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Testimony

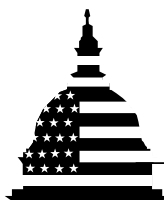
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**DOD AND VA HEALTH
CARE**

**Jointly Buying and Mailing
Out Pharmaceuticals
Could Save Millions of
Dollars**

Statement of Stephen P. Backhus, Director
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Health, Education, and Human Services Division



G A O

Accountability * Integrity * Reliability

DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss what the Departments of Veterans Affairs (VA) and Defense (DOD) have done and what more they could do to reduce drug prices and dispensing costs. In fiscal year 1999, VA and DOD together spent about \$2.4 billion—or about 2 percent of all domestic drug sales—for about 140 million prescriptions for veterans, and for active duty and retired military and their families. Recently, soaring drug costs have focused attention on the merits of having the agencies procure their drugs jointly, and better manage their pharmacy operations. The driving expectation is that, as the two agencies buy more of a particular drug, their leverage—particularly under competitively bid committed-use contracts—will permit them to exact discounts from drug manufacturers.¹ Committed-use contracts establish a fixed price for one or two products in a particular therapeutic class. In exchange for a low price, the Departments commit to use the drugs to treat patients in their health care systems. This commitment encourages the prescribing and use of contract drugs and will also lead the Departments' medical systems to treat their patients consistently. Medical necessity would require that some patients be allowed to use alternate drugs.

At your request, my testimony focuses on the extent of joint DOD and VA drug contracting thus far and the prospects for further contracting, as well as for DOD using VA's consolidated mail outpatient pharmacy (CMOP) centers to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. Also, I will briefly discuss the possible need for measures to facilitate such joint actions to bring about further improvements. As you know, our work is still underway and we plan to issue a report to you and other requesters later this year.

In summary, by April 2000, VA and DOD had awarded 18 joint, national committed-use contracts amounting to about 2 percent of their combined drug expenditures. The joint contracts largely were due to a 1999 VA/DOD agreement to work toward combining their like medical supply needs. The

¹ A health plan can exert considerable leverage in negotiating drug prices when there is a choice among competing drugs that are therapeutically equivalent and the plan can choose which one or ones to purchase. The plan will have additional leverage based on its ability to influence the volume used.

Generally, VA and DOD national committed-use contracts establish a fixed price for one or two products in a particular therapeutic class for 1 year, plus four 1-year option periods. By including the contracted drugs on their respective national and basic core formularies, VA and DOD commit to use the drugs to treat patients in their health care systems. The ability to offer a high volume of use of a particular drug enables VA and DOD to obtain the lowest prices from drug companies.

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Departments also have separate national contracts amounting to about 17 percent of their combined expenditures. The remainder, or about 81 percent of their combined expenditures, are for drugs they buy at negotiated, noncompeted, supply schedule prices, at far smaller discounts than the contracts afford.

While the drug discounts DOD and VA have gotten are impressive, only about 19 percent of their combined purchases are now made through the most cost-effective mechanism—national, committed-use contracting with a supplier. If DOD and VA could do most of their drug spending through such contracts, preferably joint contracts, we estimate they could save from about \$150 million to \$300 million, or about 6 to 12 percent of their annual combined drug spending. The Departments would need some time to clinically plan and award the contracts to achieve this annual savings level. Of course, we acknowledge the variability of drug market pricing and that drug makers may have discount limits and may or may not choose to bid on such contracts. However we believe such savings are possible based on existing data.

VA and DOD officials told us that the prospects for more joint contracting are limited because their patient populations differ and their drug needs vary widely. However, our analysis showed that about 30 high-dollar drug classes now comprise about 66 percent of VA's and DOD's combined annual drug purchases.² Each of the classes includes a number of therapeutically interchangeable drugs such, that the classes could be jointly contracted. The officials also told us that DOD lacks a national formulary (a list of prescription drugs, grouped by therapeutic class, that are selected for their medical value and price).³ The lack of such a formulary limits DOD's ability to enter into and thus commit to a particular drug's usage under such contracts so that the higher discounts can be achieved. However, DOD has met its usage commitments under its 18 joint contracts with VA and 5 separate contracts and, in our view, could continue awarding such cost-effective contracts. Also, DOD recently was

² For purposes of our analysis, we used the widely recognized *AHFS Pharmacologic-Therapeutic Classification*®, which lists 204 classes of drugs and related products in its *AHFS Drug Information*® 2000 edition.

³ A common technique used by health care system purchasers to help control their prescription drug spending is to establish a formulary, which can be used to reduce the number of products the purchaser will cover and to focus their use. A formulary is a list of drugs, grouped by therapeutic class, that the purchaser prefers its physicians to prescribe for patients. Drugs are included on the formulary based on their medical value and price.

legislatively mandated to develop a national formulary and is now doing so.⁴

Regarding DOD's possible use of VA's CMOPs to reduce dispensing costs, DOD is currently exploring commercial contracts as a way to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. Our work showed that VA's CMOPs now perform most of VA's drug refill functions in a highly efficient, low-cost way. Also, based on VA information, CMOPs would likely cost DOD less than a commercial mail-service pharmacy and may save an estimated \$45 million in current dispensing costs. However, VA and DOD officials have had a number of discussions—to date, to little effect—about using the CMOPs for DOD's refill needs.

In this regard, DOD and VA officials told us that their differing missions and cultures create rivalries, making it difficult for them to work together on mutually beneficial tasks. Given the potential savings at stake through joint contracting, through DOD possibly using the CMOPs, and through other joint activities, we believe interventions by the Congress may be needed to help bring about successful agency interactions.

Scope and Methodology

My statement is based on work we did at VA and DOD from August 1999 to the present date. We interviewed VA and DOD drug contracting, benefit management, and mail pharmacy officials in Philadelphia, Pennsylvania; San Antonio, Texas; Falls Church, Virginia; Hines, Illinois; Washington, D.C.; Charleston, South Carolina; Leavenworth, Kansas; and Los Angeles, California. We obtained and reviewed relevant reports, plans, interagency agreements, and other related documents. We also interviewed academic and private-sector experts in pharmacy benefit management and formulary and mail pharmacy use.

