US OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT OF MEDCO HEALTH SOLUTIONS, INC.
CONTRACT YEARS 2000 - 2002
FRANKLIN LAKES, NEW JERSEY

Report No. 1A-10-91-06-033

Date: March 31, 2009

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Mail Order Pharmacy Drug Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

Medco Health Solutions, Inc.
Plan Code 88
Franklin Lakes, New Jersey

REPORT NO. 1A-10-91-06-033 DATE: March 31, 2009

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
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Service Benefit Plan Contract CS 1039
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This final audit report on the Service Benefit Plan Federal Employees Health Benefits Program (FEHBP) operations at Medco Health Solutions, Inc. (Medco) in Franklin Lakes, New Jersey questions $45,283 in pharmacy benefit payments. The Association agreed with the questioned amount. The Association also agreed with one procedural finding and disagreed with one procedural finding.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered pharmacy benefit payments for contract years 2000 through 2002 as reported on the Annual Accounting Statements.

Questioned items are summarized, as follows:

PHARMACY CLAIM PAYMENTS

- **Excessive Quantities** **$45,283**

  Medco paid eight claims where the quantity billed exceeded the amount supplied to the patient.

- **Non-Covered Enrollment** **Procedural**

  Medco paid claims for patients not enrolled in the Service Benefit Plan (SBP) and thereby not eligible to receive benefits under this contract.

PROCESSING AND ADMINISTRATIVE FEES

We determined that the processing and administrative fees charged to the FEHBP by Medco were in compliance with the terms of the contract.

PHARMACY REBATES

- **Rebates** **Procedural**

  Medco's 2002 contract with the Association did not require the FEHBP to receive all manufacturers rebates earned on FEHBP prescriptions.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our performance audit of the Service Benefit Plan Federal Employees Health Benefits Program (FEHBP) mail order pharmacy operations at Medco Health Solutions, Inc. (Medco). Medco's headquarters are located in Franklin Lakes, New Jersey.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

The FEHBP was established by the Federal Employees' Health Benefits (FEHB) 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 Center for Retirement and Insurance Services has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association has contracted directly with Medco to manage the delivery and financing of mail order prescription drug benefits for Service Benefit Plan Standard Option health benefit purchasers.

The Association has established a Federal Employee Program (FEP) Director's Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, Medco, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Medco management. Also, management of Medco is responsible for establishing and maintaining a system of internal controls for the mail order prescription drug program.

This is our first audit of Medco. The results of our audit were provided to Medco in written audit inquiries; were discussed with Medco and/or Association officials throughout the audit; and were presented in detail in draft reports, dated December 8, 2005, and January 6, 2006. The Association's comments offered in response to the draft reports were considered in preparing our final report and are included as Appendices to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan's charges to the FEHBP and services provided to FEHBP members were in accordance with the terms of the contract. Specifically, our objectives were as follows:

- Pharmacy Claim Payments

  To determine whether the Plan complied with contract provisions relative to benefit payments.

  To determine if claims were properly adjudicated.

- Processing and Administrative Fees

  To determine whether processing and administrative fees charged to the FEHBP were in compliance with the terms of the contract.

  To determine if the Plan met the contractual performance guarantees.

- Pharmacy Rebates

  To determine whether rebates were correctly calculated and returned to the FEHBP.

SCOPE

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the BlueCross BlueShield Service Benefit Plan Annual Accounting Statements as they pertain to Plan Code 88 for contract years 2000 through 2002. During this period, Medco paid approximately $3.6 billion in mail order prescription drug charges (See Schedule A).

In planning and conducting our audit, we obtained an understanding of Medco's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving Medco's internal control structure and its operation. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on Medco's system of internal controls taken as a whole.

In conducting our audit, we relied to varying degrees on computer-generated data provided by Medco. Due to time constraints, we did not verify the reliability of the data generated by Medco's information systems. However, while utilizing the computer-generated data during audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve the audit objectives.

We also conducted tests to determine whether Medco had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, Medco did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that Medco had not complied, in all material respects, with those provisions.

The audit was performed at Medco's offices in Franklin Lakes, New Jersey from May 16, 2005 through June 10, 2005. We also worked closely with the Association in our Washington, D.C. office to complete this audit.

METHODOLOGY

To test Medco's compliance with the FEHBP health benefit provisions, with the assistance of ACS-Heritage Information Systems (ACS) we identified universes of claims using various criteria, including the following:

- Claims Paid Outside of Eligibility
- Claims Paid with Suspicious Quantities
- Claims Paid with Package Size Discrepancies
- Claims Paid without Prior Approval
- Non-Covered Drug Claims Paid

Statistical sampling was used for portions of the claim reviews performed due to the large claims universe. All other samples were judgmental (with or without the use of stratified sampling), although samples within a stratum could be randomly selected or statistical. We used the FEHBP contract and the Medco/Association contract to determine if processing and administrative fees charged to the FEHBP were in compliance with the terms of the contract. We also used the contracts to determine if rebates were correctly calculated and returned to the FEHBP.

The claims samples that were statistically-based did project audit results to the entire universe where irregularities occurred. Other portions of the claims review looked at the entire universe of claims. The remaining claim samples were judgementally selected. Consequently, the results related to these samples could not be projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Pharmacy Claim Payments

1. Excessive Quantities $45,283

Medco paid eight claims where the quantity billed exceeded the amount supplied to the patient. The amount over-billed totaled $45,283.

Contract CS 1039 section 3.2 (b) (1) states "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Section 2.3 (g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider."

From the claims billed by Medco from January 1, 2000 through December 31, 2002, we identified 835 claims where the quantity billed appeared to exceed the amount supplied to the patient. Of the 835 claims, we selected the 10 highest dollar claims and requested Medco review the claims. Out of the 10 claims, 7 were incorrectly dispensed. Along with these claims, Medco also identified an additional claim that was incorrectly dispensed.

Since the claims were incorrectly dispensed, the charges are unallowable. As a result, FEHBP was overcharged $45,283.

Association's Response

The Association does not contest this finding and states that the funds were returned to the FEHBP on January 25, 2006.

Recommendation 1

The Association did return the funds to the FEHBP on January 25, 2006. Consequently, no further action is required.

2. Non-Covered Enrollment Procedural

Medco paid claims for patients not enrolled in the Service Benefit Plan (SBP) and thereby not eligible to receive benefits under Contract CS 1039. As a result, the FEHBP was potentially overcharged more than $3 million for years 2000 through 2002.

