOD generally agreed with our methodology and findings. In addition, DOD noted that expressing differences between DOD and VA prices for the sample as percentages rather than actual dollar amounts may give the impression that significant dollar values are involved rather than a few cents or less per unit. While we clarified in the report the dollar amount of price differences, our findings indicated that small per-unit price differences may result in significant additional expenditures when accounting for the quantities purchased by the agencies. DOD also described additional factors beyond those mentioned in our findings that may contribute to differences in prices paid by DOD and VA.

VA expressed concerns with the content of the report and suggested additional analyses. For example, VA suggested that analyses accounting for per-beneficiary costs, formulary design, utilization management, and the mix of drugs used for a particular disease state would have provided more appropriate comparisons. While we agree that such analyses could be useful, the scope of our work was targeted to a comparison of prices paid by each agency for a sample of high-utilization and high-expenditure drugs and was not intended to capture all factors that can affect pharmaceutical spending. We noted the limitations of our results in the report, including that our results cannot be applied to all drugs purchased by the agencies. Further, our report acknowledges the limitations involved with estimating potential cost savings in this complex area. Nonetheless, we maintain that comparing unit prices paid for selected generic and brand-name drugs by different federal agencies has value in identifying specific drugs with price differences that may warrant further consideration for potential savings.

VA also noted that most of its drug purchases are made through contracts with a prime vendor that provides a negative distribution fee (i.e., discount), resulting in savings to VA. We revised the introduction to make this information more prominent earlier in the report. VA agreed with our conclusion that the maximum potential savings provided in our findings are unlikely to be achieved and noted that obtaining lower prices on brand-name drugs would require shifting utilization away from generic drugs, potentially increasing overall drug costs. VA also stated that our list of factors affecting the prices each agency is able to obtain did not specifically include the ability of VA to direct utilization toward a limited number of drugs within a therapeutic class to achieve savings. We revised the report to clarify this point.

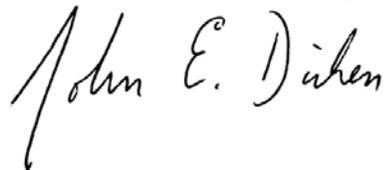
VA also stated that, under an applicable Federal Acquisition Regulation (48 C.F.R. § 8.002), it was required to purchase more expensive versions of generic minocycline through the FSS contract rather than versions otherwise available. VA therefore requested that GAO remove the potential savings related to the purchase of this drug from the total projected savings in the report. However, our report generally reflects a number of factors (including differences in purchasing authority) that may limit each agency's ability to achieve the maximum potential savings we calculated, and it was beyond the scope of our report to apply these factors to each individual drug.

DOD and VA also provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to relevant congressional committees and other interested members. The report also will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in appendix V.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial 'J' and 'D'.

John E. Dicken
Director, Health Care

Appendix I: Scope and Methodology

In order to compare direct purchase prices paid by the Department of Defense (DOD) and Department of Veterans Affairs (VA) for prescription drugs, we chose a sample of drugs important to both agencies. We obtained prime vendor data for the first calendar quarter of 2012 for drugs dispensed to DOD and VA beneficiaries through the agencies' own medical facilities and mail order pharmacies.¹ We excluded physician-administered outpatient prescription drugs and over-the-counter drugs from our sample; we also excluded items that are not traditionally considered drugs such as bandages, syringes, needles, diabetes test strips, saline, and water for irrigation.² We used data from Red Book to determine the brand-name or generic status of each drug.³ Utilization was determined using the National Council for Prescription Drug Programs (NCPDP) Billing Unit Standard.⁴ When calculating expenditures, we used the agencies' costs to purchase each drug without accounting for any

¹Direct purchases of drugs by DOD and VA are usually made under contract with one or more intermediaries, known as prime vendors, which agree to provide drugs at a fixed percentage discount off the lowest price otherwise available for each drug.

²Because Medicare Part B primarily covers physician-administered outpatient drugs, we used Part B data to identify and exclude these drugs from our sample. However, Medicare Part B uses Healthcare Common Procedure Coding System (HCPCS) codes to identify drugs while DOD and VA use national drug codes (NDC). Therefore, we used the January 2012 NDC-HCPCS Crosswalk Files for Medicare Part B to identify physician-administered drugs in the DOD and VA samples so we could exclude them.

