Statement of the Honorable
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before the

Subcommittee on Federal Workforce, Postal Service,
and the District of Columbia

on

"The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

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Chairman Lynch, Ranking Member Chaffetz, and Members of the Subcommittee:

Good morning. My name is Patrick E. McFarland. I am the Inspector General of the United States Office of Personnel Management (OPM).

Thank you for inviting me to testify at today's hearing. This is the second time in less than a year I have testified to the Subcommittee on the significance of pharmacy benefits manager (PBM) contracts and their lack of price transparency in the context of the Federal Employees Health Benefits Program (FEHBP). The first time was on June 24, 2009, at the hearing aptly titled "FEHBP's Pharmacy Benefits: Deal or No Deal?"

The FEHBP is the largest employer-sponsored health insurance program in the United States. During calendar year 2008, the 266 insurance plans under contract to the FEHBP provided health insurance coverage to approximately 7.7 million people, representing Federal employees, annuitants, and dependents. The FEHBP paid a total of $35.9 billion in premiums to these carriers, of which $29.1 billion went to the fee-for-service plans and $6.8 billion to health maintenance organizations. As reported to OPM in the financial statements of FEHBP carriers, pharmacy costs reflected more than 25 percent of health care costs paid by the fee-for-service plans. Further, according to data furnished by OPM's contracting office, 12 different PBMs provided services to one or more FEHBP plans during 2008.

The initial purpose of contracting with PBMs was to control drug costs and improve the efficiency of the FEHBP pharmacy program. However, in the years since the PBMs began servicing Federal enrollees, health care costs have continued to rise, including prescription drug costs. The Blue Cross and Blue Shield Service Benefit Plan, which covers approximately 50 percent of the FEHBP's enrollees, has incurred a steady increase in its prescription drug costs per FEHBP member since 1999. In 1999, the

claims cost per member was $591. Eight years later, the claims cost per member increased to $1,161; almost twice the amount paid in 1999. Drug cost increases averaged 13.5 percent over the 8-year time period. These steadily rising costs call into question the effectiveness of the large PBMs which the BlueCross BlueShield Association has contracted with in controlling prescription drug costs.

We have continued our efforts to learn about and audit PBMs and have concluded that the most significant issues with which OPM should be concerned do not involve the PBMs' compliance with or performance of their contracts with the FEHBP carriers, but rather the nature of the PBM contracts themselves.

In our estimation, the single most important FEHBP issue which OPM must resolve is the fact that it is dealing with PBMs from a perspective in which the cost structures of the PBMs are utterly nontransparent. This means that there is no objective basis to determine whether the terms being offered to an FEHBP carrier by a PBM represent an advantageous arrangement. From our perspective as the agency's audit component, we find the absence of transparency to be deeply troubling.

Before I discuss the proposed bill let me clarify one point about transparency. The Pharmaceutical Care Management Association (PCMA) testified at the last hearing that transparency would destroy or dilute the ability of the PBM industry to negotiate discounts and rebates with the pharmaceutical manufacturers. I do not know what the impact would be if PBM financial matters were made transparent to the general public but that's not what is being discussed, at least not by me. I am advocating transparency in the FEHBP PBM contracts only to OPM and my office, so that we can properly answer that basic question, "Deal or No Deal."

It should be noted that my office already has access to a large number of discount arrangements between carriers and health care providers. We routinely and confidentially review contract arrangements between carriers and health care providers, such as hospital chains, to ensure contract compliance. The ability of carriers to arrange discounts with health care providers has not been negatively impacted because my auditors review the contracts. In fact, in the few cases where we were contractually permitted to review some of the rebate agreements, no information regarding the rebate amounts negotiated by the PBMs has ever been disclosed by my office. Also, our office has not been notified by these PBMs indicating that their ability to negotiate rebates has been impaired. Maintaining and safeguarding all proprietary information is of paramount importance to my office.

As I discussed in my prior testimony, my office is participating in an OPM working group that is considering initiatives to strengthen the controls and oversight of FEHBP pharmacy programs. Based on what we've seen in the working group, we believe that good progress is being made.

It's my understanding OPM has adopted certain principles that will be incorporated into future FEHBP contracts with fee-for-service (FFS) carriers such as the BlueCross

BlueShield Association. These principles will require that PBMs pass all discounts, rebates and other financial incentives or payments through to the carriers, and that the PBM's only remuneration in connection with the contract is from the FEHBP carrier itself. In effect, the drug costs passed through the carrier would be based on the net cost of the drug plus a reasonable fee for the PBM's services (administrative fee). All relevant documents, including contracts with drug manufacturers, would be available to my office for audit.

If these principles are quickly and properly implemented by OPM, I believe most if not all of my concerns about the lack of transparency in the FEHBP PBM contracts will be resolved. However, as always, the devil is in the details. For example, without additional resources it is difficult to see how OPM will be able to fully implement these principles. Also, I am concerned that the existing PBM contracts may be allowed to continue for years before the new principles are incorporated. It may be more prudent to require the FFS carriers to comply with the principles no later than the 2012 plan year. Finally, I am concerned that the principles may be changed before they are incorporated into the FEHBP FFS contracts.