In both the 1999 contract (Section 2.4) and the 2002 contract (Section 1.2) between the Association and Medco, it states that the contracts are subject to Chapter 89 of Title 5 of the United States Code, and to the provisions of CS 1039. It is further stated in the contracts that nothing shall contravene the rights and obligations of either party under those provisions.

Contract CS 1039, Section 3.2(b) (1) states "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Section 3.2(b)(2)(i) states "Benefit costs consist of payments made and liabilities incurred for covered health care services on behalf of FEHBP subscribers …." In addition, Section 2.3 (g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider."

The contracts between the Association and Medco (Schedule D, Sections 7.6.1.1 and 7.6.2 of the 1999 contract and Schedule D, Sections 1.1(a) and 1.1(b) of the 2002 contract) state that for each claim, Medco will determine if the individual receiving benefits is a member who is eligible for coverage on the date the prescription was dispensed. If the claim is not for an eligible member, Medco will deny the claim.

The Association provided the SBP eligibility files for the period January 1, 2000 through December 31, 2002, which contained membership effective dates and termination dates. We compared the patient's effective and termination dates against 100 percent of the claims data to identify claims that were paid outside of the dates where a patient had eligibility. This resulted in 25,625 potentially ineligible subscribers with a total amount paid of $4,590,589. The review took into consideration the 30 day grace period of temporary continuing coverage following termination of eligibility.

Out of the 25,625 claims, we reviewed a statistical sample of 320 claims, with a total amount paid of $48,243, to determine if the patient was eligible for benefits. Our review identified 217 claims, with a total amount paid of $33,296, where the patient receiving benefits was not eligible for coverage at the time of the claim. There were two categories of ineligible claims:

- **Incorrect member eligibility determination by Medco**

  Medco incorrectly determined the eligibility for 58 claims, resulting in overcharges to FEHBP of $5,609. The majority of the 58 claims were for over-aged dependents. Projecting the error rate over the claims paid, the incorrect member eligibility determination by Medco resulted in a possible overcharge to the FEHBP of $533,627 from years 2000 through 2002.

  Association's Response

  The Association stated that given the high volume of prescriptions dispensed by Medco and the exceptionally high accuracy rate of their eligibility determiniations, these were good faith erroneous benefit payments and fall within the definition of allowable charges to the FEHBP under contract CS 1039 (section 2.3g). The Association further stated that the extrapolated error amount represented only 0.01 percent of the total dollar value of FEHBP claims processed by Medco from 2000 through 2002.

OIG Comments:

We understand that Medco processes a high volume of prescription claims within any given year. However, we contend that its claims system edits should be structured in such a way that claims with ineligible members are detected and removed prior to the payment of the claim. Medco receives regular eligibility updates from the Association, and it was this information that we utilized for our analysis.

Finally, while our review showed that 11.8 percent of the statistical sample of claims reviewed were paid incorrectly, the OIG does not intend to question the projected amount. In order to recover these funds, the Association would need to know exactly which claims were paid in error. Due to the fact that this would involve reviewing the entire universe of 25,625 claims, it would be costly and extremely time consuming to identify each claim that was paid in error to begin the recovery process.

- **Ineligible claims correctly processed by Medco but subsequently determined to be ineligible because of retroactive enrollment change.**

  As a result of retroactive enrollment changes Medco paid claims for 159 ineligible enrollees totaling $27,686. Projecting the error rate over the claims paid, retroactive enrollment changes resulted in a possible overcharge to the FEHBP of $2,633,879 from 2000 through 2002.

  Association's Response:

  The Association stated that during the period 2000 through 2002, it and Medco had worked to improve identification of enrollment changes. However, despite the efforts by the Association and Medco, they were hampered due to the lag time in receiving updates from the subscribers payroll offices. As a result, retroactive enrollment termination dates can reach back months, and sometimes years, from the date of receipt by the Association.

  The Association stated that claim errors resulting from retroactive terminations are common, however the industry has not devised a good way to accommodate the time lags that necessarily occur if the member is to be afforded time to notify their employment office of an enrollment change due to a qualifying life event.

  OIG Comments:

  The OIG agrees that the Association is not completely culpable for retroactive enrollment errors that occur. However, we also believe that given the substantial losses to the Program that continue to occur, efforts must be undertaken to address this issue and implement better controls, before millions more are lost.

Recommendation 2

We recommend that the contracting officer instruct the Association to develop a corrective action plan for identifying claims that were paid for ineligible patients so that the BCBS plans can initiate recovery efforts and recover overpayments in a timely manner.

B. Processing and Administrative Fees

We determined that the processing and administrative fees charged to the FEHBP by Medco were in compliance with the terms of the contract.

C. Pharmacy Rebates

1. Rebates — Procedural

Medco's 2002 contract with the Association did not require the FEHBP to receive all manufacturer rebates earned on FEHBP prescriptions.

The 2002 Mail Service Prescription Drug Benefit Contract (the Contract) between the Association and Medco, Schedule C.1.1, states that "The total price for Prescriptions Reimbursed and services rendered each Contract Year under the Mail Service Pharmacy Program is: (a) the lesser of (i) the amount calculated under the AWP Formula, in accordance with Section 1.2.a) of this Schedule, or (ii) the amount based on the Net Effective Rate Formula, calculated in accordance with Section 1.2.b) of this Schedule ...."

The Contract, in Schedule C.2.1(a), also states that "In the event that the AWP Formula is used to calculate the Total Price for Prescriptions Reimbursed and Services Rendered, Medco shall pay a Rebate Guarantee Amount equal to [redacted] per Prescription for a Brand Name Drug that is on the SBP Formulary, excluding Specialty Drugs."

Additionally, Section 1.2 of the Contract subjects the Contract to Chapter 89 of Title 5 of the United States Code, and to the provisions of CS 1039 and further states that nothing shall contravene the rights and obligations of either party under those provisions.

Finally, 48 CFR 31.201-5, which is incorporated as part of the prime contract between the Association and OPM, requires that the applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost, and received by or accruing to the contractor, shall be credited to the Government either as a cost reduction or by cash refund.

Medco provided documentation showing that in 2002 they received $93,327,351 in rebates from the pharmaceutical manufacturers, but they credited FEHBP with only $72,381,325 on the Annual Statement of Costs. To arrive at the amount credited, Medco multiplied the number of brand name formulary prescriptions [redacted] by the guaranteed amount per prescription [redacted]. Therefore, Medco retained over $20

million in rebates that were earned on the FEHBP prescriptions ($93,327,351 – $72,381,325).

