U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Management Advisory Report

Federal Employees Health Benefits Program
Prescription Drug Benefit Costs

Report Number 1H-01-00-18-039
Original Report Issue Date: February 27, 2020
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Errata Page
Federal Employees Health Benefits Program
Prescription Drug Benefit Costs

Our original statements made on page 15 referenced premium increases being offset by benefit reductions in the form of higher member cost shares. We have revised this language to more accurately reflect the intent of our comments to OPM's response related to the effect that increasing member copays and/or coinsurance has had on premiums.

Our original text on page 15 is as follows: "We also recognize that OPM has been able to maintain a reasonable premium increase (4 percent increase in 2020 – up from 1.3 percent the prior year), but at what cost? Premium increases have undoubtedly been offset by the actuarial values of benefit reductions that causes the members' out of pocket cost shares (i.e., copays, coinsurance, deductibles, etc.) to increase, which certainly plays a significant part in keeping FEHBP premium increases to a minimum. While reducing benefit levels can help offset premium increase, it is not a solid long-term strategy to mitigate the risks of future increases."

The page 15 text was changed to read: "We also recognize that OPM has been able to maintain reasonable premium increases in recent years. However, increases in member cost sharing (i.e., higher copays, coinsurance, deductibles, etc.) over the years have had a lowering effect on premiums, which have played a role in controlling premium costs. OPM acknowledges these increases in member cost share, as referenced in the 2020 FEHB Call Letter, which states:

> 'Over the years, several Carriers have moved away from drug copayments to coinsurance, in which the member pays a percentage of the negotiated cost of the drug. As the cost of prescription drugs continues to rise, there is concern that some FEHB members may not be able to afford their medication costs and that the amount of their cost share is less transparent. This is especially true for FEHB members in plans that do not have a maximum limit on coinsurance for prescription drugs. Research has indicated that as member out-of-pocket costs grow, the rate of prescription abandonment or delays in filling prescriptions increases, which in turn has implications for downstream health care costs'.

OPM indicates that recent premium increases are the lowest in 23 years due to initiatives they have implemented. However, the increases in member cost share over time have also had an impact on premium increases and should be factored in as a method the FEHBP has capitalized on to control costs."

The clarification made to the two paragraphs on page 15 does not alter the conclusions or recommendations made in the final report.

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program Prescription Drug Benefit Costs

Report No. 1H-01-00-18-039 **March 31, 2020**

What is a Management Advisory Report?

The primary purpose of this Management Advisory Report (MAR) is to inform the U.S. Office of Personnel Management (OPM) of concerns that the Office of the Inspector General (OIG) has regarding the escalating cost of the prescription drug benefit in the Federal Employees Health Benefits Program (FEHBP).

Why Issue a Management Advisory Report?

It is vital that OPM ensure that all possible methods to lower the cost of the prescription drug benefits in the FEHBP are explored. The OIG has identified the rising costs of prescription drugs in its "Top Management Challenges" reports issued to OPM annually. Since the inception of the FEHBP, pharmacy benefits have been provided via participating FEHBP carriers by administering pharmacy benefits internally, or by carriers contracting with Pharmacy Benefit Managers (PBM) on behalf of their enrolled population. Instead of capitalizing on the purchasing power of over 8 million FEHBP members to generate greater savings, each of the hundreds of FEHBP participating carriers separately contracts with a PBM, with sometimes less negotiating leverage, resulting in FEHBP pharmacy costs that vary greatly.

Michael R. Esser
Assistant Inspector General for Audits

What Is Our Concern?

Our concern remains that OPM may not be obtaining the most cost effective pharmacy benefit arrangements under the FEHBP.

We believe that OPM should consider all possible options, starting by conducting another independent study, to gain additional savings and maximize cost containment efforts, as discussed in this MAR.

ABBREVIATIONS

Act	**Federal Employees Health Benefits Act**
ADC	**Automated Data Collection**
AWP	**Average Wholesale Price**
FEHBP	**Federal Employees Health Benefits Program**
HIO	**Healthcare and Insurance Office**
MAR	**Management Advisory Report**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Pharmacy Benefits Manager**
PDP	**Prescription Drug Plan**
RFI	**Request for Information**
VA	**U.S. Department of Veterans Affairs**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. SUMMARY

The primary purpose of this Management Advisory Report (MAR) is to highlight and expand on a mission-critical challenge we identified several years ago and continue to address in our "Top Management Challenges" reports issued to the U.S. Office of Personnel Management (OPM) annually. Our concern remains that OPM may not be obtaining the most cost effective pharmacy benefit arrangements under the Federal Employees Health Benefits Program (FEHBP). We believe that OPM should study all options to gain additional savings and maximize cost containment efforts, as discussed in this MAR.

Prescription drug benefits are a major component of the cost for the FEHBP, currently representing over 27 percent of total premiums spent on drugs, net of member cost share. Considering that prescription drug spending in the United States is about 17 percent[1] of overall personal healthcare expenditures, there may be an opportunity to reduce the drug spend in the FEHB Program. Most FEHBP carriers report an increase in drug costs per member each year. Greater utilization of existing drugs and the expanding costs of specialty drugs[2] contribute significantly to FEHBP premiums. Prescription drug utilization and costs are expected to increase for the foreseeable future, as new pharmaceutical advancements are developed and the rapid growth of the specialty drug market continues. In fact, 2017 data reported to OPM by one large FEHBP carrier indicates that while specialty drug claims represent only a small portion (0.6 percent) of their total number of drug claims, its associated cost accounts for over one-third (37 percent) of total drug spend. That means a small-to-moderate increase in specialty drug utilization could result in extreme increases in total drug costs. This is an alarming statistic knowing that specialty drug trends are not expected to slow down anytime soon. Since prescription drugs make up over a quarter of the total FEHBP spending, OPM needs to do all it can to ensure that Federal employees and the American taxpayers are getting the best value for their dollar.

The need for impartial and extensive analysis of the FEHBP drug program and potential cost-saving options is long overdue. The last time that OPM formally studied this issue was approximately seven years ago. The PBM and prescription drug landscape has significantly changed since 2012 and as such, warrants the need to evaluate the benefits, delivery, and pricing of FEHBP prescription drugs; specifically, whether carriers' PBM contracts provide the best value to the Federal Government and FEHBP enrollees in today's pharmacy benefits environment. Moving forward, OPM will need to develop an effective, long-term strategy to

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Observations on Trends in Prescription Drug Spending" (2016), https://aspe.hhs.gov/pdf-report/observations-trends-prescription-drug-spending.