We also analyzed VA and DOD fiscal year 1999 pharmaceutical prime vendor data on \$2.4 billion in purchases for veterans and military pharmacies.⁵ We grouped and ranked each drug by therapeutic class and

⁴ As required by the National Defense Authorization Act for Fiscal Year 2000, DOD is developing a national formulary. In a June 1998 report, we recommended that DOD establish a national formulary for its pharmacy programs. See *Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness* (GAO/HEHS-98-176, June 12, 1998).

⁵ Under VA's and DOD's prime vendor process, a wholesaler buys drugs from a variety of manufacturers and the inventory is stored in commercial warehouses. A VA or DOD pharmacy orders the drugs from the prime vendor using electronic ordering systems at prices pre-negotiated by either VA or DOD. The prime vendor ships most items to the pharmacy the next day.

the dollar-volume purchased. We engaged a consulting pharmacist and he and we, in turn, consulted with other pharmaceutical experts, to review our rankings and help identify classes with therapeutically equivalent drugs that might be competitively contracted at lower costs.⁶ Lastly, we consulted with Congressional Budget Office (CBO) analysts on our estimating methods and results.

Background

The DOD and VA health care systems collectively comprise hundreds of hospitals, clinics, and health-care facilities worldwide that provide services to more than 12 million beneficiaries. In 1999, VA spent about \$15.5 billion for veterans' health care and DOD spent \$16.2 billion for active duty and retired military, and their families. Generally, DOD and VA pharmacies allow their respective beneficiaries to obtain directly up to 90-day supplies of free prescription drugs directly or by mail.⁷

VA and DOD operate their hospital and clinic outpatient pharmacies and formularies under different rules. VA has a national formulary, supplemented by 22 regional formularies, that somewhat limits the availability of nonformulary items and fills only prescriptions written by its own providers.⁸ DOD's hospitals and its national mail pharmacy maintain their own separate formularies that restrict the drugs available to varying degrees, but also fill prescriptions written by military and private physicians.⁹ DOD also has nationwide contractors that supplement its hospital care and provide drugs at retail outlets with few restrictions on drug choice.¹⁰ Reflecting national trends, between 1995 and 1999, VA and

⁶ Dr. Peter M. Penna has had extensive professional experience in managed care pharmacy operations. Most recently Vice-president of Managed Pharmacy for Cigna HealthCare (a 6-million member managed care organization), Dr. Penna is also a founding member and past president of the Academy of Managed Care Pharmacy.

⁷ Some veterans have a \$2 copayment for each 30-day supply from VA, while some DOD beneficiaries have up to a \$8 copayment for a 90-day supply through the DOD mail program.

⁸ Currently, there are about 1,100 drugs and related items on the national formulary. Drugs not on the national formulary may be available to veterans through independent formularies maintained by VA's regional networks and some medical centers. See *VA Health Care: VA's Management of Drugs on Its National Formulary* (GAO/HEHS-00-34, Dec. 14, 1999).

⁹ DOD has a basic core formulary policy that dictates a minimum of drugs to be on all military pharmacies' formularies. Currently, there are 158 drugs and drug devices on the basic core formulary.

¹⁰ The direct care system of Army, Navy, and Air Force medical facilities is supplemented by DOD's regional TRICARE managed care support contracts, under which retail pharmacy benefits are provided to eligible military beneficiaries. TRICARE contractors offer both network and non-network retail pharmacy services; 1999 retail pharmacy expenditures were \$349 million.

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DOD drug expenditures respectively rose about 75 percent and 63 percent, while their health budgets rose 7 percent and 5 percent.

In 1999, VA and DOD purchased most of their drug supplies through their separate drug supply schedules. VA administers the federal supply schedule (FSS) for brand-name and generic drugs and has noncompetitive FSS contracts with about 250 drug manufacturers covering over 17,000 products. In effect, drug manufacturers are invited to negotiate and commit to product prices for VA and other federal purchasers during the contract period.¹¹ DOD also has its own distribution and pricing agreements (DAPA) with the same drug manufacturers. The DAPAs also establish purchase prices for certain periods based on negotiations with manufacturers. DAPA prices are generally the same as FSS prices.

In 1999, VA and DOD pharmacies also purchased some drugs through national fixed-price competitive contracts. Because these contracts are based on competitive bids for products that are therapeutically or generically equivalent to others on the market, VA and DOD can choose to purchase the drugs with the lowest prices. As a result, the agencies achieve deeper discounts than under FSS and DAPA. By mandating that the contracted drugs are preferred over competing drugs and by not listing the competing drugs on their formularies, VA and DOD can ensure greater use of the selected manufacturers' drugs in their systems and, thus, get higher discounts from suppliers.¹²

Since 1996, the Congress has acted to urge VA and DOD to cooperate in procuring and managing pharmaceuticals. A study mandated by the Veterans' Benefits Improvements Act of 1996 (P.L. 104-275) concluded that DOD and VA should combine their market power to get better

¹¹ The method VA uses to obtain FSS price discounts takes advantage of "most-favored customer" discounts drug manufacturers have negotiated in the private sector. Under procurement regulations, the FSS price should generally represent the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer. FSS prices are also affected by the Veterans Health Care Act of 1992, as amended (P.L. 102-585). The act requires drug manufacturers to sell brand-name drugs covered by the act to four agencies—VA, DOD, the Public Health Service, and the Coast Guard—at a minimum of 24 percent off the nonfederal average manufacturer price, a level referred to as the federal ceiling price. The FSS price may be higher or lower than the ceiling. If it is higher, the protected purchasers pay no more than the ceiling price.

¹² Case-by-case exceptions allow VA and DOD facilities to dispense nonformulary products according to medical necessity.

pharmaceutical prices through committed-use contracts.¹³ Further, the 1999 National Defense Authorization Act (P.L. 105-261) directed the Departments to jointly review and report on DOD's current methods for contracting for and distributing drugs, and for dispensing drugs by mail. This review is still under way with a report due 60 days after the review is completed. Most recently, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) requires VA and DOD to submit a joint report in July 2000 on how joint pharmaceutical procurement can be enhanced and cost reductions realized by fiscal year 2004.