While Medco did comply with the 2002 contract they signed with the Association, because the contract was a negotiated competitive contract, mere contract compliance does not always show the complete picture. Medco only provided information for rebates on brand name formulary prescriptions. Without having access to the manufacturer contracts with Medco, we can not know how much money Medco received from the manufacturers on all drugs. Additionally, negotiated contracts that lack the necessary transparency as to terms and pricing make it extremely difficult to assess their reasonableness. Consequently, without access to the manufacturers contracts and an understanding of the monies received by Medco as a direct result of FEHBP drug utilization, we cannot determine whether contracting in this manner was in the FEHBP's best interest.

Association's Response:

"We contest this finding in its entirety. It is BCBSA's position that Medco has no legal obligation to credit $10,843,955 to BCBSA under either the plain and unambiguous terms of the 2002 Contract between BCBSA and Medco or through application of the FAR Credits Clause. In applying the AWP formula for compensating Medco for its services under the Contract, BCBSA was to receive a rebate equal to [redacted] per Prescription for a rebateable Brand Name Drug on the SBP Formulary. The $10,843,955 sought by the Draft Audit Report (purportedly under the Credits Clause) represents the difference between all 'SBP Rebates' received by Medco from pharmaceutical manufacturers and the [redacted] per rebateable Prescription that Medco credited BCBSA. But because Medco had no contractual obligation to credit BCBSA more than [redacted] per rebateable Prescription, and because BCBSA did not receive any greater rebate sum from Medco, the Credits Clause has no application. Equally important, the 2005 amendments to CS 1039 support this position."

OIG Comments:

As stated above, the 2002 contract (Section 1.2), between the Association and Medco, states that the contract is subject to Chapter 89 of Title 5 of the United States Code, and to the provisions of CS 1039. It further states in the contract that nothing shall contravene the rights and obligations of either party under those provisions.

The OIG acknowledges that per the Association's contract with Medco, it has no obligation to credit the FEHBP with more than [redacted] per rebatable prescription. Nevertheless, 48 CFR 31.201-5 requires that the applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost, and received by or accruing to the contractor, shall be credited to the Government either as a cost reduction or by cash refund. The FEHBP should, therefore, be entitled to all rebates received by Medco from pharmaceutical manufacturers.

Recommendation 3

We recommend that the contracting officer require the Association, when contracting with Pharmacy Benefit Managers on behalf of OPM, to ensure that the contracts do not contravene its obligations under its contract with OPM. This would include requiring that all monies earned as a result of FEP pharmacy claims be returned to the FEHBP, as well as requiring increased transparency as to the contract's terms and pricing components.

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An Association of Independent Blue Cross and Blue Shield Plans

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Medco Health Solutions, Inc.
Plan Code 088
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Dear [redacted]:

This is in response to the above-referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits Program (FEHBP) operations at Medco Health Solutions, Inc. Our comments addressing the Non-Covered Enrollment finding in the report are as follows:

AI 4 Non-Covered Enrollment (Revised), Questioned Amount - $3,167,506

The Draft Audit Report found that "Medco paid claims for patients not enrolled in the Service Benefit Plan (SBP) and thereby not eligible to receive benefits under Contract CS 1039," and thus concluded that the Association should "credit" the Federal Employee Health Benefits Program (FEHBP or FEHB Program) $3,167,506 for "incorrectly paid claims" from January 1, 2000 through December 31, 2002 and "ensure that Medco pays claims only for patients enrolled in SBP."

Summary of BCBSA's Response

The OPM Office of Inspector General (OPM OIG) identifies two categories of ineligible claims for which it seeks recovery in this Audit Finding. The first are claims rendered ineligible as a result of an incorrect member eligibility determination by Merck-Medco Managed Care, L.L.C. (Medco) at the time it dispensed the prescription. The second category of ineligible claims were properly processed by Medco but subsequently determined to be ineligible

because of a retroactive enrollment change. It is the Blue Cross Blue Shield Association's (BCBSA) position that CS 1039 does not require BCBSA to return $3,1676,506 to the FEHBP for drugs dispensed where BCBSA and Medco have made a good-faith attempt to recover the overpayments in issue; particularly when, as in the case of retroactive terminations, Medco properly dispensed the drugs based on eligibility data on file from the Government at the time of dispensing. BCBSA therefore contests this Audit Finding. In addition, the Audit Finding must be put into proper perspective. Medco processed 31,476,435 prescriptions valued at $3,638,678,045 during the three-year period covered by this audit and performed its member eligibility determinations at an exceptionally high accuracy rate of 99.942%. While perfection may be desirable, BCBSA and Medco should not be penalized for not returning every overpayment made in good faith to the FEHBP.

I. Ineligible Claims Resulting From Errors In Eligibility Determination At The Time Of Prescription Dispensing

Medco processed 31,476,435 prescriptions valued at $ 3,638,678,045 in the years 2000 - 2002. The audited claims that were impacted by errors in eligibility determinations at the time of prescription dispensing equaled 11.8% of the total claims audited ($5,689 out of $48,243). When applied to the extrapolated Audit Finding for the three years in question, $373,765.71 of the Audit Finding amount, or 0.01% of the total dollar value of SBP claims processed by Medco from 2000 through 2002, is attributable to Medco's errors in eligibility determination at the time of prescription dispensing.

Given the high volume of prescriptions dispensed by Medco on a daily basis, it is inevitable that processing errors will occur; however, these errors that resulted in Medco charging BCBSA for ineligible claims were good faith erroneous benefit payments and fall within the definition of allowable charges to the FEHB Program under CS 1039, § 2.3(g). Notably, when a claims error was identified, Medco's policies and procedures required Medco to follow its recovery process for recapturing the funds paid in error, and it did so. Accordingly, any benefit payments Medco was unable to recover are allowable charges to the Program. *See, e.g.*, 1999 Contract, First Amended Sched. D., § 13.1

II. Retroactive Enrollment Changes

OPM OIG identified that "the vast majority of ineligible claims ($27,686 out of $33,375) were due to retroactive enrollment changes." When a termination notice is received by BCBSA after the actual date of the terminating event, claims that were properly processed for this member prior to the notice of the termination can be rendered ineligible. Based on the Audit Finding, retroactive terminations resulted in ineligible claims for 0.077% of the total dollar value of

SBP claims processed by Medco during the three years audited. Despite the small percentage this problem represents, BCBSA and Medco had a process in place to attempt recovery of claims properly paid prior at the time of processing, that were later determined ineligible through notification of a retroactive termination.