[2] Specialty drugs are a recent designation of pharmaceuticals that are classified as high-cost, high complexity and/or requiring increased human intervention. Specialty drugs are often biologics—drugs derived from living cells that are injectable or infused.

mitigate and manage future FEHBP prescription drug costs, while maintaining overall program value and effectiveness.

II. BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits Act (Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services, which all include some level of prescription drug coverage. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

Currently, the FEHBP covers approximately 8.2 million Federal employees, retirees, and their dependents by contracting with over 200 health insurance plans on a fee-for-service, experience-rated, or community-rated funding arrangement. The FEHBP offers a wide variety of plan types and coverage options to help meet the health care needs of its enrollees. The FEHBP is the largest employer-sponsored health insurance program in the country, providing more than $53 billion in health care benefits annually, of which approximately 72 percent is paid by the Federal government and 28 percent is paid by subscribers. Many organizations and policy makers look to the FEHBP as a model for providing health care, which reinforces the need for the program to provide the best quality in health care benefits at the best possible price.

OPM requires participating health insurance plans to offer prescription drug coverage as part of its overall FEHBP health benefits package. This is known as a pharmacy "carve-in" model, where prescription drug coverage is bundled into the medical benefits. It is the traditional delivery system of pharmacy benefits for most small and mid-sized employer groups. FEHBP member cost share (i.e., copays, coinsurance, deductibles) and a health plan's drug formulary[3] vary greatly among the available options, however the vast majority of participating plans use what is known in the industry as a Pharmacy Benefit Manager, or PBM, to administer prescription drug benefits. FEHBP carriers contract with PBMs to provide benefits as well as manage drug costs and utilization for their enrolled population. The FEHBP does not contract directly for prescription drug benefits.

PBMs are primarily responsible for processing and paying prescription drug claims on behalf of many large employers and health plans. The services provided typically include retail pharmacy, mail order, and specialty drug coverage. For retail drugs, the PBM contracts directly with pharmacies located throughout the United States and many of its territories. For maintenance prescriptions that do not need to be filled immediately, PBMs typically offer the option of mail order pharmacies (usually for up to a 90-day supply of medications). PBMs also provide

[3] A drug formulary is a list of preferred drugs that the member may obtain at a lower cost share than other similar drugs in its class.

specialty pharmacy services for members with rare and/or chronic medical conditions. PBMs are used to develop, allocate, and control costs related to the pharmacy claims program it serves. PBMs negotiate terms with each individual FEHBP health plan for the services, networks, prices, rebates, guarantees, and other pricing and financial terms based on multiple market factors. In contrast with other Federal programs, the FEHBP does not regulate or negotiate drug pricing for its members. Instead, it relies solely on competition among the various participating health plans using multiple PBMs to attempt to keep prices low. OPM has no direct involvement in PBM contract negotiations. In fact, Title 5, Section 8903 prevents OPM from directly contracting with PBMs for pharmacy benefits.

III. INITIATIVES AND OTHER GOVERNMENT EXAMPLES

Over the years, OPM has taken several FEHBP prescription drug program initiatives that emphasize the need for better cost controls and improved administration of the drug benefit. The following are some of the actions OPM has taken that supports this effort.

A. OPM Call Letter Directives

Each spring, OPM issues a call letter soliciting benefits and rate proposals from FEHBP carriers for the following year. This call letter outlines specific policy goals and initiatives that are at the forefront of OPM's mission to provide high quality, cost effective health care to its enrollees. As part of this call letter, OPM typically calls on participating health plans to focus on innovative ways to optimize pharmacy benefits to ensure the safe and effective use of prescription medications while managing costs. To accomplish this objective, OPM directed participating health plans over the years to consider initiatives that seek to achieve this goal, such as the following:

- Add and expand drug management programs that control costs, and improve quality and patient outcomes;
- Expand efforts to use a common four-tiered benefit structure to improve members' understanding of their prescription drug benefits and maximize cost savings;
- Implement a prescription drug cost calculator that will allow current and prospective enrollees to compare the cost of the prescription drugs they use to verify coverage prior to enrollment;
- Establish better formulary management techniques and selective pharmacy network contracting based on costs and quality criteria, as well as a formulary exception process;
- Optimize the use of high value medication distribution channels by aligning member incentives with the most cost effective options;
- Implement, operate, and reinforce drug utilization management strategies;
- Take action to improve medication adherence, drug utilization management, and the alignment of formularies to established clinical guidelines;
- Optimize the benefit channel through which certain specialty drugs are delivered (e.g., medical or pharmacy benefit);
- Implement a cost comparison tool that gives current and prospective enrollees access to user friendly information about the formulary tier and member cost-share for prescription drugs; and,
- Strengthen efforts to prevent opioid misuse and implement effective addiction treatment programs.

Based on the above efforts, it is clear that OPM's goal for the FEHBP is to pursue ways to restrain rising health care costs while providing opportunities for members to live healthier lives. OPM is focused on ways to provide affordable, quality health plans for Federal employees, annuitants, and their families.

We commend OPM for these efforts to maximize quality drug benefits while attempting to minimize drug cost increases in a program comprised of hundreds of different drug benefit options. However, most, if not all, of the above initiatives have been delegated to the individual health plans to administer, and OPM has little to no direct control over how these efforts are implemented and the outcomes are difficult to quantify. Moreover, several of the initiatives have room for interpretation among carriers and the methods employed to meet these cost saving initiatives may vary greatly, diminishing their ability to affect the FEHBP as a whole. Nonetheless, the above efforts have undoubtedly had a positive impact on the FEHBP's prescription drug program and should continue to be a part of any comprehensive drug management program going forward.

B. Prior PBM Studies by OPM

In 2010, OPM contracted with an outside consulting firm to provide a detailed quantitative analysis of multiple alternative pharmacy benefit purchasing scenarios in order to mitigate the increasing costs of offering prescription drugs and create greater cost transparency.

The study focused on the following three cost saving strategies:

- To reduce the utilization of multi-source brand drugs through higher generic utilization;
- To negotiate a single contract with one PBM for all FEHBP pharmacy operations; and
- To reduce the size and variation of FEHBP formularies by using a single supply schedule.

The study concluded that to reduce the utilization of multi-source brand drugs from mail and retail, OPM would have to force carriers to increase generic utilization. The study found that brand and retail drug costs could be reduced by about 2.1 percent (specialty drugs showed no cost savings at the time). OPM acted on this strategy and issued call letters to the carriers requiring an 80 percent generic utilization rate by contract year 2014.