DOD/VA Have Awarded Some National Contracts But More Contracting Could Achieve Substantial Savings

Responding to congressional pressures and to rising drug costs and demands, VA and DOD have taken steps to collaborate on drug procurement. Between October 1998 and April 2000, VA and DOD awarded 18 joint national pharmaceutical contracts—mostly for the generic drugs—amounting to about \$46 million for 1999. (See app. I). This amount is about 2 percent of the Departments' combined \$2.4 billion drug spending. On average, the discount below average wholesale price (AWP) on such drug purchases has been about 94 percent overall – and about 85 percent for the brand-name drugs for which there are no generic equivalents on the market.¹⁴ (See table 1). Agency officials told us their collaboration was prompted by a VA and DOD executive council, along with the 1999 interagency agreement.¹⁵

Also, as of January 2000, VA and DOD respectively had 46 and 5 separate national contracts that amount to \$413 million, or 17 percent of their combined drug spending. On average, the comparable discount for VA on such drug purchases has been about 82 percent off AWP, and for DOD 68

¹³ VA also currently purchases drugs for the Indian Health Service and the Federal Bureau of Prisons to support each agency's health-care mission. VA has used national committed-use contracts for this purpose, distributing the drugs to Indian Health Service and Bureau of Prison facilities through its pharmaceutical prime vendor. In 1999, these agencies purchased about \$280 million in drugs from VA's prime vendor.

¹⁴ Discounts can be expressed in different ways including as a percentage below a given benchmark, such as the AWP. The AWP for a product is an average of the list prices that drug manufacturers suggest wholesalers charge pharmacies.

¹⁵ Active since February 1998, the council coordinates health care matters and oversees a variety of national initiatives. The executive council consists of chief VA and DOD health officers, key deputies, and the surgeons general from the Air Force, Army, and Navy. In May 1998 the council chartered a Federal Pharmacy Executive Steering Committee to expand joint clinical and economic evaluations to support contracts for high-dollar and high-volume pharmaceuticals. The committee is comprised of VA and DOD chief pharmacy benefit management officials and other clinical, contracting, and financial management staff from each department.

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percent. The remaining 81 percent of DOD and VA combined drug expenditures are for drugs bought through their negotiated, noncompeted supply schedule and DAPA arrangements. On average, the discount below AWP on 33 of VA's and 37 of DOD's high dollar purchases in this category was about 58 percent.

Table 1: Average VA and DOD Joint Contract Drug Prices Versus Average Wholesale Prices, as of March 2000

Contract product (selected strength and package size)^a	Generic or brand name	VA/DOD contract price (dollars)	Average wholesale price (AWP)^b (dollars)	Percent discount off AWP
Albuterol (0.09 gm/inhaler 17 gm)	Generic	\$1.66	\$21.50	92.3
Amantadine (100 mg capsules, 100)	generic	5.50	98.19	94.4
Capoten® (captopril) (12.5 mg tabs, 100)	Branded generic	1.17	90.84	98.7
Cimetidine (300 mg tabs, 100)	Generic	3.12	84.50	96.3
Fluocinonide (0.05% 15 gm topical)	Generic	1.00	8.97	88.9
Gemfibrozil (600 mg tabs, 60)	Generic	3.53	59.55	94.1
Levobunolol ophthalmic (0.25% sol, 5 ml)	Generic	1.62	14.08	88.5
Nortriptyline (10 mg capsules, 100)	Generic	1.83	38.65	95.3
Novolin® (human insulin) (100 u/ml, 10ml)	Brand name	4.49	22.94	80.4
Prazosin (1 mg capsules, 100)	Generic	1.90	26.90	92.9
Ranitidine (150 mg tab, 500)	Generic	13.57	740.00	98.2
Salsalate (500 mg tab, 500)	Generic	11.70	99.50	88.2
Tiazac® (diltiazem) (240 mg capsules, 100)	Branded generic	27.00	158.48	83.0
Timoptic® (timolol ophthalmic solution) (10 ml)	Brand name	1.94	27.07	92.8
Timoptic-XE® (timolol ophthalmic gel) (5 ml)	Brand name	5.04	25.19	80.0
Trimox® (amoxicillin) (250 mg capsules, 100)	Branded generic	2.65	23.89	88.9
Verapamil (120 mg tab, 100)	Generic	12.99	86.21	84.9
Average discount				94.4

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^aDoes not include the joint contract for Habitrol® (nicotine patches), awarded April 2000.

^bFor contracted generics, we compared VA/DOD contract prices with the AWP's listed for those companies' generic products and their dosages and package sizes.

Sources: AWP from Red Book: Pharmacy's Fundamental Reference March 2000 Update, (Medical Economics Company, Inc., Montvale, NJ) and GAO analysis.

**Additional Use of Joint
National Contracting
Could Save Millions of
Dollars**

If DOD and VA could purchase many more of their pharmaceuticals through national, committed-use contracts—particularly joint contracts—we estimate they could save substantial sums each year. Our savings projections take into account the discounts VA and DOD have received on their current national committed-use contracts.

To project the possible savings, we began by ranking DOD's and VA's drug classes by combined dollar volume purchased. Our consultant identified 30 top-ranking classes that included one or more groups of therapeutically equivalent drugs in each class and thus could be good candidates for competitive, national contracting. The 30 classes represent about 66 percent or \$1.6 billion of DOD and VA combined 1999 drug expenditures. However, some of the 30 classes would be easier to plan and contract for and have potentially greater savings than others. Therefore, we divided the 30 drug classes into 3 tiers, based largely on the expected level of difficulty the agencies would have garnering clinical agreement on encouraging the committed use of one or more drugs within the classes. (See app. II).

