Statement of the Honorable
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Inspector General
U.S. Office of Personnel Management

before the

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

on

"FEHBP's Pharmacy Benefits: Deal or No Deal?"

June 24, 2009

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).

I want to thank you for inviting me to testify at today's hearing, and for recognizing 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).

I am pleased to be appearing with my fellow panelists. Mr. Sheehan is particularly well-known to my office, as we had the privilege of participating in a number of health benefit fraud cases—some of which addressed instances of wrongdoing by PBMs—that he conducted during his tenure as an Associate United States Attorney in the Eastern District of Pennsylvania. We found both his expertise on these matters and his leadership in complex, high- value cases to be unparalleled. Similarly, key members of my office who are responsible for auditing the FEHBP plans and their PBMs have attended training programs conducted by Ms. Hayes' firm.

As a means of emphasizing the significance of PBM matters within the FEHBP, I would like to point out that 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 persons, representing Federal employees, annuitants, and eligible 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.

FEHBP carriers have been using PBMs since 1990, initially for mail order pharmacy programs, but ultimately progressing into coverage of all pharmaceutical benefits. These PBMs directly provide some pharmacy benefits, process pharmacy claims, and pay retail pharmacy providers on behalf of the FEHBP carriers. My office began addressing PBM issues in 2003, initially in response to concerns that the health and safety of persons covered by the FEHBP may have been placed at risk by certain practices of PBMs. These included:

- Unauthorized switching of medications prescribed by physicians in favor of products for which the PBM had received a financial incentive from pharmaceutical manufacturers;
- Manipulation of receipt dates of prescriptions in order to provide the appearance that they were filled within contractual timeframes;
- Use of lower paid, non-pharmacist personnel to perform functions that state law required to be performed by or under the direct supervision of a licensed pharmacist; and,
- Dispensing prescriptions without performing drug utilization reviews to assure appropriate use of medications or to avoid dangerous drug interactions.

As the result of timely law enforcement efforts, these sorts of abuses were addressed and resolved without direct harm to FEHBP covered persons. The PBMs in question agreed to:

- Disclose to physicians and patients its financial incentives for certain drug switches;
- Disclose to physicians and patients the minimum or actual cost savings for health plans and the difference in co-payments made by patients;
- Disclose to physicians material differences in side effects between prescribed drugs and proposed drugs;
- Reimburse patients for their out-of-pocket health care costs related to drug switches, and notify patients and physicians that such reimbursement is available;
- Obtain express, verifiable authorization from the physicians for all drug switches; and,
- Inform patients that they may decline the drug switch and receive the initially prescribed drug.

The PBMs also agreed to observe acceptable ethical standards of practice and to provide training for their employees on these standards. Currently, my office, together with the Office of Inspector General (OIG) of the Department of Health and Human Services, is monitoring a PBM's execution of a corporate integrity agreement designed to assure adherence to the commitments it made in response to the Federal enforcement action.

At this time, we have no information which suggests that PBMs under contract with the FEHBP are operating in a manner that would compromise the well-being of covered persons. However, I do believe that the prior violations are a strong reminder that the potential for safety risks to subscribers exists through poorly written contracts, lack of

adequate industry oversight, and the need for additional internal controls. My office is committed to providing the oversight needed to protect the safety of FEHBP enrollees.

Similarly, our early initiatives to audit PBM activities within the FEHBP, using data from the 2000 – 2003 period, revealed a number of errors and shortcomings in the PBMs' administration of their FEHBP contracts, including:

- Billing FEHBP carriers for larger amounts of pharmaceutical products than were actually dispensed to patients; and,
- Dispensing drugs to persons who did not have a current enrollment in the FEHBP.

In these situations, we recommended that OPM recover the costs of improper claims submitted to the FEHBP carriers by PBMs.

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 beneficiaries, 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 Blue Shield Association has contracted with in controlling prescription drug costs.

As we have continued our efforts to learn about and audit PBMs, we 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 issue which OPM must resolve is the fact that it is dealing with PBMs—which handle claims representing over 25 percent of fee-for-service health benefits costs—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, or if equivalent services can be obtained at a lower cost from another PBM or through use of a different means of providing pharmacy benefits. From our perspective as the agency's audit component, we find the absence of transparency to be deeply troubling, and we are planning an analytical study that should provide at least a limited basis for making bona fide comparisons regarding the costs of pharmacy benefits from various sources. To our knowledge, this type of review has not previously been conducted in the Federal sector, and thus we cannot reliably project a completion date at this time.

There are several elements of the present FEHBP contracting system that contribute to the absence of cost transparency.

- PBMs contract directly with the FEHBP insurance carriers and not with OPM. Therefore, OPM has limited control over the terms of these contracts, especially related to pricing and fees.
- Each FEHBP carrier individually negotiates the terms (pricing method, rebates, administrative fees, etc.) of its contract with a PBM. Therefore, there is no consistency among these contracts. OPM is also not provided an opportunity to approve the contracts before they are finalized.