To negotiate a single contract with one PBM for pharmacy operations, OPM would have to issue a request for proposal and set up an administrative group to oversee the bid and implementation process. OPM would also have to consider the necessary changes to current law. Finally, OPM would have to compare any cost savings against the loss of benefits to FEHBP members. The study showed that a projected cost savings of

0.8 percent could be achieved by moving the entire FEHBP into the PBM with the best discounts (at the time); however, the savings projection was based on implicit discounts derived from historical FEHBP claims and other market data. The projected savings were not based on single source bids from prospective PBMs competing for the entire FEHBP book of business, which theoretically could result in greater savings. Nonetheless, since the cost savings appeared minor compared to any loss of benefits and disruptions to the FEHBP, OPM did not implement this strategy.

To reduce the size and variation of FEHBP formularies, the study found that OPM would have to set strict formulary requirements for FEHBP carriers to follow or implement a single supply schedule. The formulary requirements could include closed formularies, program wide exclusions, and a narrower preferred list that must be used by all carriers. The study showed that the savings resulting from a reduced formulary or single supply schedule would be greater than 30 percent, with the majority of the cost shifted to the member since half of the FEHBP drugs would no longer be on the preferred formulary list. While this option showed the greatest savings potential based on the 2010 study, OPM did not implement this strategy.

In 2012, OPM conducted additional analysis by issuing a request for information (RFI) to obtain price, delivery, and other market information from prospective respondents for preferred PBM services in the FEHBP. The purpose of the RFI was to potentially make available to FEHBP carriers an arrangement with which an FEHBP carrier could contract with a preferred PBM to obtain better financial terms than their current PBM contract for FEHBP business. However, this preferred PBM strategy never came to fruition, and the idea languished.

Although these studies were beneficial in providing ways to reduce costs, OPM only implemented one strategy - requiring FEHBP carriers to increase generic utilization. The other cost saving strategies identified were not implemented for various reasons, such as the potential harm to enrollee benefits. Additionally, because these studies were performed several years ago, most of the information is outdated and no longer reliable. Consequently, we believe it is in OPM's best interest to perform a new market study on ways to reduce prescription drug costs in the current environment.

C. PBM Transparency Standards

In 2005, and then updated in 2011, PBM transparency standards were incorporated into the FEHBP fee-for-service and experience-rated carrier contracts. These terms articulated the following transparency principles:

- Pass-through transparent pricing is an arrangement based on the PBM's cost for drugs in which the carrier receives the value of the PBM's negotiated discounts, rebates, or other credits.
- The PBM's profit under the contract comes from clearly identifiable sources.
- The PBM's administrative fees, such as dispensing fees, are clearly identified on retail claims, mail claims, and clinical programs, if applicable.
- All contracts and other documentation that support amounts charged to the carrier contract are fully disclosed to and auditable by the carrier, or its agent, and the OPM Office of the Inspector General (OIG).

PBM transparency requirements improved the means by which the FEHBP carriers' PBM (large provider) agreement is audited and may have even forced PBMs to reevaluate their business models. The transparency standards defined the pass-through pricing model and was a good "first step" towards ensuring the FEHBP receives a transparent price for prescription drugs. However, while transparency standards were necessary and long overdue, they do not guarantee the best possible price for the FEHBP.

With the incorporation of pharmacy transparency standards into FEHBP contracts, we are now able to contractually request and review the detailed pricing and financial arrangements each fee-for-service and experience-rated carrier has agreed to on behalf of the Federal Government with their individual PBMs. Unfortunately, pharmacy transparency standards do not apply to community-rated carriers (Health Maintenance Organizations) and information related to those plans is still unavailable. Nonetheless, we recently reviewed the most current (at the time of this report) PBM contracts of FEHBP fee-for-service and experience-rated carriers and found that the drug pricing and financial arrangements varied greatly. Our research showed that the size of the carrier's FEHBP membership in some cases had no direct correlation to the level of discount the carrier was able to negotiate on behalf of OPM. The following is a chart showing the range of certain PBM pricing and other financial terms for fee-for-service and experience-rated carriers:

PBM Pricing and other Financial Terms
Fee-for-Service and Experience-Rated Carriers
2018

Drug Expense Category	Least Advantageous Arrangement	Most Advantageous Arrangement
Discount Rate (Retail – Generic)		
Discount Rate (Retail – Brand)		
Discount Rate (Mail – Generic)		
Discount Rate (Mail – Brand)		
Discount Rate (Specialty – Retail/Mail)		
Dispensing Fee (Retail – Generic/Brand)		
Dispensing Fee (Mail – Generic/Brand)		
Administration Fee (Retail – Generic/Brand)		
Administration Fee (Mail – Generic/Brand)		
Administration Fee (Specialty – Retail)		
Administration Fee (Specialty – Mail)		
Brand Rebate Guarantee (Retail)		
Brand Rebate Guarantee (Mail)		
Brand Rebate Guarantee (Specialty at Retail)		
Brand Rebate Guarantee (Specialty at Mail)		
Disclaimer: The financial arrangements shown above are from all of the PBM agreements reviewed and do not represent one agreement for all categories. These arrangements are for illustration purposes only and should not be considered independent of further in-depth study and evaluation. *AWP - Average Wholesale Price.*		

Based on the information above, it is evident that there is a wide range of complex financial arrangements among the PBM agreements reviewed. Consequently, potential prescription drug savings may exist for the FEHBP population. The need for expert consultation in the review of the FEHBP's value proposition for pharmacy benefits is both timely and warranted.

D. Presidential Plan for Economic Growth and Deficit Reduction

In 2011, "The President's Plan for Economic Growth and Deficit Reduction" called for streamlining FEHBP pharmacy benefit contracting and allowing OPM to contract directly for pharmacy benefit management services on behalf of all FEHBP enrollees and their dependents. The study showed $1.6 billion as potential pharmacy savings over a 10-year period. Because current FEHBP law precludes OPM from contracting directly with PBMs, OPM previously proposed statutory authority language changes, seeking to amend the current FEHBP law to permit OPM to contract directly with PBMs. However, this

proposal has become stagnant, and there have been no recent efforts by OPM to push this initiative to Congress for approval.

Allowing OPM to have direct contracting authority with PBMs may provide the FEHBP stronger purchasing power, help to ensure that the benefits and fees negotiated are in the best interests of the FEHBP, and will strengthen the controls and oversight of the FEHBP pharmacy program.