Also, among as many as 30 classes, the question becomes advisedly, which should the agencies focus on first, next, and so forth. Thus, the tiers represent the priority order in which we suggest DOD and VA perform clinical reviews and pursue further joint contracts. The first tier are classes we judged to be highly susceptible to competitive contracting, because the competing drugs are widely held to be therapeutically equivalent and providers and patients would more likely accept one or two drug choices per class. Examples are the non-sedating antihistamines Claritin® versus Allegra® and the angiotensin converting enzyme (ACE) inhibitors Prinivil®, Zestril®, Monopril®, Accupril®, and Vasotec®. The second tier are classes whose drugs' therapeutic equivalency is less widely accepted, or whose high demand drugs are new and the older substitute drugs are less preferred by physicians and patients. This tier of drug classes may require VA and DOD to do much more clinical study to support joint contracting because the choices would be tougher. Second-tier examples include the anti-migraines Amerge®, Imitrex®, and Zomig® and such antidepressants as Celexa®, Paxil®, Prozac®, and Zoloft®. The third tier are classes whose drugs' equivalencies are more controversial, and thus providers and patients would likely be more resistant if their

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pharmaceutical choice was restricted to just one or a few drugs in these classes. Examples include the cephalosporins (anti-infectives) Cipro®, Floxin®, Levaquin®, and Tequin®; and the anxiety and sleep disorder (benzodiazepine) agents Ambien®, Buspar®, and Sonata®.

Further, our consultant identified a fourth group of high-dollar drug classes that are the least susceptible now among the classes we identified to competitive contracting. Nonetheless, given the rapid and continuing introduction of new drugs on the market and the steady rise in drug costs, we believe this group of drug classes should be closely monitored for future joint contracting opportunities. The group includes six classes whose drugs' therapeutic equivalencies are not now generally accepted. Also, at this time serious and complex clinical issues exist regarding patient outcomes and safety such that contracting for just one or a few drugs in the classes is not now clinically feasible. One group example is the anticonvulsants Depakote®, Dilantin®, Klonopin®, etc. We excluded this fourth group from our savings projections.

As discussed, DOD and VA will face varying levels of difficulty in attempting to clinically justify and contract for the 30 classes of drugs. In addition to the degree of competition among drugs in a class, manufacturers' pricing strategies can also play a significant role in the discounts they are willing to offer the government. Nevertheless, we hypothesized that if the agencies could achieve one-quarter of the savings rate achieved by moving from the FSS to contracts, they would save about \$150 million or 6 percent of their combined expenditures annually. If they could save 50 percent of that average savings, they would save about \$300 million or 12 percent of such expenditures. (See table 2.) While some savings would begin to accrue during the first year of this effort, maximum savings would not be fully realized for several years because DOD and VA will need time to clinically plan and award joint contracts for drug classes in the tiers we have suggested.

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Table 2: GAO’s Estimate of Potential Savings from Expanded Joint Contracting

(Dollars in millions)

Agency	1999 purchases	Purchases in 30 high-dollar classes	Noncontracted purchases in 30 high-dollar classes	Estimated savings–joint contracts ^a
VA	\$1,531.5	\$996.7	\$617.0	\$91-\$183
DOD	\$869.5	\$590.7	\$418.7	\$56-\$112
Totals	\$2,401.0	\$1,587.4	\$1,035.7	\$147-\$295

^aSavings possible if agencies can achieve from one-quarter to one-half of the savings rate achieved by moving from FSS to contracts.

Source: GAO analysis.

Again it is important to emphasize that the amount of savings is difficult to predict. We know that drug market pricing is highly variable and that drug makers may have discount limits and can choose to bid or not on competed contracts. Current DOD and VA joint contracts are mostly on generic drugs and thus do not cover their highest-dollar or highest-volume drugs. Because those contracts may have been easier to award than would those for the classes we have identified, the savings rates may be less with future contracts. In addition, certain offsetting costs may occur, such as the administrative costs to handle increased requests to approve the use of drugs other than those jointly contracted for. Nevertheless these estimates suggest that significant savings are likely with even modest increases in discounts.

Moreover, others have estimated significant savings should the Departments leverage their buying power. In 1999, a commission established by the Congress reported among other things on its review of the merits of VA and DOD jointly buying drugs and other medical supplies.¹⁶ The commission estimated the agencies could save \$1.9 billion cumulatively over five years, or about \$383 million per year, but did not separately estimate savings due to joint pharmaceutical purchases. Since then, DOD and VA have had more experience awarding joint and separate

¹⁶ In January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance issued a report and made numerous recommendations to improve the effectiveness of programs providing benefits and services to active duty military personnel and veterans.

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contracts. Also, in a March 2000 report, the CBO estimated that the agencies could save millions of dollars by further collaborating on their drug pricing. CBO also reported that a major impediment to their jointly buying drugs was their differing formularies.¹⁷

VA and DOD officials generally agree that the best prices are available through joint national contracts and that they have already made much progress with the current joint contracts. They told us the prospects for future joint contracts are limited because DOD lacks a comprehensive national formulary. This limits DOD's ability to enter into and thus commit to a particular drug's usage under such contracts. We agree this is a serious limitation and in 1999, DOD was legislatively mandated to establish a national formulary and is now in the process of doing so.

Moreover, DOD fully meets its drug usage commitments by mandating that the drugs used in its hospital and national mail pharmacies be the ones contracted for under the existing 18 joint contracts with VA and the 5 separate national contracts. Thus, we believe DOD should continue awarding such cost-effective contracts. In our view, the prospects of greater joint contracting with VA may help both agencies in refining their formularies toward greater uniformity across the systems. This way, patients with similar drug needs could be treated consistently and far greater savings could be achieved than are now possible. Admittedly, both agencies need to make more progress before this becomes a reality.

DOD and VA officials also told us their client populations differ significantly and have different drug needs—from women and children beneficiaries in DOD facilities to elderly veterans in VA facilities. We found, however, that 8 of the top 10 high-dollar drug classes in each department are the same. (See table 3). Further, retirees continue to increase as a percentage of DOD's client load, creating drug demands increasingly similar to VA's. And, 30 drug classes now consume about 66 percent of VA's and DOD's combined annual drug purchases—the high-dollar classes we are nominating for clinical reviews and joint contracting opportunities.

¹⁷*Budget Options for National Defense*, Congressional Budget Office (March 2000).

