



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

February 25, 2009

Honorable Kent Conrad
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In response to your request, the Congressional Budget Office (CBO) has studied the Pharmaceutical Prime Vendor program, which the Department of Veterans Affairs (VA) uses to purchase prescription drugs. As you noted in your request, VA currently uses a single vendor, whereas the Department of Defense (DoD) contracts with multiple vendors to purchase drug products dispensed at military treatment facilities and through the TRICARE Mail Order Pharmacy program.

The discount that VA has negotiated with its single vendor is comparable with the corresponding discounts that DoD has negotiated with its three national vendors. Thus, CBO finds that requiring VA to award contracts to multiple vendors would be unlikely to result in substantial cost savings in VA's drug purchases.

We would be pleased to answer any further questions that you may have. The staff contact is Elizabeth Bass, who can be reached at (202) 226-2925.

Sincerely,

A handwritten signature in cursive script that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf

Enclosure

cc: Honorable Judd Gregg
Ranking Member
Senate Committee on the Budget

Honorable Kent Conrad

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Honorable John M. Spratt, Jr.
Chairman
House Committee on the Budget

Honorable Paul Ryan
Ranking Member
House Committee on the Budget

Honorable Daniel K. Akaka
Chairman
Senate Committee on Veterans' Affairs

Honorable Richard Burr
Ranking Member
Senate Committee on Veterans' Affairs

Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs

Honorable Steve Buyer
Ranking Member
House Committee on Veterans' Affairs

The Department of Veterans Affairs' Pharmaceutical Prime Vendor Program

February 25, 2009

Summary

The Department of Veterans Affairs (VA) purchases prescription drugs and outpatient medical supplies through its Pharmaceutical Prime Vendor (PPV) program. The current contract for that program is held by a single vendor. Policymakers have asked whether cost savings or efficiencies might be gained by having contracts with more than one vendor.

To answer that question, the Congressional Budget Office (CBO) examined VA's current and past PPV contracts and contacted VA officials who administer the current contract. In addition, CBO compared VA's PPV contract with similar contracts the Department of Defense (DoD) uses to purchase drug products dispensed at military treatment facilities and through the TRICARE Mail Order Pharmacy program. (TRICARE is DoD's health care program for active-duty service members, Selected Reserve members, military retirees, and their families and certain other beneficiaries.)

The main difference between the two departments' programs is that VA has one vendor for the entire nation whereas DoD has three vendors serving different parts of the country. VA's use of a single vendor may give the impression that VA operates its PPV program under sole-source (noncompetitive) procurement. However, VA's vendor was selected through competitive bidding; awarding the entire contract to one vendor was a possible, but not a preordained, outcome of that competition. VA has not stated whether its single vendor offered the best rate in each of VA's 14 distribution regions; however, VA determined that the vendor's nationwide offer provided the best value overall.

Total spending on pharmaceuticals by VA and DoD differs because of myriad factors, including the composition of the plans' formulary (the list of drugs the plan will pay for), eligibility criteria for benefits, and age and other characteristics of the populations covered by the plans. Pricing for identical drugs, however, is similar because VA negotiates ceiling prices with manufacturers on behalf of all federal purchasers. Vendors play no role in negotiations between the federal government and manufacturers and can influence the drug prices paid by federal customers only by charging distribution, or delivery, fees. Although VA and DoD contract separately with vendors, both departments have negotiated "negative delivery fees," which are, in effect, discounts based on a percentage of costs for ordered drugs. Under that arrangement, vendors pay VA and DoD for the opportunity to deliver drugs to government facilities, earning profits by charging overhead fees to manufacturers or by collecting interest during the time between receiving funds from retailers and paying them to manufacturers.

Requiring VA to contract with multiple vendors would be unlikely to result in further savings on its drug purchases, CBO estimates. The discount embodied in the delivery fee charged by VA's single vendor is comparable with, and in some cases more favorable than, corresponding discounts given by DoD's three vendors. VA's award to one vendor resulted in a single national discount that is currently set at 5.15 percent. By contrast, DoD's discounts differ by vendor, region, and contract year (see Table 1). As of January 2009, discounts for distributing drugs ranged from 4.5 percent for the West region to 5.13 percent for the North and South regions. Although larger discounts are scheduled to take effect for the North and South regions when contracts there are renewed, discounts for DoD's West region and for the TRICARE Mail Order Pharmacy will not be as large as VA's.

The remainder of this report provides an overview of the pharmaceutical distribution industry and additional information on the departments' PPV programs.