³Red Book is a drug pricing compendium with information about prices and other characteristics of drug products, published by Truven Health Analytics. A brand-name drug is a drug marketed under a proprietary, trademark-protected name. After any patent and market exclusivity for the brand-name drug expires, other drug companies may develop a generic equivalent—a similar drug that has the same active ingredient, strength, dosage form, route of administration, and intended use. Red Book identified two drugs in our sample (Klor-Con 10 and Thermazene) as “branded-generic” drugs. To determine whether to group these drugs with the brand-name subset or the generic subset, we identified the type of drug application submitted by the manufacturer for original Food and Drug Administration approval. Both drugs were originally approved using a new drug application (NDA). Because manufacturers typically submit an NDA when seeking approval for brand-name drugs, we grouped these two drugs with the other brand-name drugs in our sample.

⁴NCPDP developed the Billing Unit Standard to assist in consistent and accurate billing of pharmaceutical products and to standardize the reporting of units to the Centers for Medicare & Medicaid Services for rebate purposes. Generally, these standards report items in one of three units: each (when a product is measured in discrete units such as tablets, capsules, vials, or kits), milliliters (when a product is measured in liquid volume), and grams (when a product is measured by weight). The use of these standards may cause certain drugs (e.g., liquids) to have a higher utilization rank than they would if a different method had been used.

future offsets from beneficiary copayments for those drugs.⁵ We aggregated the utilization and expenditure data at the drug level (drug name, strength, and dosage form) separately for DOD and VA. For example, all national drug codes (NDC) corresponding to 10 mg tablets of Lipitor purchased by VA were aggregated and the associated utilization and expenditures were summed and compared to other brand-name drugs, while NDCs corresponding to 10 mg tablets of atorvastatin (the generic equivalent of Lipitor) purchased by VA were aggregated separately and compared to other generic drugs.⁶

We ranked the top 100 brand-name and top 100 generic drugs separately for each agency on the basis of utilization and expenditures and then combined these rankings to determine the top brand-name and generic drugs that were purchased by both agencies. We excluded drugs that were in the top 100 for one agency but not for the other agency in order to focus our analysis on drugs that were important for both DOD and VA. For example, if a drug was 10th highest in utilization for VA but was not in the top 100 for DOD, that drug would not be included in our sample. Some drugs that were excluded from the sample appeared to be more appropriate for the beneficiary population of one agency than the other. For example, primaquine phosphate—a drug used to treat malaria—was the fourth-highest-expenditure generic drug for DOD but was not in the top 100 for VA. Some other excluded drugs were additional strengths of drugs that did appear in our sample. For example, simvastatin (80 mg tablet) was the sixth-highest-expenditure generic drug for VA but was not in the top 100 for DOD and thus was excluded from the sample. However, the 20 mg and 40 mg strengths of simvastatin were included in the sample.

⁵DOD officials told us that direct purchase prices for drugs shipped to DOD facilities overseas include a shipping charge and therefore the prime vendor prices for these purchases will be slightly above the actual cost of the drug.

⁶NDCs are three-segment numbers that are the universal product identifiers for drugs for human use. The Food and Drug Administration assigns the first segment of the NDC, which identifies the labeler (i.e., the firm that manufactures, repackages, or distributes a drug). The labeler assigns the second and third segments. The second segment identifies a specific strength, dosage form, and formulation (e.g., 20 mg capsules) and the third segment identifies package size and type (e.g., 100 capsules in a bottle). A drug can have multiple NDCs associated with it. For example, a drug made by one manufacturer, in one strength or dosage form, but in three package sizes would have three NDCs where the first and second segments are identical and the third segment differs for each package size.

The drug sample was selected to include the top 50 brand-name and top 50 generic drugs; 25 of the brand-name drugs and 25 of the generic drugs were selected on the basis of the combined DOD and VA utilization ranks, and the other 25 brand-name and 25 generic drugs were selected on the basis of the combined DOD and VA expenditure ranks. After accounting for drugs that were in both the high-expenditure group and the high-utilization group, the final sample contained 43 brand-name drugs and 40 generic drugs and accounted for 37.0 percent of DOD utilization, 31.7 percent of DOD expenditures, 27.7 percent of VA utilization, and 34.8 percent of VA expenditures for directly purchased prescription drugs in the first calendar quarter of 2012.⁷ (See table I for a list of the drugs in the sample.)

⁷Percentages exclude physician-administered outpatient drugs.