E. Other Government Plans

One vital aspect to studying cost saving options is to determine how other government payers are administering prescription drug programs. Here are just a few government prescription drug program examples that OPM should research when looking for cost saving solutions.

TRICARE

TRICARE is the health care program for uniformed service members and their eligible family members, covering approximately 9.4 million members worldwide. Depending on eligibility, there are four plans from which to choose: TRICARE Prime, TRICARE Select, TRICARE for Life, or certain optional premium-based plans. TRICARE offers nine plan options under four separate regional programs depending on where eligible beneficiaries are located. Each regional program is administered by a commercial health insurance plan. TRICARE health plan options include a comprehensive pharmacy benefit, administered by one PBM. TRICARE's pharmacy benefits are available to all eligible uniformed service members, retirees, and family members. The TRICARE pharmacy program provides outpatient prescription drugs through home delivery, retail, and specialty pharmacy services. Its exclusive PBM handles millions of prescriptions each year through a mail order option and retail network pharmacies. The TRICARE pharmacy program is designed to provide the medications needed, in a safe, convenient, and cost-effective manner.

Veterans Health Administration

The Veterans Health Administration is a large integrated health care system operated by the U.S. Department of Veterans Affairs (VA) and offered to members of the military once they leave active duty. The VA does not merely pay prescription drug claims submitted by providers. Unlike the FEHBP and its carriers, the VA self-administers its own prescription drug benefits through the Pharmacy Benefits Management Services. By law, prescription drugs are purchased by the VA directly from the manufacturer at discounted prices. In addition, the VA also negotiates an even deeper discount on its national formulary. Due to

its ability to purchase drugs at deep discounts, the VA prescription drug program is often used as an example for other large purchasers to follow in obtaining favorable drug pricing.

Medicare

The Medicare Part D prescription drug program was based on the FEHBP model. The Medicare Prescription Drug, Improvement, and Modernization Act, also called the Medicare Modernization Act, is a Federal law, enacted in 2003, to provide prescription drug benefits to seniors and beneficiaries covered under Medicare Part A and B. Medicare contracted with PBMs as a stand-alone insurer to provide a drug benefit or in conjunction with a preferred provider organization or other managed care insurer, which would provide the standard Medicare health benefit. Thus, PBMs operate within Medicare as a Prescription Drug Plan (PDP), or they may contract with health insurers to provide PBM services. If a PBM serves as a PDP, it must comply with Medicare regulations regarding enrollment, benefits, and premiums, and it must implement a mandatory compliance plan. If a PBM only contracts with health insurers, the insurers are required to bear those compliance responsibilities. However, insurers are required to exercise proper monitoring, oversight, and auditing to ensure Medicare program compliance.

Large Employer/State Government Plans

Nearly two-thirds of all large employers in the United States contract directly with a PBM to handle their drug benefits and costs. In addition, many state governments have found that pharmacy carve out arrangements through a direct PBM contract provide greater flexibility in plan design and realize significant savings over traditional carve in programs. Many health care payers are using the additional prescription drug rebates gained through a direct PBM contract to assist their employees in offsetting copays or even premium increases. In fact, the State of West Virginia recently performed a study of its Medicaid prescription drug costs and found that bringing the program in house (which they did effective July 1, 2018) would realize significant savings (up to $70 million annually) over the carve in option that had been in place with its contracted managed care organizations. OPM has an opportunity to learn from other large employers' and states' progress in addressing prescription drug costs.

IV. CONCLUSION

As of 2019, the FEHBP and its enrollees spent over $13 billion annually on prescription drugs, comprising over 27 percent of the total cost of the program. The OIG feels strongly that OPM should take a more proactive approach to finding ways to curtail the prescription drug cost increases in the FEHBP. While the efforts made to date have undoubtedly helped control drug costs, we feel additional measures are needed to find more cost saving solutions to the problem of the growing costs of prescription drugs in the FEHBP.

As previously mentioned, the latest study conducted on FEHBP prescription drugs was in 2012. Several of the initiatives identified from this study that were projected to achieve little or no cost savings could now provide higher cost savings to the program. Changes in the industry may have borne new cost savings concepts or techniques not thought of or available nearly a decade ago. Any study undertaken should incorporate, at a minimum, all of the examples discussed in this report. OPM should evaluate each cost saving option developed from such a study to determine if it is feasible and is in the best interests of the FEHBP, its members, and the Federal Government.

The FEHBP was established nearly 60 years ago and remains the single largest employer sponsored healthcare program in the United States. During this period of time, the FEHBP has not changed the fundamental way in which it conducts business. Allowing contracted carriers to sometimes set and interpret the rules can result in a lack of controls and the stagnation of any program modernization. Since OPM's prior research in 2012, there have been dramatic changes in the way pharmacy benefits are managed that warrant a new study. OPM should research whether taking control and condensing FEHBP prescription drug benefit components would produce an overall strategy that reduces benefit costs.

V. RECOMMENDATIONS AND OPM'S RESPONSE

Recommendation 1

We recommend that OPM conduct a new, comprehensive study by seeking independent expert consultation on ways to lower prescription drug costs in the FEHBP, including but not limited to the possible cost saving options discussed in this report.

OPM's Response:

Healthcare and Insurance partially agrees with our recommendation and while it appears they are not opposed to an independent study, they state they have neither the funding nor the resources to conduct such an engagement in the near future. [redacted] ***OPM goes on to adamantly disagree with one of our Management Advisory's suggestions that a prescription drug carve-out program be considered, listing a multitude of reasons why such a fundamental change in the FEHBP would be detrimental to the integrity and operations of the program. Some of the challenges that OPM puts forth as reasons for not carving out prescription drugs include:***

- ***It would do away with a market-based competition model that has worked well since its inception of the program;***
- ***The requirements of having to establish a large administrative structure to handle separate funding and premiums, causing the Federal government to be the underwriter for the benefit (e.g., a self-funded arrangement), fundamentally changes the risk arrangement of the program;***
- ***Contracting issues and possible non-winning bidder protests;***
- ***Detrimental strategic implications;***
- ***Limited member choices;***
- ***Carriers departing the FEHBP;***
- ***Ineffective coordination of medical and pharmacy claims; and,***
- ***Other administratively burdensome activities, all of which OPM opposes.***

Furthermore, OPM highlights that a prescription drug carve-out program would fall outside the current policy and legislative framework for which OPM's Healthcare and Insurance office is responsible. OPM goes on to add that the FEHB Act required the development of a market-based Program. It did not allow for direct contracting specifically to provide pharmacy benefits. Similarly, it did not allow for direct contracting with physicians or

hospitals or for a single "one size fits all" health plan like the fee-for-service Medicare program.