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Table 3: Matching VA and DOD Top-Ten Drug Classes in 1999

Drug class	VA ranking	DOD VA purchases ^a ranking	DOD Purchases ^a	Total VA/DOD purchases ^a
Antivirals ^b	6	9	\$72.7	\$92.7
Anticancer drugs ^c	10	10	38.7	55.7
Calcium channel blockers	5	4	80.2	120.3
ACE inhibitors	9	7	39.2	69.8
Antilipemics	2	1	117.5	195.7
Antidepressants	3	3	110.5	158.3
Miscellaneous gastrointestinal agents	1	2	120.2	197.9
Antidiabetics—oral hypoglycemics	8	8	46.3	74.1
Totals			\$625.3	\$964.5

^aIn millions of dollars.

^bExcludes herpes drugs.

^cExcludes prostate cancer drugs.

Source: GAO analysis of VA and DOD information.

The geographic separation of the key DOD and VA pharmacy policy and procurement staff is a complicating factor affecting joint contracting, according to DOD and VA officials. DOD’s Pharmacoeconomic Center is in San Antonio, Texas, and its procurement staff are in Philadelphia, Pennsylvania. VA’s counterpart clinical and procurement groups are in Chicago, Illinois. Officials told us this seriously hampers communication and working relationships among the groups. We tend to agree; the organizations were created for separate organizational functions and not the joint drug contracting that we believe they need to diligently pursue in the future.

DOD Should Consider Using VA’s Mail-Out Centers to Reduce Dispensing Costs for Refills

My second topic also illustrates how DOD and VA might collaborate to achieve dispensing efficiencies in their pharmacy programs. DOD is currently considering contracting with a private vendor to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. One reason DOD is considering this is to free military hospital pharmacists from the labor-intensive task of dispensing prescriptions so they can work with patients and medical staff toward safer, more effective drug use. Another reason is that DOD wants to

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replace its current Merck-Medco contract with one that also covers retail pharmacy services. In 1999, Merck-Medco filled and mailed about 1.3 million prescriptions and provided other services.¹⁸ In 1999, DOD beneficiaries obtained 50 million prescriptions by visiting military pharmacies. An estimated 45 percent of such prescriptions were refills. In fiscal year 1997, military pharmacies' dispensing costs, on average, were about \$5.55 per prescription.¹⁹ According to DOD officials, refill dispensing costs are lower than the first-fill dispensing costs because screening for eligibility and drug interactions need not be repeated.²⁰

In February 2000, DOD officials solicited comments from pharmacy benefit management companies on whether they could dispense and mail refills for prescriptions first filled at military pharmacies.²¹ Cost proposals were not solicited. The workload was estimated to be about 23 million prescriptions annually. As of April 2000, DOD officials were reviewing the comments received. Earlier, VA's CMOP and DOD officials had a number of discussions about using CMOPs to meet DOD's refill needs. However, DOD has not followed through on the idea.

VA estimates that its CMOPs have saved millions of dollars in dispensing costs.²² VA officials provided documentation supporting that 1999 CMOP

¹⁸ DOD pays Merck-Medco a dispensing fee of \$9.85 for each prescription dispensed, but does not have to pay Merck-Medco for the cost of the drugs (drugs for this program are supplied to Merck-Medco by the Defense Supply Center Philadelphia through a prime vendor). The contract requires extensive services, such as receiving paper prescriptions through the mail from beneficiaries, verifying eligibility, and clinical drug utilization reviews in addition to dispensing and mailing the prescription.

¹⁹ Dispensing costs do not include the actual cost of the drug, but rather pharmacy personnel salaries, utilities, housekeeping, furniture, and other equipment.

²⁰ According to one estimate, refill costs are about 40 percent less than first-fill costs.

²¹ In the private sector, pharmacy benefit managers (PBMs) administer prescription drug coverage on behalf of health plan sponsors. PBMs provide their customers with services such as formulary development and management, retail pharmacy networks and mail service, claims processing, and drug utilization review.

DOD asked the industry to submit comments on processing MTF refill requests that would be transmitted electronically to a contractor's mail service facility. The military pharmacy would have already screened for beneficiary eligibility and clinical drug utilization review before the contractor would receive any prescription. The contractor would not be responsible for performing those tasks, but only for processing the refill (correct drug, patient, and address) and mailing the prescription to the beneficiary.

²² Since 1994, VA has established seven CMOPs and expects to fill 50 million, or about 60 percent, of VA prescriptions in fiscal 2000. While veterans can still elect to refill their prescriptions in person at VA pharmacies, in 1999, 52 percent—or 40 million veterans' prescriptions—were electronically sent from VA pharmacies to the CMOPs for refills, which were mailed to the veterans.

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refills cost VA pharmacies \$1.87 per prescription to dispense, on average, including \$0.78, on average, for mailing costs. Because of the CMOPs' growing workload, VA expects the dispensing costs to drop to \$1.71 per prescription this year.²³ CMOPs' low refill cost is largely due to its use of automated technologies that enable each full-time employee to dispense 100,000 prescriptions annually compared to about 15,000 prescriptions per year dispensed by VA's pharmacy employees. By 2005, VA plans to finish expanding the seven existing CMOPs and is also considering building another. That way, about 75 percent or about 90 to 100 million VA prescriptions could be filled by CMOPs.

**DOD's Concerns About
CMOPs Seem Resolvable**

DOD officials told us they are concerned whether the CMOPs could expand production to handle about an added 23 million military pharmacy refill prescriptions and whether VA would charge military pharmacies the same low rates. DOD officials questioned the difficulties and costs faced in making military pharmacy computer systems compatible with CMOPs' computer systems. DOD officials told us that the ability to accurately and timely transfer millions of DOD refill prescriptions electronically to CMOPs would be critical to such a system. Finally, DOD officials told us that shifting military pharmacy prescription workload to VA CMOPs would undercut medical readiness by reducing their prime vendor sales market.²⁴ However, the same concerns would be raised if a private contractor was engaged for this task. Also, DOD's prime vendors could supply drugs to the CMOPs as they now do to Merck-Medco.