Table 1: Direct Purchase Drug Sample, First Calendar Quarter of 2012

Drug name, strength, and dosage form	Drug utilization ranking ^a			Drug expenditure ranking		
	DOD rank	VA rank	Rank after combining DOD and VA utilization ranks ^b	DOD rank	VA rank	Rank after combining DOD and VA expenditure ranks ^b
43 Brand-Name drugs						
Abilify (5 mg tablet)				37	46	25
Actos (30 mg tablet)				11	18	5
Actos (45 mg tablet)				17	22	9
Advair Diskus 250 50 (0.25 mg/actuation-0.05 mg/actuation, disk)				5	64	19
Androgel (1% gel/jelly)	27	71	28			
Asacol (400 mg tablet, enteric coated)	43	28	15			
Atripla (600 mg-200 mg-300 mg tablet)				14	4	3
Carafate (1 gm/10 ml suspension)	44	19	12			
Celebrex (200 mg capsule)				4	73	23
Colcrys (0.6 mg tablet)				33	21	13
Combivent (0.09 mg/1 inh-0.018 mg/actuation, aerosol powder)				52	3	15
Copaxone (20 mg/1ml device)				26	10	6
Crestor (20 mg tablet)	66	17	19	38	35	21
Cymbalta (30 mg capsule, delayed release)				31	43	22
Cymbalta (60 mg capsule, delayed release)				13	25	7
Gleevec (400 mg tablet)				49	7	18
Januvia (100 mg tablet)				7	48	15
Klor Con 10 (10 meq tablet, extended release)	20	7	4			
Lantus (100 units/1ml solution)	84	8	25	40	2	10
Levitra (20 mg tablet)				10	60	20
Lidoderm (5% patch, extended release)				8	37	12
Lovaza (1 gm capsule, liquid filled)	17	62	16			
Namenda (10 mg tablet)	42	27	14	22	16	7

Appendix I: Scope and Methodology

Drug name, strength, and dosage form	Drug utilization ranking ^a			Drug expenditure ranking		
	DOD rank	VA rank	Rank after combining DOD and VA utilization ranks ^b	DOD rank	VA rank	Rank after combining DOD and VA expenditure ranks ^b
Nexium (40 mg capsule, delayed release)				3	39	10
Nitrostat (0.4 mg tablet)	82	6	21			
Periogard (0.12% liquid)	1	44	9			
Plavix (75 mg tablet)	7	3	3	1	1	1
Prevident 5000 plus (1.1% cream)	4	60	13			
Singulair (10 mg tablet)	6	34	6	2	17	4
Spiriva (18 mcg capsule)	18	12	5	6	6	2
Symbicort (160 mcg-4.5 mcg/1 actuation, aerosol liquid)				58	19	23
Synthroid (0.025 mg tablet)	65	26	23			
Synthroid (0.05 mg tablet)	24	16	6			
Synthroid (0.075 mg tablet)	16	24	6			
Synthroid (0.088mg tablet)	40	51	23			
Synthroid (0.1mg tablet)	28	23	10			
Synthroid (0.112 mg tablet)	50	43	26			
Synthroid (0.125 mg tablet)	59	29	21			
Synthroid (0.15 mg tablet)	57	38	27			
Thermazene (1% cream)	68	15	19			
Tricor (145 mg tablet)	35	46	18			
Truvada (200 mg-300mg tablet)				47	8	15
Zetia (10 mg tablet)	15	65	17	18	36	13
40 Generic Drugs						
Amlodipine besylate (5 mg tablet)	19	32	19			
Amlodipine besylate (10 mg tablet)	29	11	14			
APAP oxycodone (325 mg-5 mg tablet)	27	23	17			
Atenolol (25 mg tablet)	30	44	27			
Atenolol (50 mg tablet)	22	37	24			
Azithromycin (250 mg tablet)				14	51	12
Carbidopa levodopa (25 mg-100 mg tablet)				32	36	16
Chlorhexidine gluconate (0.12% liquid)	17	42	24			