OPM states that FEHB Program actions to control prescription drug policies are aligned with the Administration's American Patient's First Blueprint across the key strategies to Improve Negotiation, Lower List Prices, Reduce Out-of-Pocket Spending, and Create Incentives to Lower List Prices. They state that they continue to monitor FEHB Program prescription drug spending, PBMs, and pharmaceutical trends and controls within plan designs (e.g., formulary management, step therapy, etc.), related to the pharmacy benefit, at either the health plan level or through the PBM, seeking opportunities to derive greater value for FEHBP members.

OPM states they have done significant work to study prescription drug spending in the FEHB Program to control future cost increases. This includes:

- ***Identifying and outlining long-range administrative and quality goals and objectives for pharmacy benefits.***
- ***Assessing trends, new developments, and best practices (including medication management, specialty drug utilization, pharmacy benefits management, and formulary management) in the pharmaceutical industry by holding annual meetings with the major pharmaceutical benefit managers – PBMs such as CVS, Optum and Express Scripts.***
- ***Staying abreast of industry trends by attending conferences or participating in meetings sponsored by organizations such as the American Society of Health-System Pharmacists - ASHP, the Academy of Managed Care Pharmacists - AMCP, and the American Pharmacists Association - APhA. In addition, by subscribing to professional journals, accessing continuing pharmacy education resources, industry publications, and bulletins and reviewing and examining technical, scientific, and medical data in support of agency policy development and program management.***
- ***Evaluating methods to improve health outcomes related to the use of pharmaceuticals (e.g., step therapy and collaborative practice agreements between physicians and pharmacists for disease state management).***
- ***Administering the pharmacy-related automated data collection (ADC) to guide future Call Letter topics and to monitor Carrier implementation of prior guidance.***
- ***Evaluating quality and utilization measures that pertain to medication management, the use of preventive medications, and the attainment of health outcomes via medication therapy.***

OPM states that 2019's 1.3 percent FEHB Program premium increase, the lowest in 23 years, exemplifies the effective management OPM exercises over the 200+ plans in the program. They state they are committed to cost-effective prescription drug management as evidenced by the list of actions the MAR acknowledges and others that OPM has taken. These include incorporating step therapy and prior authorization in prescription benefit structures, encouraging benefits that increase the generic dispensing rate, mandating the expansion of tiers and managed formularies, narrower networks, tighter controls on opioid prescriptions and more. Per the ADC, the total drug expenditures under the prescription benefit for the FEHB Program increased 4.7 percent from 2016 to 2017. In line with industry trends, this

was a slower growth than from 2015 to 2016, which was 12.53 percent. U.S. spending on prescription medicines in 2016 increased at a slower rate in comparison to 2015 and 2014 due to fewer high-cost specialty drugs coming into the market and manufacturers facing increasing pressure on pricing and competition.

OIG's Comments:

We recognize that OPM has implemented measures to control future drug spending in the FEHBP and our goal is not to discredit these efforts. We also understand that OPM is limited with regards to funding a study. [redacted], we recommend that a funding request be included in the next budget formulation cycle and each year thereafter, until such time a study is funded. In addition, we do not argue for one solution to the rising costs of prescription drugs in the FEHBP. While entertaining a prescription drug carve-out program is one of the many possible solutions, it should not be excluded as an option before giving due consideration to its merits. Many of the points that OPM argues against the idea of carving out prescription drugs should be evaluated as part of the recommended study. They are valid points but lack the quantitative support needed to make an informed decision about carving out prescription drugs.

We also recognize that OPM has been able to maintain reasonable premium increases in recent years. However, increases in member cost sharing (i.e., higher copays, coinsurance, deductibles, etc.) over the years have had a lowering effect on premiums, which have played a role in controlling premium costs. OPM acknowledges these increases in member cost share, as referenced in the 2020 FEHB Call Letter, which states:

> "Over the years, several Carriers have moved away from drug copayments to coinsurance, in which the member pays a percentage of the negotiated cost of the drug. As the cost of prescription drugs continues to rise, there is concern that some FEHB members may not be able to afford their medication costs and that the amount of their cost share is less transparent. This is especially true for FEHB members in plans that do not have a maximum limit on coinsurance for prescription drugs. Research has indicated that as member out-of-pocket costs grow, the rate of prescription abandonment or delays in filling prescriptions increases, which in turn has implications for downstream health care costs".

OPM indicates that recent premium increases are the lowest in 23 years due to initiatives they have implemented. However, the increases in member cost share over time have also had an impact on premium increases and should be factored in as a method the FEHBP has capitalized on to control costs.
Also, OPM referenced studies and initiatives in its response to the report that were based on outdated information, and many influential factors have changed since then. We feel that a study

is long overdue and that OPM should be open to exploring different ways to reduce prescription drug costs and modernizing the FEHBP and the way the prescription drug program has been operated since the inception of the program in 1960. OPM has a fiduciary responsibility to periodically reevaluate the effectiveness of cost containment and drug reimbursement program efforts in an over $13 billion annual pharmacy benefits operation. That fiduciary responsibility should include performing studies and analysis to identify improved ways to administer and control the costs of prescription drugs in the FEHBP. Lastly, any program or legislative changes needed to produce a more effective and efficient pharmacy benefits program should not be the reason for maintaining the status quo.

Recommendation 2

We recommend that OPM evaluate any study conducted pursuant to Recommendation 1 and, with due diligence, formulate recommendations and a plan for agency action based on the best interests of the government, the FEHBP, and its enrollees.

OPM's Response:

OPM agrees with this recommendation.

APPENDIX

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Healthcare and Insurance

May 13, 2019

MEMORANDUM FOR: Michael R. Esser
Assistant Inspector General for Audits

FROM: Laurie E. Bodenheimer
Acting Director, Healthcare and Insurance

SUBJECT: Response to the Draft Management Advisory Report, FEHB Program Prescription Drug Costs 1H-01-00-18-039

OPM appreciates the opportunity to respond to the Office of the Inspector General (OIG) Draft Management Advisory Report (MAR) on the Federal Employees Health Benefits (FEHB) Program's pharmacy costs, 1H-01-00-18-039. Our strategic goal is to increase the quality and affordability of FEHB Program health plans and we value your input.