Overview of the Pharmaceutical Distribution Industry

The pharmaceutical industry in the United States has a complex supply chain. Drug manufacturers are at one end of the chain, and at the other end are organizations, such as hospitals and retail pharmacies, that dispense drugs to consumers. Drug manufacturers do not always deliver drugs directly; approximately 60 percent of brand-name drugs are distributed through vendors (also called suppliers, distributors, or wholesalers) that deliver the drugs to hospitals and retail outlets, where customers receive them. Vendors not only handle the physical logistics of moving supplies but also offer customer service, inventory control, repackaging, and education for patients. The pharmaceutical industry generated revenues of approximately \$285 billion in 2007. Despite significant sales, vendors' net profit margins are small (1.5 percent to 4.0 percent) relative to those of drug manufacturers (20 percent), in part because manufacturers hold patents on brand-name drugs.

The low profit margins of vendors have caused consolidation within the industry since the 1980s; three companies now control over 80 percent of the market. In 2007, McKesson Corporation had the largest total revenues, followed by Cardinal Health and AmerisourceBergen. Each firm has federal contracts and operates dozens of distribution centers throughout the United States. Operating numerous distribution centers minimizes the risk that the supply chain will be interrupted in the event of a natural disaster or some other disruption. In some cases, retailers guard against uncertainties by contracting with a primary vendor and a second vendor as backup.

Vendors' profits accrue through several mechanisms. Until about five years ago, most vendors followed a **buy-and-hold model** in which they purchased a large supply from manufacturers, stored the inventory in warehouses, and waited for prices to appreciate before reselling to retailers. Eventually, an increasing number of retailers and third-party payers (such as pharmacy benefit management organizations representing health

Table 1.**Percentage Discounts Given to VA and DoD by Current Pharmaceutical Prime Vendors**

Vendor	Year Contract Began	Regions Covered	Year of Contract									
			1	2	3	4	5	6	7	8	9	10
Department of Veterans Affairs												
McKesson Corporation	2004	All ^a	5.00	5.04 ^b	5.05	5.11 ^b	5.15	5.15	5.15	5.15	5.15	5.15
Department of Defense												
McKesson Corporation	2002	TMOP	4.75	4.75	4.75	4.75	4.75	4.75	4.75	4.75	4.75	4.75
AmerisourceBergen	2005	North and South	5.02	5.02	5.08 ^b	5.13	5.13	5.28	5.28	5.31 ^b	5.33	5.33
Cardinal Health	2005	West	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50

Source: Congressional Budget Office based on data from the Department of Veterans Affairs and the Department of Defense.

Notes: Shading indicates future years of the contract.

VA = Department of Veterans Affairs; DoD = Department of Defense; TMOP = TRICARE Mail Order Pharmacy.

a. Includes the entire United States and the Consolidated Mail Outpatient Pharmacy.

b. Data are weighted averages because some contract renewals take place midyear.

insurance companies) began circumventing vendors to negotiate prices directly with manufacturers.¹ Although many retailers still bargain directly with vendors, price appreciation on inventory now accounts for much less of vendors' profits. Today vendors generally have a **fee-for-service model**, charging both manufacturers and retailers delivery fees. Those fees are normally calculated as a percentage of total sales. In addition, vendors earn income by "**floating**" funds, that is, by investing the funds collected from retailers and earning interest during the time (usually a matter of weeks) between receiving those funds and paying them to manufacturers.

Federal and other government agencies bargain directly with drug manufacturers and benefit from federal statutes under which manufacturers must offer them lower prices than they offer most other classes of customers. VA negotiates ceiling prices on behalf of federal purchasers that use the Federal Supply Schedule, which lists brand-name and some generic pharmaceutical products and their prices available to federal agencies and institutions.² Prices are based on what manufacturers charge their most-favored commercial customers or on formulas stipulated in the Veterans Health Care Act of 1992.³ Although vendors could conceivably add delivery fees on top of the negotiated ceiling prices, they are not doing so for VA and DoD; in fact, vendors actually offer them additional discounts.

In 2003, the average price on the Federal Supply Schedule was 53 percent of the average wholesale price (AWP).⁴ The AWP is a standard commonly used in pharmaceutical transactions but is not necessarily the price vendors charge retailers; rather, the AWP serves as a suggested list price, similar to that for hospital procedures or hotel rooms. Customers eligible for Federal Supply Schedule pricing may negotiate further savings by entering into national contracts, committing to a minimum volume of business, or pledging to exclusively use a particular drug within a therapeutic class in return for additional price concessions from manufacturers.