Appendix I: Scope and Methodology

Drug name, strength, and dosage form	Drug utilization ranking ^a			Drug expenditure ranking		
	DOD rank	VA rank	Rank after combining DOD and VA utilization ranks ^b	DOD rank	VA rank	Rank after combining DOD and VA expenditure ranks ^b
Clonidine (0.3 mg/24 hr patch, extended release)				61	28	25
Cyclobenzaprine HCL (10 mg tablet)	28	26	22			
Finasteride (5 mg tablet)	45	21	26	16	2	3
Fluticasone propionate (0.05 mg/actuation, spray)				1	46	8
Gabapentin (300 mg capsule)	11	4	4	7	3	1
Gabapentin (600 mg tablet)				18	63	22
Gemfibrozil (600 mg tablet)				45	17	10
Glyburide (5 mg tablet)	54	22	28			
Lactulose (10 gm/15 ml solution)	25	7	10			
Lisinopril (10 mg tablet)	16	35	19			
Lisinopril (20 mg tablet)	14	25	13	41	43	24
Lisinopril (40 mg tablet)	21	9	9	51	12	11
Metformin HCL (500 mg tablet)	5	10	4	24	18	7
Metformin HCL (1000 mg tablet)	13	5	7	26	7	5
Metoprolol succinate (25 mg tablet, extended release)				5	62	15
Metoprolol succinate (50 mg tablet, extended release)				2	31	5
Metoprolol succinate (100 mg tablet, extended release)				3	27	4
Metoprolol succinate (200 mg tablet, extended release)				44	21	12
Metoprolol tartrate (25 mg tablet)	34	16	17			
Metoprolol tartrate (50 mg tablet)	24	8	10			
Minocycline HCL (100 mg capsule)				48	23	20
Naproxen (500 mg tablet)	15	36	19			
Olanzapine (10 mg tablet)				77	5	23
Omeprazole (20 mg capsule, delayed release)	4	17	8	6	11	2
Pravastatin sodium (40 mg tablet)				34	38	21
Ranitidine (150 mg tablet)	18	15	12			
Sertraline HCL (100 mg tablet)				31	35	14
Simvastatin (20 mg tablet)	7	40	16			
Simvastatin (40 mg tablet)	12	31	15	30	39	18

Drug name, strength, and dosage form	Drug utilization ranking ^a			Drug expenditure ranking		
	DOD rank	VA rank	Rank after combining DOD and VA utilization ranks ^b	DOD rank	VA rank	Rank after combining DOD and VA expenditure ranks ^b
Tamsulosin HCL (0.4 mg capsule)	37	20	23	37	15	9
Tramadol HCL (50 mg tablet)	9	3	3	72	20	26
Valacyclovir HCL (500 mg tablet)				9	60	18

Source: GAO analysis of DOD, VA, and Truven Health Analytics data.

Notes: The Truven Health Analytics data used were Red Book data. We excluded physician-administered outpatient drugs, over-the-counter drugs, and certain items such as bandages, syringes, needles, diabetes test strips, saline, and water for irrigation. Drug utilization and expenditures were determined by aggregating data for all national drug codes (NDC) corresponding to the same drug name, strength, and dosage form. If rankings are provided in either the utilization columns or the expenditure columns but not both, the drug was selected for the sample because combining the DOD and VA ranks placed the drug among the top drugs for only one of these categories. If rankings are provided in both the utilization columns and the expenditure columns, then combining the DOD and VA ranks placed the drug among the top drugs for both categories.

^aUtilization was determined on the basis of the total number of units purchased; units were defined on the basis of the National Council for Prescription Drug Programs (NCPDP) Billing Unit Standard. NCPDP developed the Billing Unit Standard to assist in consistent and accurate billing of pharmaceutical products and to standardize the reporting of units to the Centers for Medicare & Medicaid Services for rebate purposes. Generally, these standards report items in one of three units: each (when a product is measured in discrete units such as tablets, capsules, vials, or kits), milliliters (when a product is measured in liquid volume), and grams (when a product is measured by weight). The use of these standards may cause certain drugs (e.g., liquids) to have a higher utilization rank than they would if a different method had been used.

^bRankings that do not appear in the combined rankings columns (e.g., rank 1 for combined DOD and VA utilization) corresponded to items such as saline that we excluded from the sample.

After selecting the sample, we calculated average unit prices paid by DOD and VA for all individual drugs by dividing total expenditures by total utilization for each drug. We also calculated average unit prices for the entire sample, the subset of brand-name drugs, and the subset of generic drugs by dividing the total expenditures for all relevant drugs by the total utilization of those drugs. In order to maintain the confidentiality of drug prices, in each case we converted from absolute prices to relative prices by assigning 100.0 to the lowest price and determining the higher price as a percentage above the lowest price. We compared the average unit prices obtained by DOD and VA for each drug to the Federal Supply Schedule (FSS) and Big Four prices available to these agencies.⁸ We

⁸A given drug corresponds to one or more NDCs, each representing a different labeler or different package size. Each NDC may have an FSS price and a Big Four price available to government purchasers, so there may be many such prices corresponding to a given drug. We compared the average unit prices paid by DOD and VA for each drug to all FSS and Big Four prices corresponding to the drug.