A. Medco properly dispensed prescriptions to SBP members after confirming that they were active members as identified in the latest eligibility information received from the Government.

Medco was required under its 1999 and 2002 contracts with BCBSA to verify a member's eligibility prior to dispensing a prescription. *See* 1999 Mail Service Prescription Drug Benefit Contract (1999 Contract), Arts. 7.6.1.1 and 7.6.2; 2002 Mail Service Prescription Drug Benefit Contract (2002 Contract), Sched. D, §§ 1.1(a) and 1.1(b). To facilitate this process, BCBSA provided SBP member eligibility information to Medco. *See* 1999 Contract, First Amended Sched. D, § 7; 2002 Contract, Art. 4.8.

As required by the 1999 Contract, and in conjunction with Medco's 1999 claims system conversion, BCBSA and Medco executed a "Technical Specifications Document" (the "Federal Employee Program (FEP) Technical Document - 7/25/99 Re-Installation") on May 27, 1999. *See* Exhibit 1. This document detailed the respective responsibilities of the parties related to member eligibility, claims processing, billing, and erroneous prescriptions dispensed under Medco's new claims system (*see* 1999 Contract at Sched. B, § 9.3); it became Medco's policy and procedure for managing enrollment/disenrollment activities and recovering erroneous payments throughout the 1999 and 2002 Contract periods.

Throughout the audit period, BCBSA, through the Federal Employee Program Operations Center ("FEPOC"), received enrollment changes from Agencies, OPM, and members on a daily basis. *See* Exhibit 2, BCBSA *Federal Employee Program Administrative Manual* ("FAM"), Vol. 2, Chapt. 21, § 821 – Enrollment Guidelines and Procedures, Procedures for Membership Changes at 11-18 (Mar. 2005).[1] Member eligibility changes were aggregated in the enrollment system at the FEPOC and, pursuant to the Technical Specifications, transmitted to Medco daily as a replacement Eligibility File, Monday through Saturday (excluding holidays). As a result of this process, Medco's eligibility files were "current" by 8:00 a.m. the following business day. *See* Exhibit 1 Technical Specifications Document § 5.1.1. Medco therefore adjudicated member claims

[1] The FAM is a compilation of all BCBSA policies and procedures for the SBP. It is provided to and reviewed by the OPM on a periodic basis.

for mail order prescriptions using the most accurate enrollment information available at the time of dispensing.

Despite the FEPOC's transfer of eligibility files to Medco within twenty-four hours of FEPOC's receipt, the information transmitted was only as accurate as the information provided by the Agencies, OPM, and SBP members. Due to the many hands through which eligibility changes must pass before receipt by FEPOC, they are often submitted to FEPOC long after the date of the event or occurrence that affected eligibility. This reality results in retroactive termination dates that can reach back months, and sometimes years, from the date of receipt by FEPOC.

For example, some of the most common types of enrollment changes resulting in a retroactive termination date are legal separation, divorce, or death of the spouse of a federal employee who is the contract holder or enrollee. Under the FAM, contract holders have up to sixty days after a traumatic life event to file a form with their employing office. *See* Exhibit 2, FAM at 37 (Events that Permit Enrollment Change using the (SF) 2809). Given the stress on the employee or annuitant that often accompanies a change associated with the death of a family member, divorce, or separation, it is not uncommon for employment offices to extend that notification period well beyond the sixty days referenced in the FAM. Upon the contract holder's filing with the employment office, there typically is another period of time during which the agency processes the paperwork before submitting the termination date for the individual in question to FEPOC as a disenrollment.

Once FEPOC was notified of the spouse or dependent's termination, it promptly updated the eligibility record and transmitted the file to Medco for processing; however, this process often left a period of time (months and occasionally years) between the terminating event and the date FEPOC was notified of the termination. During this transition period neither FEPOC nor Medco knew the member had been terminated. If a claim came in for the disenrolled spouse or dependent during this time, Medco would have processed the claim in accordance with the eligibility files in the FEPOC system, which, absent notification, would still have shown the member as active.

Claims errors resulting from retroactive terminations are not unique to SBP, yet the industry has not devised a good way to accommodate the time lags that necessarily occur if the member is to be afforded time to notify their employment office of a life qualifying event. Often the expense of the manual work required to identify claims paid before a retroactive termination was received far exceeds

what can be recovered from disenrolled members.[2] As a result, even to date, few if any commercial plans attempt to recover from members claims properly paid prior to the retroactive termination but after the effective date of termination. Medco believes SBP is the only plan that has required it to conduct recovery from members of the cost of prescriptions properly dispensed prior to a retroactive termination but after the effective date of termination. Despite the fact there was no successful template for retroactive recoveries from members in the industry, in recognition of its role as steward of SBP funds and in accordance with CS 1039, Section 2.3(g)[3], BCBSA endeavored to create a process whereby Medco and FEPOC could combine their systems to "make a diligent effort to" identify and recover the cost of prescriptions properly filled prior to a retroactive termination but after the effective date of termination.

B. FEPOC and Medco combined resources to develop a state-of-the-art, technologically advanced, recovery system for the period 1999-2002.

In 1999, attempting to build on the strengths of Medco's new claims processing platform, BCBSA "requested a more automated and elaborated recovery process than requested in past contracts" from Medco. See Exhibit 1, Technical Specifications Document § 11 (Recovery Project). FEPOC was to compile all the retroactive changes[4] to enrollment that occurred during a month, hold these changes for sixty days to verify that they were valid enrollment changes, and then forward these retroactive changes and terminations (including the effected claims) to Medco in a file called the Retroactive Notification File. *See* Exhibit 1, Technical Specifications Document (Functional Specifications); *see also* Exhibit 4, Change Management Record ("CMR") #287317 (Medco Retros,

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[2] Carriers have achieved greater success in recovering medical benefits paid for retroactively terminated members. This is primarily due to the fact that medical benefit overpayments are recovered from providers with whom carriers generally have an ongoing, less emotional, relationship. In fact, recovery can often be achieved by offsetting subsequent payments from the carrier to the provider. When recovering for pharmacy benefits claims, the PBM is forced to recover the cost of the drugs dispensed directly from a former member. Thus, the nature of retroactive termination recovery efforts for pharmacy benefits is a much more sensitive process.