My office believes that this lack of transparency invites bad pricing and contracting practices, because of such factors as:

- FEHBP carriers have little incentive to negotiate the "best price" for pharmacy services, because OPM reimburses them for all costs charged by the PBM in any event.
- No FEHBP carrier's contract with a PBM is based on the actual cost of pharmaceutical products. Most if not all PBMs participating in the FEHBP use an "average wholesale price" (AWP) or similar methodology on which to base the price of their services to the carriers. The AWP was originally determined by comparing the average price that pharmacists paid for the drugs from several drug wholesalers and was assumed to be the "actual acquisition cost" (AAC) of the retail pharmacies that purchased from wholesalers. However, today the AWP is more comparable to a new car sticker price. It has little relationship to the true costs of drugs, which may include wholesaler rebates, chargebacks and incentive and volume discounts.
- Many PBM contracts do not require that the FEHBP receive the benefit of the pharmacy rebates associated with its claims. The carriers claim that they are able to negotiate a lower drug price for the FEHBP in lieu of the rebates. However, this has been difficult to verify because:
    - PBMs' contracts with pharmaceutical manufacturers fluctuate and are modified regularly.
    - Manufacturers will offer lower rates/prices to PBMs with larger membership. In most cases, the FEHBP carriers add greatly to PBM enrollment. However, because of a current lack of transparency in the PBM contracts, it has been difficult if not impossible to determine whether the Federal group has received the benefit of these lower rates/prices.
    - Rebates are not related to the drug price from the manufacturer and there is no feasible means under the current PBM contracts to determine whether the FEHBP is saving or losing money as a result of foregoing rebates.

The result of these practices may in fact be a higher cost for the FEHBP but this in turn cannot be verified in the absence of cost transparency. For example, we are aware that

pharmaceutical manufacturers provide rebates to PBMs that steer members by use of preferred drug lists and other methods to use a given company's products. It has been the practice of major FEHBP carriers to allow the PBMs to retain all manufacturer rebates in exchange for what are claimed to be discounted drug prices. However, because the FEHBP carriers' contracts with PBMs do not require that they make their cost data available for audit, PBMs have refused to allow us to determine the actual rebate amounts paid to the PBM. This prevents us from determining whether the FEHBP has actually benefited more by the lower drug prices than it would have by demanding that the rebates be credited to it.

As stated above, FEHBP carriers have no incentive to negotiate the best price. A recent audit revealed a perfect example of the consequences that may flow from this situation. An FEHBP carrier's multiyear contract with a PBM limited increases in the monthly service fee unless membership increased by a certain minimum amount. The actual membership increase did not meet the minimum, but the carrier allowed the PBM to renegotiate the contract to increase the service fee (and thus the cost to the FEHBP) as if membership had increased.

Because of concerns about increasing prescription drug costs, numerous fraud and abuse allegations against pharmacy benefits managers, and the concerns of my office mentioned above, a working group comprised of representatives from OPM's Strategic Human Resources Policy (SHRP) Division, Human Resources Products and Services (HRPS) Division, and my office has been formed to consider short-term and long-term initiatives to strengthen the controls and oversight of FEHBP pharmacy programs. We hope that the working group will assist OPM in reviewing, rethinking, and redesigning the management of the FEHBP pharmacy benefits.

As part of this process, we have suggested that OPM consider the following contract and regulatory changes:

- Require the PBM contract's administrative costs to be paid based on actual costs not fixed fees.
- Require carriers using self owned PBM's for the FEHBP contract to pass-through the actual drug costs to the FEHBP and its subscribers (i.e., eliminating profit automatically built into their internal systems).
- Require that FEHBP carriers' contracts with PBMs allow OPM/OIG auditors to access the PBMs' pricing data (AWP/Wholesale Acquisition Cost/Maximum Allowable Cost and similar defined terms).
- Require consistency among the carriers' contracts with PBMs. Currently, each carrier negotiates the terms of the contract (i.e., pricing, rebates, administrative fees, etc.) with its PBM. Standard terms would facilitate oversight of the contracts, allow the implementation of "best pricing" practices across all FEHBP plans, and afford the carriers/PBMs less opportunity to overcharge the FEHBP.
- Change the language in the Federal Employees Health Benefits Acquisition Regulations to designate PBMs as Federal subcontractors. This would allow

OPM to impose stricter requirements on the PBMs. Also, Federal procurement rules would apply, which is another means to standardize PBM contracts.

- Require the PBMs to disclose the actual amounts paid for drugs and then reimburse them based on the actual costs of the drugs dispensed.
- Require the FEHBP carriers to provide Explanation of Benefits forms to FEHBP enrollees when drug benefits are utilized. This will allow enrollees to determine whether someone else is using their benefits and is a good tool in helping to prevent health care fraud and medical identity theft.

My office also believes that structural changes to the FEHBP itself may create transparency and lower the cost of pharmacy benefits. The following are examples of potentially advantageous changes:

- The pharmacy benefit could be carved out of the existing FEHBP benefit structure and be offered as a separate stand alone benefit open to all FEHBP enrollees. The PBM contract to administer this program would be negotiated directly by OPM. Because it would be a Federal procurement, the Truth in Negotiations Act would apply and require full disclosure of cost data by the PBM. The contract could be a cost plus fixed fee contract, based on the actual net cost of the drug to the PBM plus a fixed dispensing fee. Since market share is key in negotiating lower drug prices, the large size of a benefit covering all FEHBP enrollees should generate better contract terms (i.e., pricing) than could be negotiated by the individual carriers negotiating separately. This would be similar to the approach just taken by TRICARE in negotiating its new pharmacy benefit.
- As above, the pharmacy benefit could be carved out of the existing FEHBP benefit structure and be offered as a separate stand alone benefit open to all FEHBP enrollees. However, rather than contracting with a PBM, OPM could enter into an Economy Act (i.e., reimbursable) arrangement with TRICARE to administer the benefit for FEHBP enrollees.
- The Federal Supply Schedule (FSS) could be made available to the FEHBP PBMs. The Department of Veterans Affairs' (VA) National Acquisition Center negotiates Federal Supply Schedule (FSS) prices with drug manufacturers. These prices are available to Federal agencies but not to FEHBP carriers. FSS prices are intended to be no more than the prices manufacturers charge their most-favored nonfederal customers under comparable terms and conditions. Under Federal law, drug manufacturers must list their brand drugs on the FSS to receive reimbursement for drugs covered by Medicaid. All FSS prices include a fee of 0.5 percent of the price to fund VA's National Acquisition Center.

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