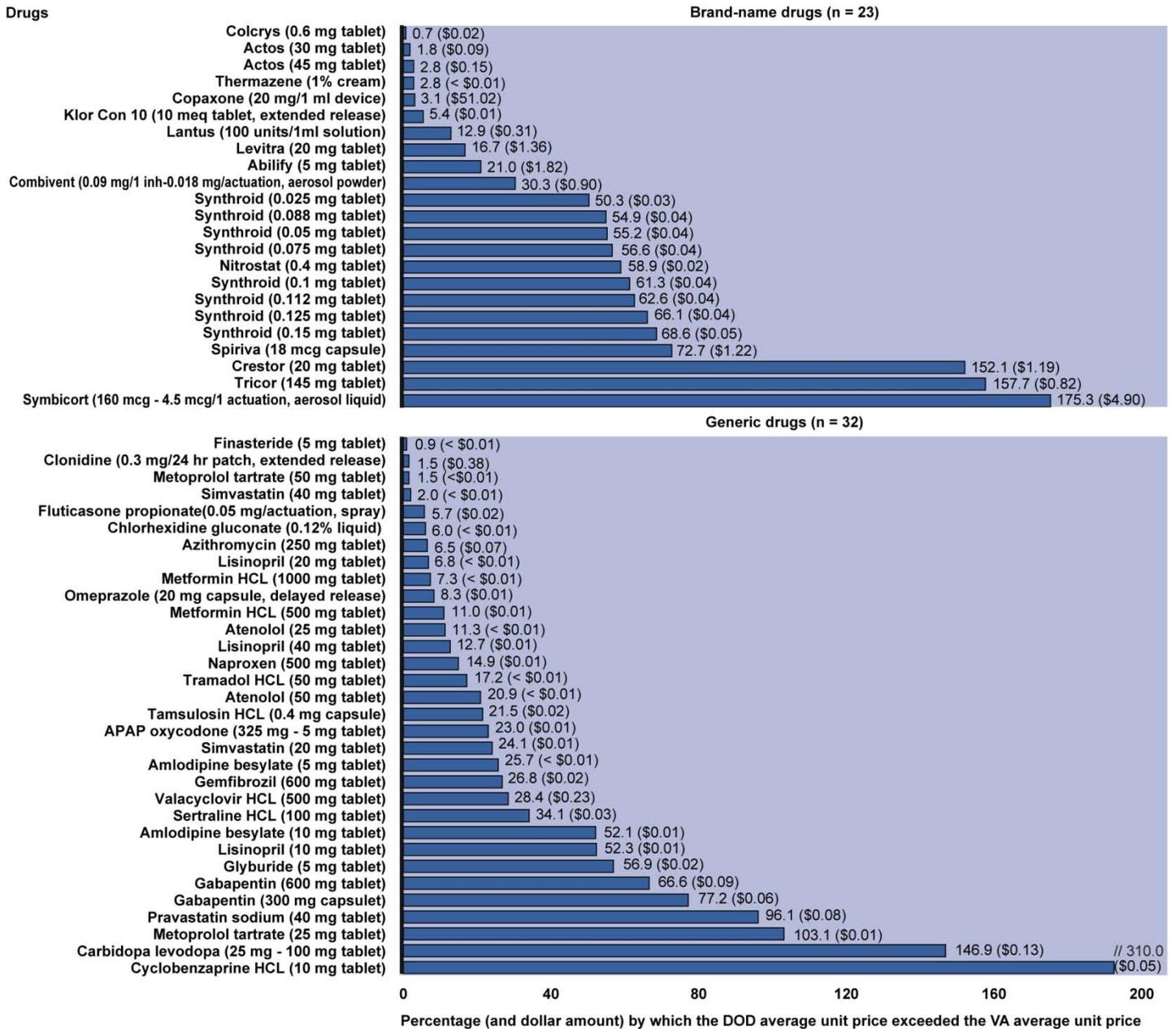
interviewed DOD and VA officials about drug purchasing approaches they use and factors affecting the prices they are able to obtain. Finally, we determined the maximum potential savings that might have been obtained if each agency had been able to obtain the lower of the DOD and VA average unit prices for each of the 83 drugs in the sample. The results of our analyses are limited to the 83 high-utilization and high-expenditure drugs in our sample for the first calendar quarter of 2012 and are not necessarily applicable across all drugs.

