U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of the Hawaii Medical Service Association's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Caremark for Contract Years 2016 through 2019

Report Number 1H-02-00-20-033
November 15, 2021

Executive Summary

Audit of the Hawaii Medical Service Association's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Caremark for Contract Years 2016 through 2019

Report No. 1H-02-00-20-033 **November 15, 2021**

Why Did We Conduct the Audit?

The objective of the audit was to determine whether costs charged to the Federal Employees Health Benefits Program FEHBP) and services provided to its members were in accordance with the U.S. Office of Personnel Management Contract Number CS 1058 and applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Hawaii Medical Service Association's Carrier) FEHBP pharmacy operations as administered by Caremark (the Pharmacy Benefit Manager or PBM). Our audit consisted of a review of the administrative fees, annual accounting statements, claims pricing and eligibility, drug manufacturer rebates, fraud and abuse program, and performance guarantees for pharmacy operations from contract years 2016 through 2019. Audit work was completed remotely from our locations in Florida and Pennsylvania due to COVID-19 restrictions.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the PBM and the Carrier need to strengthen their procedures and controls related to prescription drug pricing and termination of ineligible dependents.

Specifically, our audit identified the following deficiencies that require corrective action:

1. The PBM overcharged the FEHBP $2,327,880 (including lost investment income) by not providing pass-through transparent pricing based on the actual acquisition cost of drugs filled by its mail order warehouses and specialty pharmacies from 2016 through 2019.
2. The Carrier overcharged the FEHBP $2,508,534 (including lost investment income) by not returning the 2016 retail generic drug pricing guarantees that were paid by the PBM to the Carrier.
3. The Carrier failed to properly terminate ineligible dependents after their 26th birthday in cases where a premium change was needed, resulting in prescription drug overcharges of $6,808 (including lost investment income) for 2019.

No other exceptions were identified from our reviews of the administrative fees, annual accounting statements, drug manufacturer rebates, fraud and abuse program, and performance guarantees.

Abbreviations

5 CFR 890	**Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890**
AAC	**Actual Acquisition Cost**
Act	**Federal Employees Health Benefits Act**
Agreement	**The Pharmacy Benefit Management Agreement between the Carrier and the PBM**
Carrier	**Hawaii Medical Service Association**
Contract	**OPM Contract CS 1058**
CY	**Contract Year**
FEHBP	**Federal Employees Health Benefits Program**
HIO	**Healthcare and Insurance Office**
LII	**Lost Investment Income**
LOCA	**Letter of Credit Account**
NDC	**National Drug Code**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Caremark (Pharmacy Benefit Manager)**
SF	**Standard Form**

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I. Background

This report details the results of our audit of the Hawaii Medical Service Association's (Carrier) pharmacy operations as administered by Caremark (Pharmacy Benefit Manager or PBM) for contract years (CY) 2016 through 2019. The audit was conducted pursuant to the provisions of Contract CS 1058 (Contract) between the U.S. Office of Personnel Management (OPM) and the Carrier; the Pharmacy Benefit Management Agreement between the Carrier and the PBM (Agreement); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The Federal Employees Health Benefits Program (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 the overall responsibility for the 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. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890 and the Contract with the Carrier.

Pharmacy Benefit Managers are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM contracts directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, the PBM offers the option of a mail order pharmacy benefit. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. Pharmacy Benefit Managers are used to develop, allocate, and control costs related to the pharmacy claims program.

The Carrier contracted with the PBM, located in Scottsdale, Arizona, to provide pharmacy benefits and services to FEHBP members for CYs 2016 through 2019. Section 1.11 of the Contract includes a provision that allows for audits of the program's operations. Additionally, section 1.28(a) of the Contract outlines transparency standards that require the PBM to provide pass-through pricing based on its cost for drugs. Our responsibility is to review the performance of the PBM to determine if the Carrier charged costs to the FEHBP and provided services to its members in accordance with the Contract, the Agreement, and Federal regulations.

This is the first audit of the Carrier's pharmacy operations as administered by the PBM. The results of our audit were discussed with the Carrier and PBM officials at an exit conference on June 29, 2021. In addition, a draft audit report, dated July 15, 2021, was provided to the Carrier and PBM for review and comment. The Carrier's response to the draft report was considered in preparing the final report and is included as an Appendix to this report.

II. Objectives, Scope, and Methodology

Objectives

The main objective of the audit was to determine whether the costs charged to the FEHBP and services provided to its members were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations.

Our specific audit objectives were to determine if:

Administrative Fees Review

- The Carrier paid the PBM's administrative fees in accordance with their Agreement.

Annual Accounting Statements Review

- The Carrier accurately reported to OPM the prescription drug charges and drug manufacturer rebates related to FEHBP operations.

Claims Pricing Review

- The pricing elements for retail, mail order, specialty, and other drug claims were transparent and priced correctly in accordance with the Contract, the Agreement, and individual pharmacy contracts.
- The financial pricing guarantees were met, and if any penalties were accurately returned/credited to the FEHBP.

Claims Eligibility Review

- Any claims were paid for ineligible dependents age 26 and older, excluded drugs, non-FEHBP members, or FEHBP members from another group.

Drug Manufacturer Rebates Review

- The drug manufacturer rebates were properly credited to the FEHBP.

Fraud and Abuse Program Review

- The Carrier and the PBM complied with FEHBP fraud and abuse program requirements.