VA officials told us they are aware of DOD's concerns and believe each can be satisfactorily resolved. VA officials told us that, if need be, they could expand CMOP production to accommodate about an added 23 million military pharmacy prescriptions. As mentioned above, VA already plans to double CMOP capacity at eight facilities by 2005 to dispense up to 100 million VA prescriptions per year. They pointed out that between 1996 and 2000, the CMOPs will have increased their prescription processing by 30 percent per year. VA officials told us they had discussed with DOD pilot testing the use of the Charleston, South Carolina, CMOP with the nearby

²³ In addition to drug costs, CMOPs generally charge the VA pharmacies current operating costs, not fixed facility costs such as building and equipping the automated CMOP facility. In fiscal year 2000, VA estimates total CMOP operating costs to be \$85 million (\$35 million (mail); \$33 million (salaries); and \$17 million (utilities, lease, pharmacy and office supplies, etc.).

²⁴ The Defense Supply Center Philadelphia's operations are funded by surcharges on its prime vendor sales to military pharmacies. The revenue is also used to fund DOD-wide medical materiel planning and readiness to respond worldwide military deployments and related missions.

Navy pharmacy at Camp Lejeune, North Carolina. They said the pilot would enable both parties to assess any computer system concerns and provide a basis to estimate the costs and benefits of such a permanent arrangement. However, DOD has not yet pursued the idea.

CMOPs appear to be a cost-competitive option for DOD to meet its military prescription refills-by-mail requirements. Also, their use by DOD would be compatible with legislation to promote more cost effective use of DOD and VA medical resources and the more efficient delivery of care.²⁵ Specifically the legislation authorizes VA and DOD medical facilities to become partners and enter into sharing agreements to buy, sell, and barter medical and support services. Based on data provided by VA moreover, we estimate that CMOPs would likely charge military pharmacies, on average, about \$2.10 per prescription.²⁶ This would cut the average military pharmacy refill dispensing costs almost in half, resulting in annual cost savings of about \$45 million. To provide enough capacity for DOD's added 23 million prescriptions, VA would have to build or lease and equip the equivalent of two new CMOPs. We asked several commercial mail service pharmacies what dispensing fee they might charge military pharmacies to handle 23 million military refill prescriptions. The companies told us they likely would charge between \$5 and \$20 per prescription. Thus, in addition to considering commercial contractors, we believe DOD should give serious consideration to using VA CMOPs to handle their hospital pharmacies refills-by-mail workloads.

DOD and VA Rivalries May Necessitate Interventions to Facilitate Joint Actions

DOD and VA officials told us that their differing missions and cultures have created rivalries that make it difficult for them to act together on mutually beneficial tasks. We believe, however, ways can and must be found to bring about successful agency relationships where one organization seeks to help the other and both benefit.

To illustrate the difficulties, last year's interagency agreement provided that the departments would work together, although without a deadline, to cancel DOD's DAPAs with drug companies by converting them to VA's equal or lower FSS prices. As discussed above, VA and DOD have differing

²⁵The VA and DOD Health Resources Sharing and Emergency Operations Act (Sharing Act) (P.L. 97-174, 96 Stat. 70). See *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies* (GAO/HEHS-00-52, May 17, 2000).

²⁶This would include an estimated \$1.71 (salaries, mail, utilities, and other operating costs), \$0.20 (other VA overhead costs), and \$0.17 (building and equipment depreciation).

price arrangements with many of the same companies. By converting the DAPAs, some small economies would follow and both agencies would pay the same FSS prices to drug makers. As of April, however, only about 43 of the 248 extant DAPAs have been converted. Moreover, serious disagreements between the agencies' procurement groups have soured relations and the process may be in jeopardy. In short, the conversion exercise may have raised the agencies' apparent antagonism toward one another to an even greater level.

Given the potential savings from joint contracting and possibly from DOD using the CMOPs, we believe the Congress may need to intervene to help bring about successful agency interactions. Such actions could include assigning the agencies a deadline to complete clinical reviews and joint contracting on the selected high-dollar drug classes. Another might be to establish an independent board to review VA's and DOD's progress toward these objectives. We plan in our final report to more fully address such possible courses of action.

Conclusions

Nationally, prescription drug spending is increasing by about 12 percent per year—twice as fast as the general health care spending rate. However, large pharmaceutical users can realize huge price discounts by contracting with drug makers to use therapeutically acceptable drug brands within their health systems.

VA and DOD are the largest direct federal drug purchasers, though their combined purchases are less than 2 percent of total domestic drug sales. The Departments already enjoy varying, though significant, discounts on their drug purchases. Their largest discounts have occurred when they contracted jointly to purchase the same drugs for their systems and through their separate national contracts with drug makers. However, the joint and separate contracting has been limited. Only about 19 percent of DOD and VA combined drug purchases are made through such contracts. Most of their drug purchases are made at far smaller discounts. If the agencies could jointly contract for most of 30 drug classes that now make up about 66 percent of their combined drug purchases, we estimate they could save hundreds of millions of dollars annually.

There are obstacles to overcome before joint contracting and other joint activities can be routinely and vigorously pursued, including DOD's need to develop a national drug formulary. In the interim, DOD can build upon its successful performance under its current national contracts and continue seeking to award such contracts. In addition, the Departments need to mitigate their institutional competitiveness and steadfastly pursue

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such joint actions as drug contracting. For example, DOD is considering commercially contracting for its hospital pharmacies refills-by-mail workloads, even though VA has available a highly efficient system that could meet DOD's needs and achieve savings in the process. Our concern is that agency rivalries could keep DOD from also seriously considering, as it is commercial vendors, the use of VA's CMOPs to handle its prescription drug refill needs.

In the end, interventions may be needed to facilitate effective agency interactions on these issues. Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions you or other Subcommittee members may have.