[3] CS 1039, Section 2.3 (g) reads: "If the Carrier or OPM determines that a member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider."

[4] Retroactive changes transferred on the Retroactive Notification File include terminations, enrollment changes, Medicare changes, and POS changes. *See* Exhibit 3, Blue Cross Blue Shield Federal Employee Program Retroactive Notification Layout at 1 (Oct. 23, 2000).

resolved July 24, 1999). Medco was then to send recovery letters to retroactively terminated members identified on this file and track and return all funds recovered. *See* Exhibit 1, Technical Specifications Document § 11 (Recovery Project).

Medco sent the first batch of recovery letters to members on July 1, 2000. *See* Exhibit 5, Medco "Letter Totals Report." Within days of the mailing of these 655 letters, BCBSA understands that Medco received over 100 calls from members upset that they had been asked to pay for their mail order prescriptions, when in fact they were active SBP members at the time of prescription dispensing. *See* Exhibit 6, Email from Medco to BCBSA (July 17, 2000). Medco quickly identified that many of the members calling were in fact eligible for SBP services on the dates for which recovery was attempted, some of whom were dual eligibles who had received a new R number after their old number was terminated. Concerned with the volume of upset members who had been sent a recovery letter in error, Medco stopped sending recovery letters until the process was refined.

C. Medco and FEPOC made a diligent effort to resolve system problems that arose with the Retroactive Notification Files.

Discussions with FEPOC regarding Retroactive Notification File problems began as early as July 7, 2000. *See* Exhibit 7, Email from Medco to BCBSA (July 17, 2000). Throughout 2000 and 2001, FEPOC continued to make improvements to the Retroactive Notification Files that it sent to the BCBS Plans and the PBMs. *See* Exhibit 8, CMR #309255 ("PCS/Medco – Problem with Retro Term," resolved September 25, 2000, correcting errors in Retroactive Notification Files resulting in recovery letters to family members requesting payment for prescriptions provided to deceased members); Exhibit 9, CMR #309251 ("POS Deletes Are Not Included on Retro Report," resolved January 1, 2001, correcting errors resulting from POS and Medicare enrollment changes); Exhibit 10, CMR #323669 ("Retroactive Report Documentation – Tracking," resolved July 23, 2001, correcting errors on Retroactive Notification files that resulted in members wrongly listed as terminated and eligible claims incorrectly identified for recovery).

While these system corrections were being made, FEPOC continued to send Retroactive Notification Files on a monthly basis to Medco. FEPOC believed that Medco was continuing to send recovery letters and, since BCBSA was not receiving complaints, that Medco had found a way to successfully manage the problems in the Retroactive Notification Files. Fearing the high volume of member complaints that quickly surfaced after the first set of recovery letters in July 2000, Medco held all subsequent files awaiting word from FEPOC that the problems with the Retroactive Notification Files had been corrected. This misunderstanding between Medco and FEPOC resulted in delays in sending

recovery letters during the audit time period, but also avoided members, and families of deceased members, who were incorrectly identified on the Retroactive Termination Files in 2000 – 2001, from receiving letters demanding payment for benefits they were entitled to receive. In November 2001, Medco and FEPOC determined that there had been a misunderstanding regarding the processing of the recovery letters. *See* Exhibit 11, Email from Medco to BCBSA (Nov. 6, 2001). Within a week of this problem being identified, Medco and FEPOC began working closely together to resolve the situation. *See* Exhibit 12, Email chain ending with email from Medco to BCBSA (Nov. 12, 2001). FEPOC worked with Medco to address their customer service concerns, and in March 2002, Medco resumed its processing of recovery letters. *See* Exhibit 5, Letter Totals Report. Ultimately, in January 2003, the Retroactive Recovery Process achieved the level of regularity and acceptable error ratio originally envisioned for the Recovery Project and outlined in Section 11 of the Technical Specifications.

D. Medco and BCBSA complied with the provisions of CS 1039 requiring BCBSA to make a diligent effort to recover overpayments.

CS 1039 does not require or anticipate recovery of 100% of claims properly paid (or the cost of prescriptions properly filled) prior to notification of a retroactive termination and after the effective date of termination; rather, it requires that BCBSA make a *diligent effort* to recover good faith erroneous payments. As explained above, endeavoring to recover as many payments as possible, FEPOC developed a detailed, state-of-the-art system to capture retroactive terminations, that is to identify claims paid after the actual termination date but before FEPOC received notification of the termination. Unfortunately, errors in the Retroactive Recovery Notification Files (and Medco's good-faith misunderstanding of some processes) resulted in active members (and families of deceased members) receiving recovery letters that demanded repayment for prescriptions that were covered. During 2000-2002, FEPOC worked through many of these errors. While both Medco and BCBSA share the OIG's aspiration that the Recovery Project be implemented flawlessly, this is not the requirement under CS 1039. As evidenced by Medco's and FEPOC's repeated meetings and substantial efforts, BCBSA met the "diligent effort" requirement of CS 1039 and is not legally obligated to credit the SBP for good faith erroneous payments; that is, payments for prescriptions properly dispensed at the time they were received based on current agency eligibility data then in the file, but which subsequently were identified through the retroactive termination process as eligible for recovery.

Further, and very importantly, OIG's assumption – that the FEHBP should be credited 100% of all paid claims eligible for recovery after receipt of a retroactive termination notice and after the effective date of termination – fails to account for

the actual recovered claims experience. Actual recovery rates for the cost of mail order prescriptions filled properly at the time of dispensing but subsequently determined to have been filled for ineligible members due to a retroactive termination for 2003 and beyond (when the Retroactive Recovery Process was functioning at its best) only reached 4.9%.[5] Thus, while we believe that no monies are contractually due FEHBP beyond those actually recovered during the audit period, FEHBP certainly is not entitled to recover via a retrospective audit what it would not have been able to recover under the best of circumstances as the result of the overpayment recovery process.

We appreciate the opportunity to provide our response to this Draft Audit Report and would request that our comments be included in their entirety as part of the Final Audit Report. After you have had an opportunity to review our response, we request a meeting with you to discuss questions and concerns prior to your issuance of the Final Report.