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1. Health insurance companies also rely on pharmacy benefits managers to administer their prescription drug programs. Typical responsibilities are developing and maintaining the formulary, contracting with pharmacies, negotiating discounts with manufacturers, and processing claims.
 2. The prices VA has negotiated for itself, DoD, the Public Health Service (including the Indian Health Service), and the Coast Guard—referred to as the "Big Four" because, among federal agencies, they purchase the largest volume—are more advantageous than those under the Federal Supply Schedule for all other government agencies. Although the Federal Supply Schedule covers federal agencies, some state, county, city, and local customers also have access to its contracts.
 3. Public Law 102-585, 38 U.S.C. 8126(a)(4).
 4. For methodology and a complete set of estimates, see Congressional Budget Office, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005).

VA's Pharmaceutical Prime Vendor Program

The Department of Veterans Affairs provides prescription drugs as part of its medical benefits package for all enrolled veterans. Prescriptions are typically written by VA physicians and filled by VA pharmacies at medical centers or by the Consolidated Mail Outpatient Pharmacy (CMOP) program. Outpatient drugs may be subject to a copayment of \$8, depending on a veteran's VA disability rating.

In 1994, VA implemented its Pharmaceutical Prime Vendor program nationwide to avoid costs of operating its warehouse system for storing and distributing drugs and supplies. The VA's National Acquisition Center in Chicago solicits, awards, and administers all contracts, including the PPV contract, through its National Contract Service and administers the Federal Supply Schedule for VA and other government agencies. The National Acquisition Center supervised 1,900 contracts with annual sales of over \$14 billion in 2008. The center covers its operating costs through user fees of 0.50 percent of sales to VA facilities and 0.75 percent for other government customers.

VA's pharmacy benefits management (PBM) service works closely with the National Acquisition Center, evaluating practices, monitoring costs, and managing VA's National Formulary. Also known as a preferred drug list, a formulary contains all drugs covered by a particular plan. Health care systems and insurance companies use formularies to reduce the number of distinct drugs that are stocked and dispensed, which enables them to purchase fewer drugs in larger quantities and obtain discounts from drug manufacturers.⁵

The PPV contract covers inpatient drugs, outpatient prescriptions, outpatient medical and surgical supplies, and prescriptions for patients discharged from VA medical centers. The vendor agrees to provide next-day delivery of drugs and additional services such as customer-service evaluations, paperless invoices, bar-coding of drugs and corresponding facility shelves, and installation and maintenance of equipment and software for automated ordering. All VA facilities must place orders through the PPV, which delivers pharmaceuticals to the facilities and receives payment directly.

Vendors' profits come from several sources. In 1999, VA negotiated discounts (in the form of negative delivery fees) from its PPV, which at the time was Amerisource. (Following a merger in 2001, Amerisource is now called AmerisourceBergen.) Many retailers pay vendors a delivery fee in addition to the price of the drug, whereas negative delivery fees result in a further discount of drug prices. The presence of those discounts implies that the vendor must earn income on the VA contract from some

5. VA's National Formulary is a core formulary, which means that listed drugs must be available at all VA medical centers. Individual regions within the VA network can, however, supplement the National Formulary with additional drugs. VA's intent is for all medical centers to use the National Formulary exclusively and not add drugs, but no official policy has yet been established.

other mechanism, such as interest from “floating” funds between the time the vendor receives payment from its customer and reimburses the drug manufacturer.⁶

Vendors also look to manufacturers for profits. Manufacturers not only pay vendors administrative fees ranging from 1 percent to 3 percent of total sales but may also accept from vendors whatever price VA pays the PPV (including any discounts). For example, suppose that VA and the manufacturer have negotiated a price of \$100 for a certain drug. If the vendor offers VA a discount of 5 percent (a typical discount), then VA pays the vendor \$95. Combined with a 2 percent administrative fee, the vendor might reimburse the manufacturer \$93, earning \$2 in profit.

VA's Process for Awarding a PPV Contract

In accordance with the Federal Acquisition Regulation, VA awarded the current PPV contract for prescription drugs by a competitive process conducted within each of 14 regions.⁷ Thirteen of the regions are geographic; the Consolidated Mail Outpatient Pharmacy is considered the 14th region for contracting purposes but covers the entire nation.