Appendix II: Relative Prices Paid by DOD and VA for the 83 Drugs in the Direct Purchase Sample

Figure 3 shows the 55 drugs (out of 83 drugs in our sample) for which the Department of Defense (DOD) paid a higher average unit price than the Department of Veterans Affairs (VA) and the percentage by which the DOD price exceeded the VA price. Figure 4 shows the 28 drugs (out of 83) for which VA paid a higher average unit price than DOD and the percentage by which the VA price exceeded the DOD price.

Appendix II: Relative Prices Paid by DOD and VA for the 83 Drugs in the Direct Purchase Sample

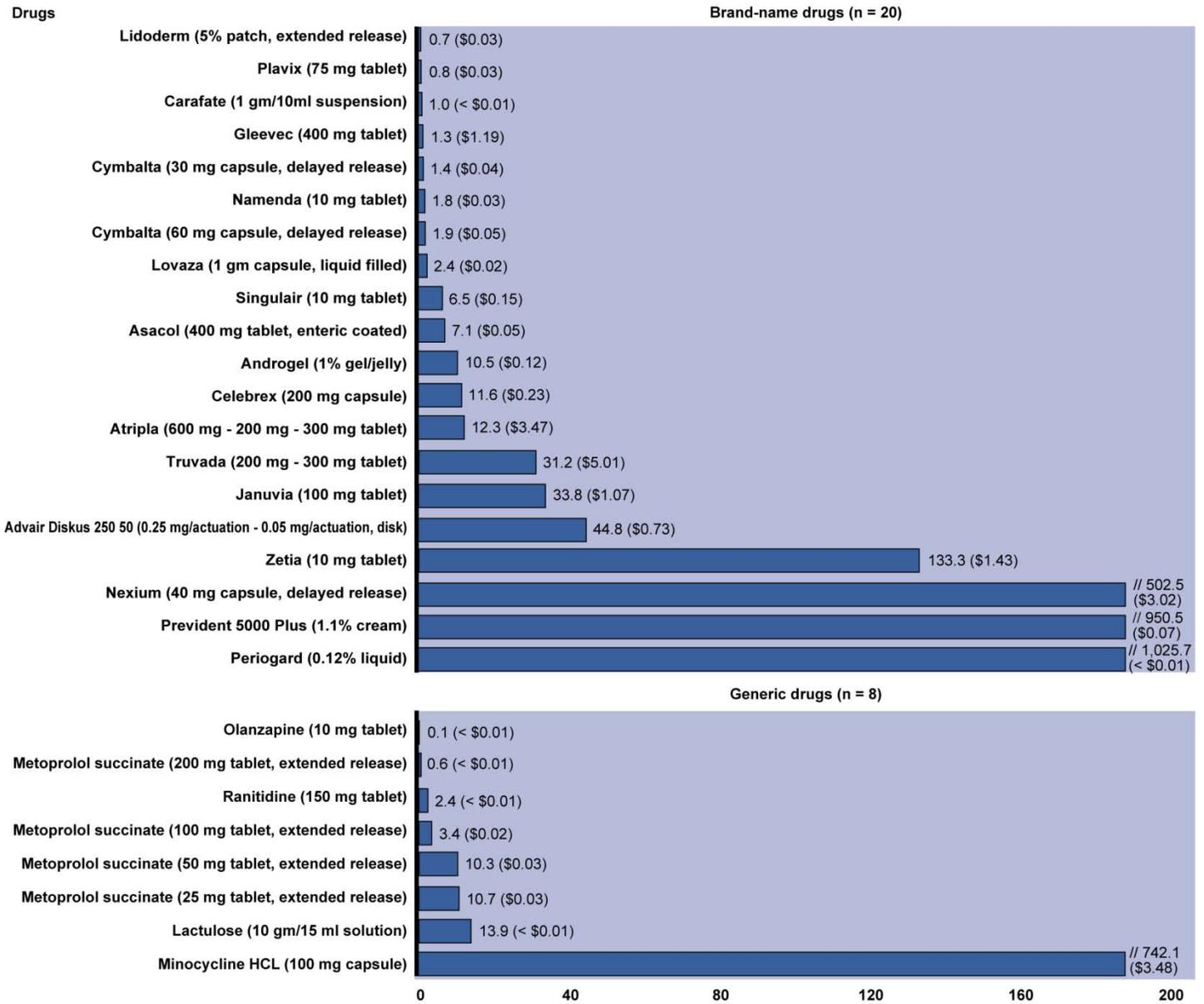
Figure 3: Drugs for Which DOD Paid a Higher Average Unit Price Than VA, First Calendar Quarter of 2012



Note: The Truven Health Analytics data used were Red Book data.