Sincerely,

[redacted]

Executive Director
Program Integrity

[redacted]

Attachment

cc: [redacted]

[5] If the erroneous Retroactive Notification Files in 2000 through 2002 are taken into account, the recovery rate drops to 2.6%.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
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May 5, 2006

Mr. Michael R. Esser
Assistant Inspector General for Audits
U. S. Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W, Room 6400
Washington, DC 20415

Reference: OIG DRAFT AUDIT REPORT
Medco Health Solutions, Inc.
Plan Code 088
Audit Report Number 1A-10-91-06-033
(Report Dated and Received January 6, 2006)

Dear Mr. Esser:

This letter responds to the above-referenced U.S. Office of Personal Management (OPM) Office of Inspector General (OIG) Draft Audit Report related to the OIG audit of Federal Employees Health Benefits Program (FEHBP) operations at Medco Health Solutions, Inc. (Medco), previously Merck-Medco Managed Care, L.L.C. Our comments in response to the findings in the report are as follows.

I. Executive Summary

The OPM OIG issued Draft Audit Report No. 1A-10-91-06-033 to the Blue Cross and Blue Shield Association (BCBSA or Association) on January 6, 2006. The report relates to BCBSA payments to Medco for pharmacy benefit management (PBM) services during the period 2000 through 2002 under two Service Benefit Plan (SBP) Mail Service Prescription Drug Benefit contracts. There are two Audit Findings: 1) **Deleted by the OIG** BCBSA "did not credit the FEHBP with all credits [*i.e.*, rebates] received by Medco as required by Contract CS 1039." BCBSA contests both Audit Findings.

As a steward of FEHBP funds, BCBSA takes great measure to ensure that its contracts with providers are fairly and reasonably priced and that BCBSA, in turn, only charges reasonable costs to the FEHBP. *See* 48 C.F.R. § 15.402(a).

Negotiated price contracts for commercial items, such as pharmaceuticals and PBM services, are generally exempt from cost and pricing data submission and analysis.[1] *See* 48 C.F.R. § 15.403-1(c)(3). BCBSA therefore undertook price analysis prior to execution of the Medco contracts to discern the reasonableness of Medco's pricing. Price analysis is the process of examining and evaluating a proposed price without evaluating its separate cost elements and proposed profit. *See* 48 C.F.R.48 C.F.R. § 15.404-1(b). Examples of types of price analysis that establish price reasonableness include, but are not limited to: (i) adequate competition, (ii) comparison of prior pricing and commercial contract prices for similar items; (iii) comparison with independent cost estimates; (iv) field pricing information and other reports. 48 C.F.R. § 15.404-1(b)(2). BCBSA's thorough analysis of Medco's proposed pricing for the 1999 – 2001 contract and vigorous competition for the 2002 – 2004 contract both fall within the realm of "reasonable price analysis" under the Federal Acquisition Regulation (FAR).

Moreover, the FAR recognizes that where cost and pricing data is not required, such as for commercial or competed contracts (like the Medco contracts), collection and analysis of cost and pricing data, including profitability, can lead to increased costs for the contractor and, ultimately, the Government. *See* 48 C.F.R. § 15.402(a)(3) ("Contracting Officers must not require unnecessarily the submission of cost and pricing data, because it leads to increased proposal preparation costs, generally extends acquisition lead time, and consumes additional contractor and Government resources."). Thus, by cooperating with the OIG and addressing Medco's self-disclosed profitability solely in the context of this audit, BCBSA does not concede that assessing price reasonableness requires it to request and analyze profitability data from its providers or other vendors before or *after* entering into fixed-price contracts. Indeed, "a firm fixed-price contract provides for a price that is not subject to *any* adjustment on the basis of the contractor's cost experience in performing the contract." 48 C.F.R. § 16.202-1 (emphasis added). Accordingly, it is BCBSA's position that the price analysis it undertook for its contracts with Medco sufficiently established price reasonableness. See Section II.B.

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Not Relevant to the Final Report

[1] Pricing data includes profit applicable to the contract. *See* 48 C.F.R. § 15.401.

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Not Relevant to the Final Report

BCBSA also contests the OIG's second Audit Finding that *all rebates* received by Medco from pharmaceutical manufacturers must be passed on to BCBSA and then to the FEHBP pursuant to the FAR and FEHBAR Credits Clauses, thus ignoring the terms of BCBSA's contracts with Medco. First, these Credits Clauses do not apply to firm fixed-price contracts. Although BCBSA's contract with OPM, CS 1039, incorporates the FAR and FEHBAR Credits Clauses by reference, under these regulations BCBSA is not obligated to pay the FEHBP any rebates other than those BCBSA is entitled to receive under its contracts with Medco. Neither the Credit Clauses, nor any other law, regulation or guidance, or CS 1039 requires Medco to pass through to BCBSA (and ultimately FEHBP) *all rebates* Medco receives from pharmaceutical manufacturers. BCBSA acknowledges, however, that it is required by these regulations to share all rebates it *actually* receives from Medco, and BCBSA is confident it has complied with this requirement.

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[2] BCBSA presented preliminary calculations of Medco profitability for the period 2000 – 2002 to OPM OIG on April 21, 2006. The profitability information contained in this response differs slightly from the information presented on April 21, 2006, as it reflects the completed work of BCBSA consultant, Beers & Cutler.

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Not Relevant to the Final Report

III. BCBSA Did Not Fail To Credit Rebates To The FEHBP

A. The OIG's Draft Finding and Recommendations

The Draft Audit Report found that "[t]he Association did not credit the FEHBP with all credits received by Medco," and thus recommended that BCBSA should "credit the FEHBP approximately $211 million for formulary and non-formulary rebates." The Draft Audit Report also recommends that BCBSA "credit FEHBP with the applicable portion of any income, rebate, allowance, or other credit to any allowable cost and received by or accruing to Medco."

B. Summary of BCBSA's Response

It is BCBSA's position that it has no legal obligation to credit $211 million to the FEHBP through application of the FAR Credits Clause or under the plain and unambiguous terms of the 1999 or 2002 Contract between BCBSA and Medco. The $211 million sought by the Draft Audit Report under the Credits Clause represents the OIG's estimated difference between the total of all rebates (formulary and non-formulary) earned by Medco in 2000-2002 and the total rebates already credited to the FEHBP program for that time period. Because Medco had no contractual obligation to credit rebates to BCBSA in excess of the amount required in the 1999 Mail Service Prescription Drug Benefit Contract between BCBSA and Medco (1999 Contract) or the 2002 Mail Service Prescription Drug Benefit Contract between BCBSA and Medco (2002 Contract) (collectively referred to as "the Contracts"), and because BCBSA did not receive any greater rebate sum from Medco, the Credits

Clause has no application. Equally important, the 2005 amendments to CS 1039 support this position.