Now let me turn my attention to the proposed FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act. I do have some areas of concern regarding the Act, but first let me thank the Subcommittee for devoting so much time and attention to the issue of PBM transparency in the FEHBP. Thank you especially for your time and diligence to resolve this issue. I feel confident that the attention of the Subcommittee has focused the agency's interest and resources on this matter.

My first concern with the Act is of a philosophical nature. The more detailed a statute is the harder it is for the agency implementing the statute in a highly complex area such as this to adapt to changes occurring over time. All things being equal, it is often better to allow the agency room to exercise its discretion on how to structure the program. However, I understand the reluctance to give that discretion if it appears the agency is not doing enough to resolve the matter itself. In this case I know OPM hasn't been as quick as many hoped to address the PBM transparency issue. I hope that OPM now implements its proposed transparency and pass-through principles quickly and efficiently.

In addition, the Act does not distinguish between the different types of FEHBP carriers. FFS carriers operate very differently from community-rated HMO carriers. Imposing the same pricing and contracting rules on both is not appropriate. My concern on lack of transparency focuses on the FFS carriers since the full PBM cost is passed through to the Federal government and FEHBP subscribers. These plans comprise about 80 percent of the total cost of the FEHBP. Rate development for community-rated HMOs differs significantly from that of FFS carriers. The premiums for community-rated HMOs are based on what other similarly sized subscriber groups are paying for the benefits, not the actual cost of the benefits. The Act doesn't really fit the community-rated HMO model.

My next concern is the use of the average manufacturer price (AMP), which based on my understanding, sets a ceiling price for prescription drugs. The Act would also require that

OPM enter into master agreements with drug manufacturers to determine AMP. This will impose a great strain on OPM resources. In addition, while it is unlikely some drug manufacturers may choose to not enter into the master agreement, and thus could eliminate their drugs from reimbursement under the FEHBP. This would be detrimental to FEHBP enrollees.

AMP appears to be the same as the average manufacturer price that is required to be reported to the Secretary of Health and Human Services (HHS) before purchase of that drug can be reimbursed by Medicaid or Medicare Part D (HHS AMP). The Deficit Reduction Act of 2005 requires that HHS make the HHS AMP publicly available. My understanding is that HHS is currently enjoined from doing so because of a pending lawsuit. If the lawsuit is successful and HHS is permanently enjoined from making the HHS AMP publicly available, it would create significant additional expense and administrative burden for OPM under the Act.

Use of AMP as a ceiling price under the Act means that claim payments by PBMs will need to be compared to the AMP and, if higher, the price is adjusted to the AMP. Since OPM would be required to maintain the AMP, it would also be responsible for ensuring that this analysis is completed for each prescription drug claim payment. This would require a large increase in OPM resources, including a large sophisticated claims data processing system, and substantial expertise to make such adjustments. Alternatively, OPM could provide the AMP to the FEHBP PBMs to allow them to correctly compute the price. However, if the HHS AMP is not publicly available because of the lawsuit, the PBMs contracting with FEHBP carriers will have a competitive advantage over other PBMs that do not have contracts with FEHBP carriers because they will know the AMP of drugs.

Furthermore, the Act will potentially prohibit one of the largest PBMs from contracting with an FEHBP carrier because of the PBM's relationship with a major retail pharmacy chain. The FEHBP is based on competition. Prohibiting one of the largest PBMs from program participation is contrary to the concept of competition in the FEHBP and may result in a higher cost to the enrollees and the Federal government. This is not to say that the danger posed to the FEHBP by a PBM/retail pharmacy chain combination is non-existent. In a cost pass-through model, such as the one being considered by OPM, it is assumed the retail pharmacy cost incurred by the PBM is a cost negotiated with an independent third party without ties to the PBM. If the PBM and retail pharmacy are related, the structure would have to be ignored and costs of the PBM computed on the actual costs of the retail pharmacy purchasing the drug for resale.

I note in passing that there are many ways the relationship between a PBM and retail pharmacy or drug manufacturer under common control can be structured, but the Act only envisions a few. If this restriction on PBM ownership remains in the Act, broadening the possible ways the two entities can be under common control should be considered.

I also have several minor concerns. For example:

- OPM may not have the resources or expertise to determine maximum allowable dispensing fees.
- The heading "Civil Monetary Penalties" is confusing because the section deals with the False Claims Act rather than a Civil Monetary Penalty.
- The ability of PBMs to retain 1 percent of rebates may result in current discount arrangements being converted to rebates. Providing incentives to PBMs to reduce overall drug costs is an excellent strategy. However, legislation should be careful not to strictly limit incentive options.
- It is questionable whether interim final regulations can be issued within six months of enactment because of the complexity of the subject matter and the lack of agency resources.

Despite my concerns, the status quo must be changed. I believe that an amendment to the Federal Employees Health Benefits Act on PBM benefits can be beneficial, particularly if OPM does not quickly require FFS FEHBP carriers to enter into PBM contracts that require some sort of pass-through transparent pricing. A pass-through pricing model, in our opinion, would be easier to administer and fair to all parties.

The private sector and other public plans have also recognized this lack of transparency as a problem and are moving toward more transparent pricing and contracts. FEHBP enrollees and taxpayers must have confidence that FEHBP premiums are reasonable and fair, especially in times of premium increases. Without transparency in FEHBP PBM contracts, OPM can not give any assurances that the premiums are reasonable and fair.

Thank you again for inviting me here today. I would be happy to respond to any questions you may have.