Appendix II: Relative Prices Paid by DOD and VA for the 83 Drugs in the Direct Purchase Sample

Figure 4: Drugs for Which VA Paid a Higher Average Unit Price Than DOD, First Calendar Quarter of 2012



Percentage (and dollar amount) by which the VA average unit price exceeded the DOD average unit price

Source: GAO analysis of Department of Defense (DOD), Department of Veterans Affairs (VA), and Truven Health Analytics data.

Note: The Truven Health Analytics data used were Red Book data.

Appendix III: Comments from the Department of Defense

Note: Page numbers in the draft report may differ from those in this report.



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

APR 01 2013

Mr. John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dicken:

This is the Department of Defense's (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-13-358, "PRESCRIPTION DRUGS: Comparison of DOD and VA Direct Purchase Prices," dated March 5, 2013, (GAO Code 291040). Thank you for the opportunity to provide comments on the draft report.

Overall, I generally concur with the GAO's methodology and findings of the audit. While the draft report does not provide any recommendations, I will take this opportunity to provide additional information to illustrate that the differences in prices as noted in the report are in many cases a difference of one cent or less. I believe this information will improve the accuracy and value of the final report by preventing misinterpretation of the magnitude of the findings and by mitigating conclusions that could be drawn out of context.

A review of the actual per unit pricing differences for the drugs listed in Appendix II, "Relative Prices Paid by DoD and VA for the 83 Drugs in the Direct Purchase Sample" provides a realistic context of these pricing differences versus the statement on page 5 of the draft report: "...DoD's average unit price for the subset of 40 generic drugs was 66.6 percent (%) higher than VA's average price." This percentage can give the impression of a significant dollar value which is clarified only in footnote #17 stating that the actual difference is only 4 cents per unit. Of the 32 generics that DoD paid more than the Department of Veterans Affairs (VA), 23 generics had a difference in unit cost of 2 cents or less, with 19 of the 23 differing by a cent or less. The perspective that one product in the chart shows a 103.1 percent difference in price seems outrageous, until one realizes that the actual difference was only one cent per unit.

There are several confounders that may contribute to very small actual differences in per unit pricing between DoD and VA for both the generics and branded pharmaceuticals in the report, including:

- DoD's prime vendor pricing provided to GAO was all procurements worldwide, which included a higher cost recovery factor for shipping and delivery to overseas locations. Conversely, the VA has no overseas locations.
- The review period of the first calendar quarter of 2012 introduces anomalies created by the expiration of contracts at the end of the calendar year with gaps in effective

dates of follow-on national contracts. Such was the case for cyclobenzaprine with a change of \$0.02 to \$0.07 during the gap.

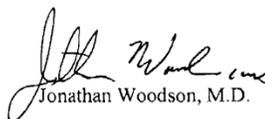
- Discontinuance of Federal Supply Schedule pricing by several manufacturers at the end of the calendar year forced DoD to procure higher priced carbidopa/levodopa because the contractor supporting VA at a lower price was unable to meet the demands of both Departments.
- The report does not state that DoD is already identifying and reaching out to facilities unknowingly or inadvertently ordering higher priced packaging or products when a lower priced product exists, which will close the gap in actual per unit pricing, though already very small.

The DoD and VA pharmacy programs are vastly different in structure, statutory parameters, and regulatory guidance. For the medications (primarily brand name) with large actual differences in unit cost, these differences are due to differences in formulary design, prescribing practices, and population served. This is supported by GAO's observation that medications with substantially higher unit costs at one agency tended to have lower utilization at that agency.