In June 2003, VA issued one solicitation, and vendors were permitted to bid on one, more than one, or every one of the 13 geographic regions and CMOP. Each region was to be served by a single vendor; no sharing of regions among vendors would occur. Alternate bids and multiple proposals were also acceptable.⁸ That approach permitted VA to piece together regional or national contracts, whichever combination resulted in the best value overall. VA considered price (discounts), past performance, technical approach, and participation of small disadvantaged businesses (that is, subcontracting to a socially and economically disadvantaged firm as determined by the Small Business Administration) in selecting the present PPV. (VA defines a small business as a for-profit entity with 500 or fewer employees.) The solicitation specified that price alone was as important as the combination of past performance and technical approach; participation by small disadvantaged businesses was given less consideration.

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6. All VA facilities use the Fast Pay system, paying the PPV within 48 hours of receiving the invoice. The PPV, in turn, pays a \$0.80 transaction fee to the financial institution processing Fast Pay invoices. Other government customers typically pay the vendor within the terms and conditions of a “net 15 day payment,” meaning no later than 15 days after receiving the vendor’s invoice. VA expects the vendor to offer more favorable discounts to other government customers who also use Fast Pay.
 7. For administrative purposes, VA divides the country into 21 geographic regions called Veterans Integrated Service Networks. For purposes of PPV contracts, however, there are only 14 regions.
 8. Awards could be based on the initial proposal, but the VA contracting officer could also conduct follow-up negotiations. Any such negotiations would include all bidders, who could then submit a revised proposal.

Seven distributors bid on all or portions of the contract, but the entire award went exclusively to McKesson Corporation, with an effective date of April 1, 2004. The term of the contract can be up to eight years, consisting of an initial two-year award followed by three optional two-year renewals. The Federal Acquisition Regulation mandates that VA review its contract to ensure continuing value (that is, exercise due diligence) for each option period. VA expects to carry out all option periods unless market forces or factors related to service quality dictate otherwise.

Although VA did not indicate whether McKesson offered the largest discount in each of the 14 regions, VA did determine that McKesson's nationwide offer provided the best value overall. Moreover, the award survived a federal lawsuit brought by a competing vendor.⁹ Granting the contract to a single vendor in this case is not the same as a sole-source award because the contract was awarded competitively. The previous PPV contract was also a single award—to Amerisource in 1999—but VA's first PPV contracts (in 1994) included multiple vendors. VA sets aside specific regions for contracts with small businesses, but the department indicated that it received insufficient bids in the recent contract cycle to make an award to any small businesses.

Historical Pharmaceutical Spending by VA

The Department of Veterans Affairs provided CBO with historical data on pharmaceutical costs and spending in several forms:

- Average cost per 30-day equivalent (a common metric because outpatient prescriptions are typically dispensed in a one-month supply),
- Average annual cost per patient, and
- Total annual spending.

By all three measures, VA's costs, adjusted for inflation, have been falling since 2005 (see Figure 1). For example, inflation-adjusted prices for 30-day equivalents were 19 percent lower in 2008 than they had been in 1999. Although the decrease in costs and spending has occurred during the period in which McKesson Corporation has held the PPV contract exclusively, many developments in the pharmaceutical market may have contributed to that decline.