We note that the draft "Management Advisory Report" is not focused primarily on OPM's management of prescription drug costs in the FEHB Program that Congress created in long-standing law, but on alternative models of a federal health insurance benefit program design that would require fundamental policy and legislative change. In fact, significant elements of the MAR fall outside of the current legislative framework that Healthcare and Insurance (HI) is charged to implement. The MAR indicates: "Instead of capitalizing on the purchasing power of over 8 million FEHB Program members to generate greater savings, each of the hundreds of FEHB Program participating carriers separately contract with a PBM, with sometimes less negotiating leverage, resulting in FEHB Program pharmacy costs that vary greatly." The FEHB Act required the development of a market-based Program. It did not allow for direct contracting specifically to provide pharmacy benefits. Similarly, it did not allow for direct contracting with physicians or hospitals or for a single "one size fits all" health plan like the fee-for-service Medicare program.

In accordance with the Act, each FEHB plan offers comprehensive medical services, including services provided by physicians and other health care professionals, hospital services, surgical services, prescription medications, medical supplies and devices, and mental health services. A proposal to carve out any of these services or the other services covered under the contract, and administer the benefit as a separate contract or program would significantly change the fundamental market-based nature of the Program. FEHB plans compete to offer all of the aforementioned benefits in a high quality manner at the most competitive price possible.
HI has previously indicated our position that we do not support legislative change to carve out pharmacy benefits. In the Top Management Challenge: Fiscal Year 2018[4], the OIG includes

[4] https://www.opm.gov/about-us/budget-performance/performance/2018-agency-financial-report.pdf

prescription drug benefits and costs as a challenge and states that OPM should consider contracting with one PBM to gain additional savings and maximize cost containment efforts. In answer to this challenge, HI provided the response below in 2018 and a very similar response in 2017:

OPM does not concur with OIG's suggestion that OPM continue to pursue efforts towards a prescription carve-out program. The Federal Employees Health Benefits (FEHB) Program is a market-based program that provides complete health benefits within each FEHB plan. The FEHB Program is not a self-funded plan and its statutory framework does not contemplate it to be the direct payer of benefits. Each FEHB Program plan offers comprehensive medical services including services provided by physicians and other health care professionals, hospital services, surgical services, prescription medications, medical supplies and devices, and mental health services. FEHB Program plans compete to offer all of these benefits in a high quality manner at the most competitive price possible.

Carving out pharmacy benefits or any of the other services normally covered under an FEHB Program contract and administering the benefit as a separate contract or program, could undermine the fundamental market-based nature of the FEHB Program. It would be disruptive and could lead to a reduction in plan participation, and limit the ability of FEHB carriers to focus on comprehensively improving the health of the population. There would likely be less effective coordination of medical and pharmacy claims, and potentially less effective, one-size-fits-all pharmacy utilization and disease management programs. OPM is now assessing carrier performance on the basis of clinical quality measures that require tight coordination between medical and pharmacy benefits. A carved out pharmacy benefit is not consistent with or supportive of plan performance assessment, and may impair achievement of OPM's long-term population health goals. As an example, carriers being held accountable for controlling diabetes and hypertension in the population they serve cannot do so readily if they do not have control over pharmacy benefit design and real time access to adherence data.

To control the cost of prescription drugs, OPM works with carriers to better manage pharmacy networks, focus on drug utilization techniques, coordinate coverage of specialty drugs between the medical and pharmacy benefit, optimize the prescription drug benefit via formulary design, and implement effective cost comparison tools for members and prospective enrollees. Additionally, OPM notes that the most recent drug trend reported by FEHB carriers showed a significantly slower rate of growth compared with previous years, in line with industry trends.

In addition, in the 2019 Congressional Budget Justification HI indicated:

The FEHB Program is market-based. Each FEHB Program plan offers comprehensive medical services, including services provided by physicians and other health care professionals, hospital services, surgical services, prescription medications, medical supplies and devices, and mental health services. At present, HI is not pursuing carving out pharmacy benefits. A proposal to carve out any of these services or the other services covered under the contract, and administer the benefit as a separate contract or program could undermine the fundamental market-based nature of the FEHB Program. OPM's research in this area has not proven that cost savings could be achieved that may offset the substantial risk of pursuing such a proposal. FEHB

Program plans compete to offer all of the aforementioned benefits in a high quality manner at the most competitive price possible. In order to manage the cost of prescription drugs, OPM works with carriers to better manage pharmacy networks, focus on drug utilization techniques, coordinate coverage of specialty drugs between the medical and pharmacy benefit, optimize the prescription drug benefit via formulary design, implement effective cost comparison tools for members and prospective enrollees, and encourage sharing of best practices between the health plans.

Actions Taken

FEHB Program actions to control prescription drug policies are aligned with the Administration's American Patient's First Blueprint across the key strategies to Improve Negotiation, Lower List Prices, Reduce Out-of-Pocket Spending and Create Incentives to Lower List Prices[5], see Attachment I. We continue to monitor FEHB Program prescription drug spending, PBMs, and pharmaceutical trends and controls within plan designs (e.g., formulary management, step therapy, etc.) related to pharmacy at either the health plan level or through the PBM, seeking opportunities to derive greater value for our members.

OPM has done significant work to study prescription drug spending in the FEHB Program to control future cost increases. This includes:

- Identifying and outlining long-range administrative and quality goals and objectives for pharmacy benefits.
- Assessing trends, new developments and best practices (including medication management, specialty drug utilization, pharmacy benefits management, and formulary management) in the pharmaceutical industry by holding annual meetings with the major pharmaceutical benefit managers – PBMs such as CVS, Optum and Express Scripts.
- The Chief Pharmacy Officer stays abreast of industry trends by attending conferences or participating in meetings sponsored by organizations such as: American Society of Health-System Pharmacists - ASHP, Academy of Managed Care Pharmacists - AMCP, American Pharmacists Association - APhA, subscribing to professional journals accessing continuing pharmacy education resources, industry publications, and bulletins and reviewing and examining technical, scientific and medical data in support of agency policy development and program management.
- Evaluating methods to improve health outcomes related to the use of pharmaceuticals (e.g., step therapy, collaborative practice agreements between physicians and pharmacists for disease state management).
- Administering the pharmacy-related automated data collection (ADC) to guide future Call Letter topics and to monitor Carrier implementation of prior guidance.

[5] https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf

- Evaluating quality and utilization measures that pertain to medication management, the use of preventive medications, and the attainment of health outcomes via medication therapy.