**GAO Contacts and
Acknowledgments**

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Appendix I

Joint VA and DOD National Pharmaceutical Contracts as of April 2000

Product	Class (use)	Manufacturer	Award date	Contracting agency
Anti-infective agents				
Trimox® (amoxicillin)	Penicillins (antibiotic)	Apothecon	July 6, 1999	VA
Amantadine	Antivirals (influenza)	Invamed, Inc.	August 8, 1999	VA
Autonomic drugs				
Albuterol inhaler	Inhaled bronchodilators (asthma)	Warrick Pharmaceuticals	October 2, 1998	DOD
Habitrol® (nicotine patch)	Miscellaneous autonomic (smoking cessation)	Novartis	April 20, 2000	DOD
Cardiovascular drugs				
Tiazac® (diltiazem)	Calcium channel blockers (high blood pressure)	Forrest Labs	November 12, 1998	VA
Verapamil	Calcium channel blockers (high blood pressure)	Zenith/Goldline	December 1, 1999	VA
Capoten® (captopril)	ACE inhibitors (high blood pressure)	Bristol-Myers Squibb, Apothecon	September 1, 1999	VA
Gemfibrozil	Antilipemics (cholesterol reducer)	Warner Chilcott	December 8, 1999	VA
Prazosin	Hypotensive agents (high blood pressure)	Zenith/Goldline	October 7, 1999	VA
Central nervous system agents				
Salsalate	Nonsteroidal anti-inflammatory agents (arthritis)	Able	February 1, 2000	VA
Nortriptyline	Antidepressants	Teva Pharmaceuticals	August 31, 1999	VA
Eye, ear, nose, and throat (EENT) preparations				
Timoptic® (timolol ophthalmic solution)	Miscellaneous EENT (antiglaucoma)	Alcon Laboratories	November 26, 1999	VA
Timoptic-XE® (timolol ophthalmic gel)	Miscellaneous EENT (anti-glaucoma)	Merck & Co.	November 26, 1999	VA
Levobunolol	Miscellaneous EENT (antiglaucoma)	Bausch & Lomb	November 26, 1999	VA

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Contracts as of April 2000**

Product	Class (use)	Manufacturer	Award date	Contracting agency
Gastrointestinal agents				
Cimetidine	Miscellaneous (H2 receptor antagonists) (ulcers, esophageal reflux)	Sidmak Labs	October 2, 1998	VA
Ranitidine	Miscellaneous (H2 receptor antagonists) (ulcers, esophageal reflux)	Geneva Pharmaceuticals	October 2, 1998	VA
Hormones and synthetic substitutes				
Novolin® (human insulin)	Antidiabetic agents (insulin)	Novo Nordisk Pharmaceuticals	October 1, 1999	DOD
Skin and mucous membrane agents				
Fluocinonide	Anti-inflammatory agents (topical corticosteroid)	Teva Pharmaceuticals	August 3, 1999	VA

Sources: VA and DOD.

Proposed High-Dollar Drug Classes for Joint VA–DOD National Contracting

The table below lists the high-dollar classes that could be candidates for VA and DOD joint drug class reviews and committed-use contracting. Based on the judgments of our consultant and other private sector pharmacists, the drugs in the different classes have varying degrees of clinical acceptance on therapeutic interchangeability and different priorities with respect to additional VA and DOD joint contracting.

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Antihistamine drugs (\$48.0)^a				
Antihistamines (particularly nonsedating)	Allegra® Claritin®	\$48.0	First	VA–promethazine
Anti-infective agents (\$223.5)^a				
Antifungals (particularly agents used for fungal infections of the toenails)	Lamisil® Sporonox®	\$29.4	First	FSS or DAPA prices only
Cephalosporins (particularly oral)	Ceftin® Cefzil® Cedax® Lorabid® Omnicef® Suprax®	\$18.7	Second	VA–Zolicef® Injection VA–cephalexin VA–ceftazidime
Penicillins	Augmentin® Unasyn® Zosyn®	\$28.7	Third	VA–Penicillin V-K® VA–dicloxacillin Joint–Trimox®
Macrolides (particularly newer, potent agents)	Biaxin® Zithromax®	\$19.9	Second	FSS or DAPA prices only
Quinolones	Avelox® Cipro® Floxin® Levaquin® Tequin®	\$29.5	Third	FSS or DAPA prices only
Antivirals (herpes virus) (Particularly generics or generic prices on Valtrex®, branded generic of acyclovir)	Valtrex® Zovirax®	\$4.7	Second	Joint contract pending–acyclovir
Antivirals (AIDS virus)	Combivir® Crixivan® Epivir® Sustiva® Viracept®	\$92.7	Closely monitor	FSS or DAPA prices only
Antineoplastic (cancer) agents (\$88.2)^a				
Antineoplastics (prostate cancer)	Lupron® Zoladex®	\$32.5	Third	VA–Zoladex®

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VA-DOD National Contracting**

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Antineoplastics (other cancers) (particularly Casodex® versus Eulexin®; as the science of antineoplastics changes, new contracting opportunities may arise)	Casodex® Eulexin® Nolvadex® Tamoxifen® Taxol®	\$55.7	Closely monitor	FSS or DAPA prices only
Autonomic (regulates autonomous nervous system) drugs (\$87.3)^a				
Antiparkinson drugs	Mirapex® Requip®	\$14.4	Closely monitor	VA-Trihexidyl-2® VA-benzotropine mesylate VA-carbidopa/ Levodopa
Antimuscarinics (inhaled drugs for asthma and related diseases) (particularly generic versions of Atrovent®)	Atrovent® Combivent®	\$38.4	Third	FSS or DAPA prices only
Sympathomimetic adrenergic agents (beta agonist inhalers used to treat acute asthma)	Proventil® Ventolin® Xopenex®	\$34.4	First	Joint-albuterol inhaler
Blood formation and coagulation (\$99.2)^a				
Anticoagulants (to prevent clotting) (particularly generic warfarin (Coumadin®) and also heparin/low molecular weight heparins)	Coumadin® Plavix® Lovenox® (heparin)	\$50.5	Second	FSS or DAPA prices only
Hematopoetic agents (blood building for AIDS, chemotherapy, kidney dialysis)	Epogen® Procrit®	\$48.7	Second	FSS or DAPA prices only
Cardiovascular drugs (\$421.7)^a				
Antiarrhythmics	Cardarone® Pacerone® Rhythmol®	\$15.4	Closely monitor	Joint contract pending – amiodarone
ACE Inhibitors and ACE IIs (to treat high blood pressure)	Accupril® Lotensin® Monopril® Prinivil® Vasotec® Zestril® Atacand® Avapro® Cozaar® Diovan® Hyzaar® Micardis®	\$69.8	First	Joint-Capoten® VA-Monopril® VA-Prinivil® DOD-Zestril®
Beta blockers (to treat high blood pressure, migraines, arrhythmias, etc.) (particularly widely available generics)	Coreg® Normodyne®	\$20.4	Second	VA-atenolol VA-metoprolol VA-pindolol