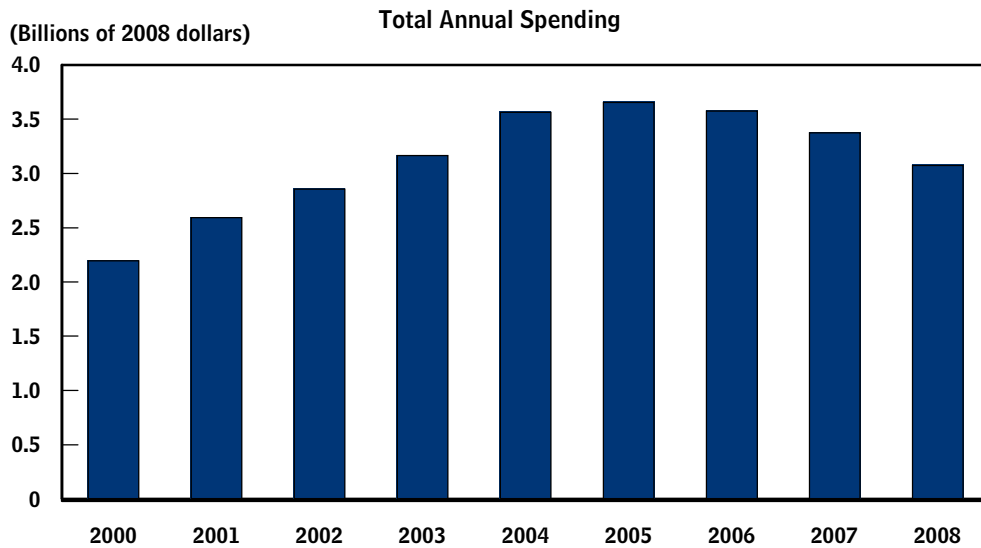
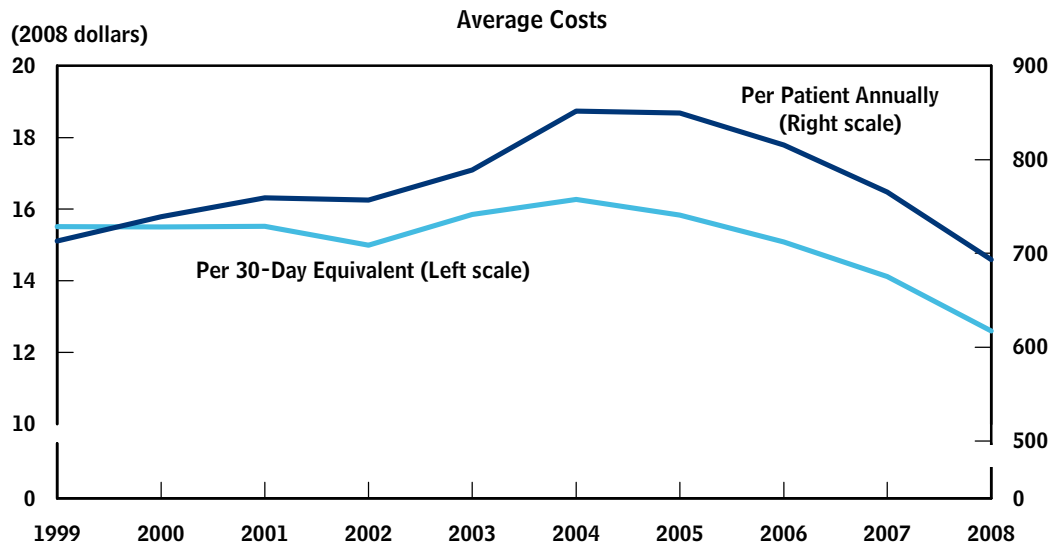
DoD's Pharmaceutical Prime Vendor Program

Like VA, the Department of Defense administers a PPV program. DoD's program for inpatient drugs and outpatient drugs and supplies has many similarities with VA's: competitive bidding, set-asides for small businesses, federal pricing schedules, and

9. The United States Court of Federal Claims found "that [the] plaintiff has failed to establish that the VA's award to McKesson was irrational, arbitrary, capricious, an abuse of discretion, or otherwise in violation of applicable statutes and regulations." See *AmerisourceBergen Drug Corp. v. United States*, 60 Fed. Cl. 30, 38 (2004).

Figure 1.

Average Costs and Total Annual Spending for VA's Pharmaceutical Prime Vendor Program, Fiscal Years 1999 to 2008



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: Costs include drug ingredients only; they do not cover processing and distribution costs such as those for labor, supplies, shipping, and building management.

discounts from vendors. DoD's experience provides a potential benchmark for assessing the performance of VA's program.

Beneficiaries of TRICARE are active-duty service members (including activated members of the reserve and National Guard), Selected Reserve members, retired military personnel, and eligible family members and survivors. The TRICARE Management Activity oversees the pharmacy benefit and manages the Uniform Formulary—DoD's equivalent of VA's National Formulary—which specifies the prescription medications available through DoD.¹⁰ Beneficiaries may fill prescriptions at four different points of service: military treatment facilities (MTFs), the TRICARE Mail Order Pharmacy (TMOP), in-network retail pharmacies, and out-of-network retail pharmacies. Multiple points of service make DoD's pharmacy program more complex than VA's.

TRICARE beneficiaries obtaining prescriptions at an MTF have no copayment, regardless of whether the prescriptions were written at the MTF or elsewhere. (That policy differs from VA's, under which, generally, prescriptions are filled only if written by VA physicians.) Beneficiaries using TMOP to obtain a three-month supply have copayments of \$3 for formulary generics, \$9 for formulary brand-names, and up to \$22 for nonformulary drugs; they pay no charges for standard shipping (14 days from when the prescription is received). In-network retail pharmacies fill a 30-day supply (rather than the three-month supply that TMOP provides) for the same copayment schedule. Beneficiaries may have to pay full price at out-of-network pharmacies but can submit claim forms to DoD for partial reimbursement.