In addition, this year's 1.3 percent FEHB Program premium increase, the lowest in 23 years, exemplifies the effective management OPM exercises over the 200+ plans in the program. We are committed to cost-effective prescription drug management as evidenced by the list of actions the MAR acknowledges and others that OPM has taken. These include incorporating step therapy and prior authorization in prescription benefit structures, encouraging benefits that increase the generic dispensing rate, mandating the expansion of tiers and managed formularies, narrower networks, tighter controls on opioid prescriptions and more. Per the ADC, the total drug expenditures under the prescription benefit for the FEHB Program increased 4.7% from 2016 to 2017. In line with industry trends, this was a slower growth than from 2015 to 2016 (12.53%). U.S. spending on prescription medicines in 2016 increased at a slower rate in comparison to 2015 and 2014 due to fewer high-cost specialty drugs coming into the market and manufacturers facing increasing pressure on pricing and competition.

In 2013, HI employed the services of a Registered Pharmacist as the Chief Pharmacy Officer. This first Chief Pharmacy Officer had deep knowledge and experience in Pharmacy Benefit Management, having negotiated PBM contracts for one of the largest health insurers. In 2016, OPM hired as our next Chief Pharmacy Officer a person who holds both a PharmD, and an MBA. The Chief Pharmacy Officer's primary responsibilities include monitoring of the pharmacy industry; benchmarking the FEHB Program with the private sector; developing and analyzing ADC questions, responses and trends; assisting in the negotiation of prescription drug benefits; strengthening controls surrounding PBMs; and tailoring guidance to carriers to continuously improve prescription drug benefits, services, and costs. This position has enabled OPM to feature prescription drug initiatives in the annual FEHB Program Call Letters for each of the last several years, resulting in benefit enhancements and cost savings. HI has also devoted additional staffing resources with legal, economics and public health expertise to support pharmacy initiatives.

Federal Supply Schedule

The Federal Supply Schedule (FSS) is a multiple award, multi-year federal contract that is available for use by any Federal Government agency. Section 603(a)(1) of the Veterans Healthcare Act of 1992 (Act), 38 U.S.C. §8126(a)(1), requires drug manufacturers to make their "covered drugs" available for procurement on the FSS. If an entity manufactures or sells drugs covered under Public Law 102-585 § 603, offering those drugs to the FSS is mandatory in order to receive any revenue from the Federal Government for covered drugs, including through Medicaid or Medicare. Legislative action would be required to enable FEHB Program plans to take advantage of discounts extended in the Federal Supply Schedule.

For those drugs covered under Public Law 102-585, Veterans Health Care Act of 1992, pricing is either negotiated based on vendor's most favored commercial customer pricing or statutorily-required pricing calculations. Vendors have an opportunity to establish FSS Big 4 prices and FSS dual prices. Big 4 prices are only available to the Department of Veterans Affairs (VA), the

Department of Defense (DoD), the Public Health Service (Indian Health Service), and U.S. Coast Guard customers, and are based on pricing calculations outlined under the Public Law. Dual prices are negotiated for Other Government Agencies (OGAs) that comprise the remaining authorized users of the FSS program. Dual prices are based on most favored commercial customer pricing negotiations held with the vendors.

A study conducted by the Congressional Budget Office in 2005[6] compared multiple Federal purchaser prices to Average Wholesale Price costs of drugs including the FSS, Federal Ceiling Price and Medicaid Best Pricing. On average, the report found that FSS prices were 53 percent of AWP, Medicaid net manufacturer prices were 51 percent of AWP and Federal Ceiling Price were 50 percent of AWP. For some sense of private sector prices, the report also included comparison to "best price" used in Medicaid pricing calculations, which is the lowest price paid by any private-sector purchaser for the drug product, including discounts, rebates, chargebacks, and other pricing adjustments. Best price was 63 percent of AWP.

While it might appear that allowing FEHB plans to purchase drugs from the FSS or at the Medicaid best price has the potential to save the government money in prescription drug costs, this would require legislation. The VA and pharmaceutical manufacturers raised strong concerns when OPM proposed a pilot purchase program with an FEHB carrier in 1999. VA was concerned that if FEHB plans were allowed to purchase drugs from the FSS, the prices negotiated for VA and others under the FSS would be at risk. In other words, drug manufacturers would not negotiate equally favorable pricing if the group purchasing off the schedule included private sector entities and reduced manufacturer revenue by charging lower prices to a larger group. Pharmaceutical manufacturers maintained that they were not required to sell to non-Federal entities and that drugs potentially could be diverted to unauthorized users. There was no Congressional interest in this proposal.

Potential OPM Actions

There are several actions OPM is currently taking and/or considering. These include:

1. The 2019 Call Letter[7] initiatives:
   Addressing the opioid epidemic
   - Encourage implementation or review of processes for detecting, treating, and coordinating care for opioid use disorder in pregnant women and affected babies.
   - Proposals should include how to identify and refer members at risk, evidence-based pain management through non-opioid and non-pharmacological interventions, telehealth for opioid use and other substance use disorders, access to treatment programs including for certain high-risk populations like youth and pregnant women, develop or update policies for extending addiction treatment, identify improvements from retrospective review of care

[6]Congressional Budget Office, Prices for Brand Name Drugs Under Selected Federal Programs, June 2005 https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/64xx/doc6481/06-16-prescriptdrug.pdf

[7] https://www.opm.gov/healthcare-insurance/healthcare/carriers/2019/2019-01.pdf

for pregnant women with opioid use disorder, and promote comprehensive and coordinated care approach.

Affordability through transparency, prescription drug management, and controlling fraud, waste, and abuse

- Carriers should continue to improve the drug cost transparency tool for current and prospective members and promote the use of available provider tools at the point of prescribing.
- Carriers are expected to have a robust specialty drug management program that coordinates medical and pharmacy benefit. Carriers should also propose a site-of-care management program.
- Carriers may deliver rebate value at the point of sale and are encouraged to submit innovative proposals to do so. Point-of-sale rebates and all drug price components should be identifiable.
- Carriers should describe policies and programs to incentivize generic drug use, especially where there is a demonstrable mechanism for addressing multi-source brand couponing without undue burden on the member.
- OPM will gather through the ADC additional data on utilization and trends.
- Carriers should have processes to monitor pharmacy claims to identify possible evidence of fraud, waste, and abuse, such as recent schemes involving compounding pharmacies.

2. HI is drafting a Carrier Letter that consolidates and expands upon guidance related to the management of pharmacy benefits for the FEHB Program.
3. The 2019 Plan Performance Assessment measures for the Clinical Quality Performance[8] area shows OPM's focus on prescription drug benefits, including measures for Asthma Medication Ratio, Avoidance of Antibiotics in Adults with Acute Bronchitis, Statin Therapy for Patients with Cardiovascular Disease (Adherence), Controlling High Blood Pressure, and Comprehensive Diabetes Care HbA1C < 8%.