C. The OIG Misapplies the Credits Clause

The Federal Acquisition Regulation ("FAR") Credits Clause requires that:

> The ***applicable portion*** of any income, rebate, allowance, or other credit relating to any allowable cost and ***received by or accruing to the contractor*** shall be credited to the Government either as a cost reduction or by cash refund.[9]

48 C.F.R. § 31.201-5 (emphasis added). The OIG finding appears to read into the FAR requirement that BCBSA must receive and credit to the FEHBP *any and all* rebates earned by Medco, irrespective of the parties' negotiated provider agreement. Not only does this reading ignore the plain words of the Credits Clause but it also overlooks the fact that the Credits Clause only applies to cost-based contracts.

1. The Credits Clause is not applicable to a firm fixed-price provider contract such as the 1999 and 2002 Contracts

While the Credits Clause applies to BCBSA's obligations under CS 1039, it does not flow down to the provider's obligations to BCBSA unless specifically called for in the provider's contract. As long recognized by OPM, Medco is a provider and not a CS 1039 subcontractor. The 1999 and 2002 Contracts between BCBSA and Medco are firm fixed-price provider contracts, and Part 31 of the FAR (including the Credits Clause) thus does not apply to Medco unless Medco and BCBSA have expressly made the Credits Clause applicable to Schedule C, which they have not.[10] The Credits Clause therefore cannot be applied to the 1999 or 2002 Contracts.

"A firm fixed-price contract provides for a price that is not subject to ***any*** adjustment on the basis of the contractor's cost experience in performing the contract." 48 C.F.R. § 16.202-1 (emphasis added). FAR Part 31 consists entirely of principles and procedures to be used in cost based contracting. *See* 48 C.F.R. 31.000. As a result, the applicability of FAR Part 31 (including the Credits Clause) to fixed-price

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[9] The FAR Credits Clause, 48 C.F.R. § 31.201-5, is made applicable to the Federal Employee Program ("FEP") through the Federal Employees Health Benefits Acquisition Regulation ("FEHBAR"), 31 C.F.R. § 1631.201-70.

[10] The only instance in which the Credits Clause applies to the Contracts is where BCBSA purchases additional services that are not priced under Schedule C and that requires Medco to submit supporting cost or pricing data to BCBSA. *See, e.g.*, 2002 Contract, Article 9.

contracts is limited to fixed-price contracts that require cost analysis either under the terms of the contract or as a means of determining the price to be paid.[11] Neither the 1999 Contract nor the 2002 Contract calls for cost analysis to determine pricing or payments.[12] Payments and credits between Medco and BCBSA were negotiated between the parties and are solely dictated by Schedule C to the 1999 and 2002 Contracts. Thus, even the limited situation in which Part 31 principles might be brought to bear on a firm fixed-price contract is inapplicable to the 1999 and 2002 Contracts and this Audit Finding. Given the inapplicability of FAR Part 31 to the 1999 and 2002 Contracts, BCBSA is only entitled to, and can only credit the FEHBP, those rebates allowed by the express terms of the 1999 and 2002 Contracts.

2. The Credits Clause only requires Medco to credit BCBSA with rebates expressly dictated by the terms of the 1999 and 2002 Contracts

But even were this not the law, and the Credits Clause were found applicable to the 1999 and 2002 Contracts, it would not give the OIG the result it seeks. The Credits Clause does not require a contractor to credit ***all*** rebates received by a subcontractor to the Government ***regardless*** of the terms of the contract between the contractor and its subcontractor. The Credits Clause states, "***the applicable portion***" of any rebate "***received by or accruing to the contractor*** shall be credited to the Government." (Emphasis added.) Accordingly, for the Government to be entitled to additional rebates from Medco beyond those negotiated in the 1999 and 2002 Contracts, those rebates must (1) relate to an allowable cost under the contract, and (2) be received by or credited to BCBSA. *See Colorado Dental Service*, ASBCA No. 2466, May 28, 1982, 82-2 BCA ¶ 15836 ("The [Credits] clause restricts the right of Government recovery to refunds, rebates, or credits accruing to or received by a contractor.") (citing *Grumman Aerospace Corp. v. United States*, 587 F.2d 498 (Cl. Ct. 1978) (emphasis added)).

The additional rebates sought by the Draft Audit Report do not meet this two-part test. First, the FAR limits "allowable costs" to "only" those costs that comply with the "terms of the contract" and the other applicable cost principles of the FAR." 48 C.F.R. § 31.201-2. In the 1999 and 2002 Contracts, the parties negotiated a fixed-rate pricing arrangement, in which the price to BCBSA was tied to AWP, rather than a cost reimbursement calculation. *See* 1999 Contract, Schedule C, Section 1.1;

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[11] 48 C.F.R. § 31.102 ("[P]art 31 shall be used in the pricing of fixed-price contracts whenever (a) cost analysis is performed, or (b) a fixed-price contract requires the determination or negotiation of costs.").

[12] Moreover, the FAR is clear that the possible "application of cost principles to fixed-price contracts and subcontracts shall not be construed as a requirement to negotiate agreements on individual elements of cost in arriving at agreement on the total price." *Id.*

2002 Contract, Schedule C, Section 1.2. Additionally, both Contracts fixed the amount of rebate to be credited to BCBSA, and subsequently the FEHBP. *See* 1999 Contract, Schedule C, Section 1.2.5; 2002 Contract, Schedule C, Section 2.1. Neither Contract calls for all rebates to be credited to BCBSA.

As explained in the FAR, it is the very nature of a firm fixed-price contract that the contractor (here Medco) solely bears the financial benefit or burdens of the deal. *See* 48 C.F.R. 16.202-1 ("This contract type places upon the contractor maximum risk and responsibility for all costs and resulting profit or loss."); *see also* 48 C.F.R. 15.404-4(d)(1)(ii)(B) ("The Contractor assumes the greatest cost risk in a closely priced firm fixed-price contract under which it agrees to perform a complex undertaking on time and at a pre-determined price."). When entering into the 1999 and 2002 firm fixed-price Contracts, Medco assumed the risk that its costs might exceed the fixed rate it promised to BCBSA, thus insulating BCBSA (and thus the FEHBP) from any costs above the fixed rate. Conversely, and again under the terms of the 1999 and 2002 Contracts, BCBSA was not to share in any savings beyond the fixed rate, or in rebates other than those specifically included by the AWP Pricing Formula. *See* 1999 Contract, Schedule C, Section 1.1; 2002 Contract, Schedule C, Section 1.2.