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VA-DOD National Contracting**

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Calcium channel blockers (to treat high blood pressure)	Cardene® Dilacor® Norvasc® Plendil® Tiazac® (diltiazem) Adalat CC® Procardia-XL®	\$120.3	First	Joint-Tiazac® Joint-verapamil VA-Adalat CC® VA-diltiazem VA-nifedipine
Antilipemic drugs (to lower cholesterol) (particularly Hmg-CoA reductase inhibitors)	Baycol® Lescol® Lipitor® Mevacor® Pravachol® Zocor®	\$195.7	First	DOD-Baycol DOD-Zocor VA-Mevacor VA-Zocor
Central nervous system agents (\$447.5)^a				
Nonsteroidal anti-inflammatory agents (NSAIDs) (used to treat arthritis, relieve pain) (particularly newer COXII agents and continue joint contracting on older NSAIDs)	Celebrex® Vioxx®	\$33.1	Second	Joint-salsalate Joint contract pending-tolmetin Joint contract pending-aproxen VA-ibuprofen VA-indomethacin VA-naproxen VA-sulindac
Opiate agonists (painkillers)	Duragesic® Oxycontin®	\$33.2	Third	FSS or DAPA prices only
Anticonvulsants (used to treat a variety of convulsive disorders, such as epilepsy, also pain, migraine, and attention deficit disorder)	Depakote® Dilantin® Klonopin® Lamictal® Neurontin® Progestamate®	\$72.6	Closely monitor	FSS or DAPA prices only
Antidepressants (particularly selective serotonin reuptake inhibitors and continue joint contracting on generics)	Celexa® Effexor® Luvox® Paxil® Prozac® Remeron® Zoloft®	\$158.3	Second	Joint-nortriptyline VA-amitriptyline VA-amitriptyline/ Perphenazine VA-amoxapine VA-desipramine VA-imipramine VA-trazadone
Antipsychotic agents (used to treat schizophrenia and other psychiatric disorders)	Risperdal® Seroquel® Zyprexa®	\$97.7	Third	VA-chlorpromazine VA-haloperidol VA-fluphenazine VA-perphenazine VA-thiothexine VA-trifluoperazine
Benzodiazepines (sedative and other anti-anxiety agents)	Ambien® BuSpar® Xanax®	\$37.3	Third	VA-Serax®
Migraine drugs (particularly the generally newer migraine agents)	Amerge® Imitrex® Maxalt® Zomig®	\$15.3	Second	FSS or DAPA prices only

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Diagnostic agents (\$40.2)^a				
Diabetes (used to test blood glucose levels)	Accu-Chek® Advantage® One Touch® Precision Q-I-D®	\$40.2	Second	FSS or DAPA prices only
Gastrointestinal (GI) drugs (\$197.9)^a				
Miscellaneous GI drugs (for ulcers, esophageal reflux) (particularly proton pump inhibitors and continue joint contracting of generic H2 receptor antagonists)	Aciphex® Prilosec® Prevacid® Protonix®	\$197.9	First	Joint-cimetidine Joint-ranitidine VA-Prevacid® VA-metoclopramide DOD-Prilosec®
Hormones and synthetic substitutes (\$142.1)^a				
Bronchial steroids (for asthma)	AeroBid® Azmecort® Beclovent® Flovent® Pulmicort® Vanceril®	\$19.8	First	FSS or DAPA prices only
Nasal steroids (for allergies, sinus congestion)	Beconase® Flonase® Nasacort® Nasonex® Vancenase®	\$16.0	Second	VA-Vancenase®
Oral contraceptives (birth control)	Desogen® Lo-Ovral® Ortho-Cept® Ortho-Cyclen® Ortho-Novum® Norinyl®	\$16.2	Second	FSS or DAPA prices only
Estrogens (osteoporosis prevention, menopause symptoms) (particularly patches and oral agents)	Climara® Vivelle® EstraTab® Premarin® Prempro®	\$16.0	Third	Joint contract pending
Antidiabetic agents (particularly newer agents for non-insulin dependent diabetes in the fast evolving "glitazones" market)	Actos® Avandia®	\$74.1	First	VA-glyburide
Serums, toxoids, vaccines (\$42.6)^a				
Vaccines (Several companies make the bulk of these products, with significant overlap. Several such products could be consolidated for contracting purposes.)	Diphtheria/ pertussis/ tetanus Hemophilus B Hepatitis A Hepatitis B Influenza Measles/mumps/ Rubella Pneumococcal Tetanus Varicella	\$42.6	3 rd	DOD-Vaqtac® (for hepatitis A)

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Unclassified therapeutic agents (\$28.5)^a			
Immunosuppressives (antirejection drugs used for transplant patients)	Cellcept® Prograf® Neoral® Sandimmune®	\$28.5	Closely monitor FSS or DAPA prices only

^a All dollars in millions.

Source: GAO analysis of VA and DOD information.

After performing drug class reviews to determine that some brand-name drugs in a class are therapeutically interchangeable, VA can use its national formulary and DOD its basic core formulary policies to encourage use of the drugs. This enables them to obtain better prices for the drugs through competitive bidding aimed at closing—or partially closing—a class to contracted drugs only. The closed class—or its particular segment that is partially closed—usually contains brand name drugs that have a high volume of use or are high cost. To close a class, VA and DOD evaluate the clinical evidence to determine whether a class’ brand-name drugs are basically equivalent in terms of efficacy, safety, and outcomes and thus generally have the same therapeutic effect. Once VA and DOD decide to close a class, the drugs determined to be therapeutically interchangeable are referred for contracting purposes to either the National Acquisition Center or the Defense Supply Center Philadelphia. Also, VA and DOD may solicit separate national committed-use contracts to get lower prices on generic drugs, but in those cases drug class reviews are not needed since the competing products are chemically and therapeutically alike.

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