In conclusion, OPM is taking several actions to mitigate pharmacy cost concerns and believes the information provided fully supports our strategic goal to increase the quality and affordability of FEHB health plans.

Responses to your recommendations are provided below.

Recommendation #1: We recommend that OPM conduct a new, comprehensive study by seeking independent expert consultation on ways to lower prescription drug costs in the FEHB Program, including but not limited to the possible cost saving options discussed in this MAR.

Management Response: Partially Concur

While the MAR recommends a new study be undertaken to identify cost-saving measures, it is grounded in the suggestion that the FEHB Program carve-out its prescription drug benefits from

[8] https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-11a1.pdf

the medical services, which would fundamentally undermine one of the bedrocks of the program's structure—competition. There are myriad additional implications in such a concept including that it would require separate premium and funding to administer, and the creation of a large administrative structure that does not currently exist. Key issues include:

1. Aligning Financial Accountability and Benefits Management Responsibility – This issue can also be thought of as "Who 'owns' the drug spend?" In the typical private sector employer pharmacy carve-out arrangement, the self-funded employer is responsible for financing the pharmacy benefit. However, the FEHB Program is not self-funded. Such an approach would require the establishment of new financing requirements including the creation of a new reserve fund and the payment of premiums directly to OPM. This would put the federal government in the role of a direct underwriter of this benefit.

OPM could potentially seek to attach the drug spend for carrier's enrollees to that carrier's premium. However, under the FEHB Program, both experience-rated and community-rated carriers carry underwriting risk. Attributing claims costs to a carrier for a benefit it does not manage would create an untenable situation where the carrier would be asked to assume risk but would have no ability to manage that risk. This would create additional administrative problems and a distortion in the market dynamics of the FEHB Program. To mitigate this problem, carriers could be provided with some degree of control over plan design, formulary and drug utilization and other clinical management programs. This might be done by establishing a limited set of standard plan designs, formularies and clinical programs that carriers could choose. The more carrier-to-carrier variation allowed the less group purchasing economies could be gained through drug manufacturer rebates.

2. Administrative Challenges – Developing a pharmacy carve-out program, including plan design, formulary and clinical programs, procuring a PBM, managing the transition and ongoing management of the program would require new funding for OPM, expansion of staff, and developing new capabilities. In addition, carriers would incur the costs of making system changes to accommodate the new OPM-managed PBM vendor, as well as to manage the transition, and integrate the new vendor's pharmacy claims data feeds into their medical management processes. While these costs might not exceed those generally expected in implementing a PBM transition, they could pose an unexpected burden on carriers not otherwise planning to change PBMs. Some Carriers are their own PBM and closely integrate with the medical benefits. Other Carriers contract with a PBM and could be locked into a contract for a period of approximately 3 years.

   Some key points to consider in this area are:
   - Unlike large self-funded employers in the private sector or TRICARE, OPM does not have a central enrollment file for PBMs to use.
   - Even if pharmacy claims costs could be attributed to the enrollee's medical carrier of record, it is not clear how OPM administrative costs would be funded.
   - The limitations and uncertainty of federal government funding (e.g. sequester, furloughs, etc.) create a significant risk that incremental staffing to administer this program would not be approved or once approved and in place could later be

reduced or eliminated, compromising the ongoing administration of the new program.

3. Contracting – A "winner take all" (or, for that matter, a "winner take most" or "2-3 winners take all") procurement may result in formal bid protests by the losing bidders. This has been the experience of TRICARE since its inception and there is no reason to believe that an OPM pharmacy benefit carve-out PBM procurement would be any different.

   Another dimension of contracting would be the relationship between the carrier and the OPM PBM vendor. Currently, FEHB carriers hold the contracts with their selected PBMs, who are then accountable to that carrier for their performance on everything from claims and customer service to reporting timely and accurate prescription drug claims data feeds into the carrier's data systems. To assure effective coordination between carriers and the OPM PBM vendor, some kind of operating agreement or other arrangement would need to be executed between the carrier and the vendor. One way of doing this would be to envision OPM as holding the "master agreement" with the vendor, like a group purchasing contract, but then requiring all (or most) FEHB carriers to contract with this vendor under a standard set of terms. However, since the PBM vendor would not be accountable to the carrier, but to OPM, there may be disputes by carriers if they experience performance issues that affect their members or their operations.

4. Strategic Implications – Going down the path of a pharmacy benefit carve out has significant strategic implications for OPM as an agency and for the FEHB Program. It would fundamentally change the role of the agency from its "managed competition" role of establishing ground rules, encouraging innovation and benefit enhancements, overseeing contractual performance and managing FEHB Program trust funds to a direct benefits management role.

Another strategic implication is that a pharmacy carve out, with a uniform program design (or highly limited variations) administered by a single vendor runs contrary to promotion of consumer choice of both plan design and benefits provider, which has been a fundamental underpinning of the FEHB Program since its inception in 1960. A carve-out arrangement would have significant effects on the competitive market of FEHB carriers and could lead to the departure of many plans.

Finally, the premise that OPM is not capitalizing on the purchasing power of over 8 million FEHB members is a false premise. For any FEHB carrier that also offers health benefits in the commercial market, the FEHB Program enrollment is but a small portion of the Carrier's business. Even for the largest FEHB Carrier, FEHB enrollment may represent 5 percent or less of the overall Carrier population. However, for most of the FEHB plans, the Carrier uses the same PBM for which it contracts across its larger commercial book of business. This purchasing power may represent far more than 8 million covered lives and there is no guarantee that the FEHB Program could negotiate a better deal with a PBM or for that matter as a direct purchaser of prescription drugs.

OPM is not opposed to an additional unbiased study of the FEHB Program's prescription drug costs. However, neither the current FY2019 funding level for HI, nor the Administration's proposed funding levels for FY2020 would enable us to fund such a study. The earliest opportunity for OPM to request funding for a study would be in FY2021.

Healthcare and Insurance (HI) will request funding in the next budget formulation cycle (for FY2021) to conduct an independent study that will include administrative, regulatory, and legislative options.

Deleted by the OIG
Not relevant to the final report

We appreciate the opportunity to respond to this draft report and request a meeting to discuss the findings and our responses. If you have any questions regarding our response, please contact Angela Calarco, Branch Chief, Audit Resolution and Compliance, FEIO.

Report Fraud, Waste, and Mismanagement

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