Pharmaceuticals are less costly for DoD to provide at military treatment facilities than at other points of service: In fiscal year 2007, the average cost of 30-day equivalents at an MTF was \$23.53; it was somewhat higher for TMOP (\$33.78) and much higher at retail pharmacies (\$68.80).¹¹ DoD promotes the use of MTF pharmacies by waiving all copayments at that point of service. However, according to DoD officials, MTFs do not have enough capacity to absorb a major rerouting from retail service, and not all beneficiaries live near an MTF. DoD has therefore engaged in a marketing campaign to convince its beneficiaries to use its second-cheapest point of service—mail order.¹²

10. Pharmaceuticals listed on the Basic Core Formulary, a subset of the Uniform Formulary, must be provided at all full-service military treatment facilities regardless of military branch. To provide some flexibility, TRICARE also has an Extended Core Formulary, which includes optional medications that those treatment facilities may supply on the basis of need within local populations.

11. Historical MTF data include only the costs of ingredients, whereas TMOP and retail data also include dispensing fees. In an apparent attempt to incorporate overhead for more equitable cost comparisons by point of service, DoD now records a flat \$8.00 dispensing fee for each MTF prescription. That amount may be too high, in which case the actual 30-day equivalent cost at MTFs would be lower than \$23.53.

12. For an example of this marketing drive, see "Eight Things Every Beneficiary Should Know About TMOP," www.express-scripts.com/custom/dod/docs/TMOPEightThings.pdf.

DoD's Process for Awarding a PPV Contract

The Department of Defense also uses a competitive bidding process to select its vendors. It uses a PPV program to supply its military treatment facilities. In-network and out-of-network retail pharmacies have their own vendors or maintain their own warehouses, and TMOP has a separate PPV (the Pharmaceutical National Prime Vendor) program. The Defense Supply Center in Philadelphia, which is part of the Defense Logistics Agency, manages the prime vendor programs for DoD and other eligible federal, state, and local customers. The Defense Supply Center does not receive direct appropriations; rather, it covers operating costs through user fees.

An internal panel at the Defense Supply Center evaluates and scores distributors' bids on the basis of the proposal. The PPV must deliver all drugs belonging to DoD's Basic Core Formulary (a subset of drugs in the Uniform Formulary that all MTFs must carry) directly to the Department's facilities and customers. When all bidders meet DoD's requirements, the discount receives key consideration. If no bids are acceptable, further negotiations allow all parties to rebid.

For contract purposes, DoD divides the United States into three regions—North, South, and West.¹³ Five companies responded to the solicitations for the contracts that were awarded in 2005. Cardinal Health received the contract for the West region, and AmerisourceBergen was given contracts for the North and South regions. DoD set aside the states of North Dakota, South Dakota, and Minnesota for a small business contract, which was awarded to the Dakota Drug Company. Whereas VA's award to one vendor resulted in a single national set of discounts for VA facilities and CMOP, DoD's PPV discounts differ by vendor, region, and contract period (see Table 1). The PPV contract covers 10 years: one 30-month initial period and three optional 30-month renewals.

The TRICARE Mail Order Pharmacy program involves two separate contracts: one for the Pharmaceutical National Prime Vendor and one for the pharmacy benefits management services. McKesson Corporation serves as the Pharmaceutical National Prime Vendor on a 10-year contract that started in 2002. Express Scripts was awarded, for the second time in a row, the five-year PBM contract in 2008. The arrangement between the two is similar to DoD's PPV program: The PBM replenishes mail orders using the Pharmaceutical National Prime Vendor, and the vendor receives payment from DoD, minus a discount of 4.75 percent.