DoD continually seeks opportunities for cost savings in managing the very complex environment of pharmaceutical procurement as suggested in the report's concluding observations. In addition to the several examples provided above, the report acknowledges other factors that may contribute to the pricing differences between DoD and VA. Considering these factors, DoD strongly agrees that the results of this report cannot be extrapolated beyond the 83 drugs reviewed, and that it is unlikely this magnitude of savings could be achieved in practice due to the complexity of the prescription drug market and other factors that affect the prices DoD and VA are able to obtain for drugs.

My points of contact on this issue are Rear Admiral (RADM) Thomas McGinnis (Functional) and Mr. Gunther Zimmerman (Audit Liaison). RADM McGinnis may be reached at (703) 681-2890, and Mr. Zimmerman may be reached at (703) 681-4360.

Sincerely,


Jonathan Woodson, M.D.

Appendix IV: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 2, 2013

Mr. John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dicken:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**PRESCRIPTION DRUGS: Comparison of VA and DOD Direct Purchase Prices**" (GAO-13-358). VA has significant concerns regarding the content of this report. The attachment details specific information from the report that could lead to misinterpretation of the Veterans Health Administration's (VHA) prescription benefit. These comments will provide insight into relevant VHA data that have not been included in the report.

VA's commitment to drug savings has been a priority for over 30 years and, as such, VA has achieved what is potentially the lowest cost per patient per year in the entire Federal Government and private sector.

VA's primary concern is that the report focuses on the unit cost of medications, rather than the overall cost effectiveness of each Department's prescription benefit. It is VA's position that the true cost of providing a prescription benefit is total pharmaceutical expenditures divided by the number of covered lives or actual unique users. VA requests that GAO include its average cost per unique user of outpatient pharmacy from fiscal years 1999 to 2012, which has only risen from \$599 to \$723.

GAO focused only on the acquisition prices of specific drugs, and did not take into account the significant impact of formulary design and utilization management. GAO does not mention the most important factor in achieving cost savings – the ability of the agency to direct standardization to the lowest cost effective drug(s) within each therapeutic drug class.

VHA purchases the majority of its pharmaceuticals through the pharmaceutical prime vendor (PPV) rather than directly from the manufacturer. VHA receives a negative distribution fee from the PPV; therefore, it is more cost-effective for VHA to purchase from the PPV as opposed to directly from the manufacturer. VA finds GAO's usage of "direct purchase drug prices" fails to accurately represent VHA drug purchase cost benefits.

Page 2.

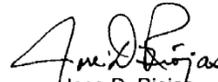
Mr. John E. Dicken

From VA's perspective, GAO's methodology for reporting maximum potential savings appears problematic. GAO should consider addressing the fact that the mix of drugs used for a specific disease state as well as the cost per drug is what drives cost savings. VA requests that GAO revisit and lower the projected maximum cost savings for VHA to exclude GAO's cost savings associated with brand-name drugs.

Additionally, the Federal Acquisition Regulation (FAR) (8.002) requires VHA to purchase the more expensive generic minocycline on the Federal Supply Schedule contract. VA would be supportive of a GAO recommendation for regulatory changes that exempt VA from purchasing the higher priced drugs from the Federal Supply Schedule. VA requests GAO remove the savings related to the purchase of generic minocycline from VA's total projected savings.

The enclosure contains general comments related to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,


Jose D. Riojas
Interim Chief of Staff

Enclosure

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Robert Copeland, Assistant Director; Zhi Boon; Karen Howard; Laurie Pachter; and Carmen Rivera-Lowitt.

Related GAO Products

DOD and VA Health Care: Medication Needs during Transitions May Not Be Managed for All Service Members. [GAO-13-26](#). Washington, D.C.: November 2, 2012.

2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue. [GAO-12-342SP](#). Washington, D.C.: February 28, 2012.

Follow-Up on 2011 Report: Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue. [GAO-12-453SP](#). Washington, D.C.: February 28, 2012.

Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue. [GAO-11-318SP](#). Washington, D.C.: March 1, 2011.

VA Drug Formulary: Drug Review Process Is Standardized at the National Level, but Actions Are Needed to Ensure Timely Adjudication of Nonformulary Drug Requests. [GAO-10-776](#). Washington, D.C.: August 31, 2010.

Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs. [GAO-09-819T](#). Washington, D.C.: June 24, 2009.

Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated. [GAO-07-647](#). Washington, D.C.: May 31, 2007.

Prescription Drugs: An Overview of Approaches to Negotiate Drug Prices Used by Other Countries and U.S. Private Payers and Federal Programs. [GAO-07-358T](#). Washington, D.C.: January 11, 2007.

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