Applying the second part of the test above, the FEHBP, under the Credits Clause, is only entitled (via CS 1039) to rebates "accruing to or received by the contractor." Thus, because the additional rebates sought by the OIG, by the very terms of the Contracts between Medco and BCBSA, do not accrue to BCBSA, the FEHBP cannot claim them via the Credits Clause. Quite simply, "applicable credits" under the FAR does not mean "all rebates" accruing to Medco.

The 2005 amendments to CS 1039 recognize and apply this understanding of the Credits Clause. Under Section 1.26, the carrier must ensure that a number of "standards" are included in new, renewing, or amended contracts with its PBM. One of the "Transparency Standards" requires PBMs to agree:

> to credit to the Health Plan either as a price reduction or by cash refund all Manufacturer Payments ***to the extent negotiated, if such an arrangements exists between the Carrier and the PBM.*** Manufacturer Payments are any and all compensation or remuneration the PBM receives from a pharmaceutical manufacturer, including but not limited to, discounts; credits; rebates, regardless of how categorized; market share incentives; commissions; mail service purchase discounts; and administrative or management fees.

CS 1039, Section 1.26(a)(2) (emphasis added). The Transparency Standards also state that "***if the Carrier has negotiated with the PBM*** to receive ***all or a portion of*** Manufacturer Payments" as described above, "the PBM will provide the Carrier with quarterly and annual Manufacturer Payment Reports."[13] CS 1039, Section 1.26(a)(2) (emphasis added).

The PBM Transparency Standards clearly recognize the conditional nature of the applicability of the Credits Clause.[14] It is only applicable "to the extent negotiated, if such an arrangement exists between the Carrier and the PBM." BCBSA submits that the Transparency Standards incorporate the proper understanding and application of the Credits Clause and the PBM's and Carrier's obligations with respect to rebate sharing. If the parties choose not to negotiate rebates, and/or the contract states that the PBM shall retain all or some rebates, then CS 1039, which incorporates the Credits Clause by reference, does not require the PBM to credit such rebates to the Carrier and thus to the FEHBP.

D. The OIG's Application of the 2004 10K Percentages Cannot Be Used To Estimate Total Rebates on FEHBP Prescriptions Earned by Medco During 2000-2002

As the prior discussion establishes, the FEHBP is not legally entitled to all rebates received by Medco. Without wavering from that argument, it should be noted that the OIG's calculation of $211 million due is a gross estimate that may be wholly inaccurate. Medco's 2002 10K reports that Medco retained an average of 50% of the pharmaceutical manufacturers' rebates for fiscal year 2002. The OIG appears to have used this percentage to determine that the amount of rebate credited to the FEHBP on Medco's Annual Statements in 2000 through 2002 is 50% of the total *SBP* manufacturer rebates received by Medco. As such, the OIG appears to assert that the FEHBP is entitled (under the OIG's flawed Credit's Clause analysis) to double the rebates it received for the entire audit period. *See* Audit Inquiry regarding Excess Profits, p.2.

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[13] For example, as Medco reported to BCBSA on its 2002 Annual Statement, $93,327,351 represents all Service Benefit Plan ("SBP") Rebates received by Medco during 2002. While Medco was required to "fully disclose all SBP Rebates received by Medco during a Contract Year" pursuant to Article 7.3 of the 2002 Contract, there is no provision in the 2002 Contract entitling BCBSA to receive all "SBP Rebates." The significance and inclusion of all the SBP Rebates in the 2002 Contract is only to provide BCBSA with certain defined data and audit rights. *See* 2002 Contract, Article 8.

[14] Although, as explained above, the Credits Clause does not apply to PBM contracts by operation of law, OPM may, and has chosen to, apply the Credits Clause to such contracts through amendment to CS 1039.

The OIG's application of the average rebate amount retained in fiscal year 2002 to Medco's actual experience under its SBP contracts is fatally flawed for two reasons. First, the 10K reports the average rebate amount retained across *all* lines of business, not for the SBP under the 1999 and 2002 Contracts. This does not mean, and indeed there is no evidence that, Medco did not pay BCBSA all SBP Rebates due under the Contracts. Further, average rebates retained has little bearing on the price reasonableness of the Contracts, as rebates are but one consideration in establishing fair and reasonable pricing. Second, the 10K reports the average rebate amount retained for fiscal year 2002. This too has little bearing on the actual SBP Rebates paid BCBSA for calendar years 2000, 2001, and 2002, which are the reporting periods for Medco's Annual Statements.

E. Conclusion

The OPM OIG could not expect to amend the rebate sharing formula and require Medco to pass through all rebates to BCBSA (and thus credit BCBSA with far greater rebates – both as to type and total dollar value – than ever negotiated between the parties) without understanding that the value of the rebates Medco credits to BCBSA affects the discount off AWP that Medco is willing to provide BCBSA. The economic deal as a whole must be considered. Thus, if Medco must pass on greater rebates to BCBSA, Medco logically will argue it has a right to reduce the AWP discount. As shown above "Government regulations" do not require that "all rebates and credits should be returned to the Program" as the OIG asserts. Neither does CS 1039 mandate that BCBSA require its PBM providers to credit all rebates to the FEHBP. To the contrary, both CS 1039, the FAR, and the FEHBAR simply require that those rebates due to BCBSA under the terms of its Contracts with Medco be credited to the FEHBP.[15] BCBSA and Medco have fully complied with this requirement.[16]

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as part of the Final Audit

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[15] In the event this Audit Finding calls into question the actual calculations of the negotiated rebates paid BCBSA under the 1999 and 2002 Contracts, BCBSA herein incorporates by reference BCBSA's reply to Draft Audit Report No, 1H-01-00-04-101, Audit Inquiry No. 5, submitted to the OIG on February 8, 2006.

[16] To imply, as does the Audit Finding without any explanation, that Maine law may place greater obligations upon BCBSA to require its PBMs to pass on to BCBSA all rebates they receive from pharmaceutical manufacturers is folly and entirely unsupported by the Federal Employees Health Benefits Act and long-standing case law confirming that federal law, not state law, governs the contractual obligations of BCBSA, its providers, and OPM. *See* 5 U.S.C. § 8902(m)(1).

Report. After the OIG has had an opportunity to review our response, we request a meeting with you to discuss questions and concerns prior to issuance of the Final Report.

[redacted]
Executive Director
Program Integrity

Attachments

c: [redacted]