Historical Pharmaceutical Spending by DoD

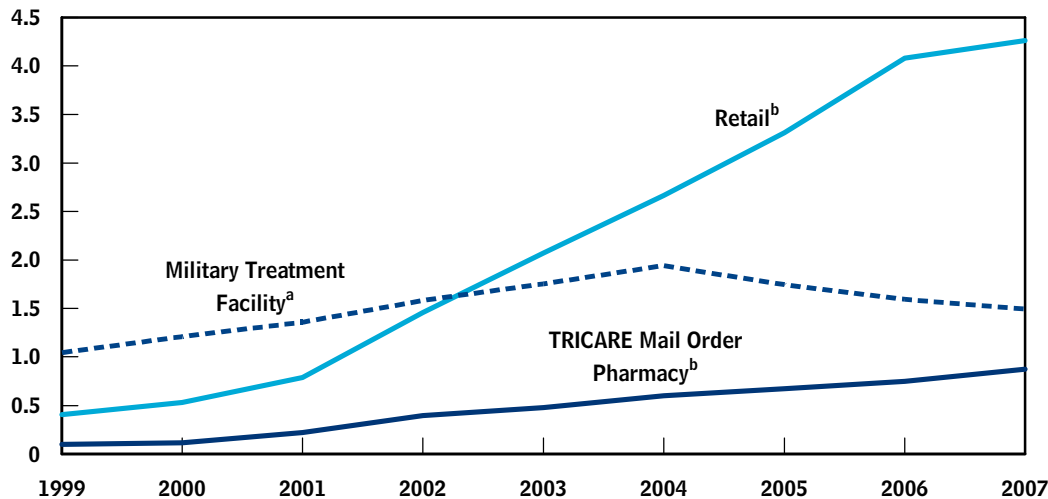
The Department of Defense provided CBO with nine years of historical data on pharmaceutical spending (see Figure 2). Overall spending by DoD on drugs increased considerably after 2002 with the introduction of TRICARE for Life, a program that enables certain TRICARE beneficiaries to retain their benefits when they

13. Deliveries of pharmaceuticals for Europe and the Pacific are addressed in separate contracts.

Figure 2.

Total Annual Pharmaceutical Spending for the Department of Defense, by Point of Service, Fiscal Years 1999 to 2007

(Billions of 2008 dollars)



Source: Congressional Budget Office based on data from the Department of Defense.

a. Includes costs for drug ingredients only.

b. Includes costs for drug ingredients and for processing and distribution (such as costs for labor, supplies, shipping, and building management).

reach age 65.¹⁴ By 2007, DoD had reduced the combined annual inflation-adjusted growth of drug spending for all points of service to 4 percent. DoD is still attempting to force retail pharmacies to accept Federal Supply Schedule pricing for TRICARE beneficiaries.¹⁵

14. Before 2002, TRICARE coverage expired at age 65, when beneficiaries became eligible for Medicare. The National Defense Authorization Act for Fiscal Year 2001 (Public Law 106-398) established TRICARE for Life, which allows military retirees and their families and survivors to retain benefits of TRICARE and acts as a secondary payer to Medicare. For the many military retirees who do not enroll in Part D of Medicare, TRICARE acts as the primary payer for drugs.

15. In fiscal year 2007, retail pharmacies accounted for 64 percent of DoD's spending, compared with 23 percent at MTFs and 13 percent for TMOP. In 2008, the Government Accountability Office released a report, *DoD Pharmacy Program: Continued Efforts Needed to Reduce Growth in Spending at Retail Pharmacies* (GAO-08-327, April 4, 2008), which concluded that federal pricing had not been applied to any retail orders. Although DoD began obtaining voluntary rebates from manufacturers for formulary drugs dispensed at retail network pharmacies in 2006 and started a campaign to switch beneficiaries from retail pharmacies to TMOP, manufacturers sued in federal court. DoD claimed that the Veterans Health Care Act of 1992 directed drug manufacturers to grant discounts on all drugs supplied to DoD, VA, the Public Health Service, and the Coast Guard, regardless of point of service. Manufacturers argued successfully against that assertion. The National Defense Authorization Act for Fiscal Year 2008 attempted to clarify that issue using explicit language (Public Law 110-181, sec. 703, Inclusion of TRICARE Retail Pharmacy Program in Federal Procurement of Pharmaceuticals). DoD published its proposed rule change in the *Federal Register* (vol. 73, no. 144 [July 25, 2008]), but as of the date of this letter, DoD had not issued a final rule.

Comparison of the Discounts Vendors Provide to VA and DoD

A number of approaches could be used to assess the arrangements that VA and DoD have with vendors. Both departments pay similar prices for brand-name drugs.¹⁶ But drug pricing is not the same as drug spending. Because DoD's inflation-adjusted spending for drugs is growing while VA's is declining, it may appear that VA controls costs more effectively than DoD does for its MTFs and TMOP.¹⁷ (CBO excludes retail pharmacies from the comparison because that DoD program does not have a federal prime vendor.¹⁸) However, a number of factors—including direct bargaining with manufacturers, the composition of the formulary, and differences between the two departments in terms of eligibility requirements and characteristics of their beneficiary populations—affect pharmaceutical spending.¹⁹ In addition, vendors do not participate in price negotiations between the department and the drug manufacturer and influence final drug costs only through their discounts. Therefore, a more accurate method for comparing the financial impact of having single versus multiple vendors is to evaluate the discounts offered under various contractual arrangements.

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16. CBO estimated that MTFs paid, on average, 41 percent of the average wholesale price for single-source drugs in 2003, essentially equal to VA's price of 42 percent of AWP. Those figures include vendors' discounts. See Congressional Budget Office, *Prices for Brand-Name Drugs Under Selected Federal Programs*.
 17. VA's average cost for a 30-day-equivalent prescription was \$13.83 in fiscal year 2007, compared with DoD's average costs of \$23.53 at MTFs and \$33.78 for TMOP. Those comparisons are not exact because VA reports ingredients only, MTFs add an \$8 dispensing fee to each prescription, and TMOP includes costs for processing orders and for distributing the medications. In addition, those figures do not include beneficiaries' copayments. For example, if a TMOP prescription costs \$50, the beneficiary may pay \$3 and DoD pays \$47: DoD's costs reflect the \$47, not the total \$50.
 18. VA reimburses retail pharmacy expenditures in two cases—for veterans treated in smaller, isolated VA facilities who need an immediate supply from a local pharmacist, and for users of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Through CHAMPVA, health care costs are partially covered by VA for beneficiaries who are not eligible for TRICARE but who are in one of the following categories: the spouse or child of a veteran rated permanently and totally disabled for a service-connected disability; the surviving spouse or child of a veteran who died from a service-connected disability; the surviving spouse or child of a veteran who at the time death was rated permanently and totally disabled from a service-connected disability; or, in exceptional cases, the surviving spouse or child of a military member who died in the line of duty (normally those survivors are eligible for TRICARE).
 19. An estimated 5.8 million veterans receive care from the Veterans Health Administration, and 4.4 million use the pharmacy benefit. DoD's TRICARE program serves 9.2 million beneficiaries, of whom 6.7 million use the pharmacy benefit. Although population demographics differ, 1.1 million receive health care from both departments. DoD and VA also collaborate in caring for wounded veterans returning from Iraq and Afghanistan. Deactivated reservists (including those who remain on the Selected Reserve rolls) from those two conflicts are eligible for five years of medical care by VA under the provisions of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110–181, sec. 1707, Extension of Period of Eligibility for Health Care for Veterans of Combat Service During Certain Periods of Hostilities and War).

VA is in the fifth year of its contract and pays one discount of 5.15 percent to McKesson Corporation for supplying all of its medical centers and its mail-order program (see Table 1). McKesson voluntarily increased its discount during the contract's initial period from 5.00 percent to 5.05 percent, the level specified for the first renewal period (10 months ahead of schedule)—and then further boosted its discount to the level specified for the third renewal period, 5.15 percent, in October 2007 (more than two and one-half years ahead of schedule).

By contrast, DoD's discounts vary by vendor, region, and contract period. In 2008, DoD's PPV contracts were in the first renewal period, and the discounts for day-to-day (regular peacetime) business were 5.13 percent for the North and South regions (AmerisourceBergen) and 4.5 percent for the West region (Cardinal Health). The Pharmaceutical National Prime Vendor contract (McKesson Corporation) for TMOP was in its sixth year, and its discount was 4.75 percent. Both the West region and TMOP have fixed discounts for the duration of the contract. Discounts for the North and South regions are scheduled to further improve—to 5.28 percent in the second renewal period and 5.33 percent in the third renewal period.

There are a number of probable reasons VA receives an advantageous discount with a single vendor. VA reports that bidders offer larger discounts when the anticipated volume of business is high, because vendors can better spread overhead costs, thereby generating economies of scale. Because total business volume is set—VA would not order more drugs if it had more vendors—multiple firms sharing one profit margin could result in each vendor offering a less favorable discount. In other words, a mandate to use multiple vendors could increase costs if one vendor was the lowest bidder. Moreover, a contract's administrative costs are probably lower with a single national vendor.

VA's discount of 5.15 percent is generally comparable with that offered by DoD's PPVs (for military treatment facilities) and the Pharmaceutical National Prime Vendor (for TMOP). In 2009, VA has a larger discount from its vendor than DoD has in any of its regions. Although DoD's discount for the North and South regions will increase to 5.33 percent when the contracts enter their third renewal period, VA's arrangement will retain its advantage compared with DoD's contracts for the West region and TMOP. Therefore, CBO finds it unlikely that requiring VA to award contracts to multiple vendors would result in substantially lower costs than VA currently pays for pharmaceuticals.