Performance Guarantees Review

- The Carrier and the PBM's performance standards were properly calculated, if the guarantees were met, and if any associated penalties were paid.

Scope and Methodology

We conducted this 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 the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

This performance audit included a review of the administrative fees, annual accounting statements, claims pricing and eligibility, drug manufacturer rebates, fraud and abuse program, and performance guarantees related to FEHBP pharmacy operations for CYs 2016 through 2019. As part of our survey work, we conducted informational meetings with the PBM on December 9 and 10, 2020. The audit fieldwork was completed remotely from our locations in Florida and Pennsylvania due to COVID-19 restrictions, from January 26 through June 29, 2021.

The Carrier is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Carrier collected healthcare premium payments of approximately $1.4 billion in CYs 2016 through 2019, of which approximately two-thirds was paid for by the Federal government on behalf of Federal subscribers. In its annual accounting statements, the Carrier reported total pharmacy claims paid of approximately $304 million for CYs 2016 through 2019 (See below).

Contract Year	Earned Healthcare Premiums	Number of Pharmacy Claims	Amount of Pharmacy Claims Paid	Amount of Medical Claims Paid
2016	$316,687,111	600,577	$72,257,548	$214,657,954
2017	$348,102,056	633,112	$71,561,527	$209,417,615
2018	$345,792,560	561,697	$80,218,513	$222,222,283
2019	$345,849,078	556,051	$79,755,498	$239,675,504
Total	**$1,356,430,805**	**2,351,437**	**$303,793,086**	**$885,973,356**

In planning and conducting the audit, we obtained an understanding of the Carrier's and the PBM's internal control structures 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. Additionally, since our audit would not necessarily disclose all significant matters in

the internal control structure, we do not express an opinion on the Carrier's and the PBM's systems of internal controls taken as a whole.

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine compliance with the Contract, the Agreement, and Federal regulations. Exceptions noted in the areas reviewed are set forth in the "Audit Findings and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Carrier and the PBM had not complied, in all material respects, with those provisions.

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

To determine whether costs charged to the FEHBP and services provided to its members for CYs 2016 through 2019 were in accordance with the terms of the Contract, Agreement, and applicable Federal regulations, we performed the following audit steps:

Administrative Fees Review

- For each CY, we reviewed the monthly administrative fee invoices and line items to determine if the PBM's fees were properly calculated and supported in accordance with the terms of the Agreement.

Annual Accounting Statements Review

- For each CY, we reviewed the annual accounting statements to determine if the prescription drug charges and drug manufacturer rebates were properly reported based on a reconciliation with the claims data and the Letter of Credit Account (LOCA).

Claims Pricing Review

Unless stated otherwise, the claim samples below were selected from the paid claims greater than zero universe of 2,208,593 claims totaling $345,947,172 for CYs 2016 through 2019 (the paid claims data differs from the amounts reported in the table above due to timing, claim adjustments, and reversals).

- From a population of 1,973,153 retail pharmacy claims totaling $299,616,281 (*excluding long-term care, dispensing physician, VA, institution, HMO pharmacy, DME, clinical pharmacy, military, and compounding drugs claims* , we randomly selected 80 claims

using SAS[1], totaling $26,449, to determine if the pricing elements were transparent and if the claims were paid correctly.

- From a population of 24,313 specialty pharmacy claims totaling $69,573,758 (*including those processed at a retail pharmacy* , we randomly selected 80 claims using SAS, totaling $203,785, to determine if the pricing elements were transparent and if the claims were paid correctly.
- From a population of 147,268 mail order pharmacy claims totaling $20,002,214, we randomly selected 80 claims using SAS, totaling $32,322, to determine if the pricing elements were transparent and if the claims were paid correctly.

Claims Eligibility Review

- We identified and reviewed all dependents 26 years of age or older from the 2019 paid claims data, the most current year in our audit scope, to determine if the members were eligible for coverage due to a disability and incapable of self-support.
- We identified and reviewed the Carrier's non-covered drugs list to determine if any claims were paid for excluded drugs.
- We reviewed all claims to determine if any were paid for non-FEHBP members or members enrolled in another FEHBP plan in which the Carrier participates.

Drug Manufacturer Rebates Review

- From a universe of 7,550 different drug manufacturer rebates by National Drug Code (NDC), totaling $56,070,314 for CYs 2016 through 2019, we judgmentally selected all 14 NDCs with an amount greater than $1 million, totaling $25,535,235. We then reviewed the collections to determine if the rebates were properly supported, accurately calculated, and fully remitted to the Carrier and FEHBP.

Fraud and Abuse Program Review

- We reviewed all potential fraud and abuse cases that were reported by the PBM to the Carrier to determine if those cases were subsequently reported to OPM.
- We reviewed the Carrier and PBM's policies and procedures for fraud and abuse to ensure that they complied with the most recent carrier letter guidelines.

[1] SAS is a statistical software suite developed by SAS Institute for data management, advanced analytics, multivariate analysis, business intelligence, criminal investigation, and predictive analytics.

Performance Guarantees Review

- For each CY, we reviewed all performance guarantees to determine if the performance was accurately measured and compared to the guarantee, and if any penalties were properly calculated and credited to the FEHBP.

The samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results were not 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. Administrative Fees Review

The results of our review showed that the administrative fees charged by the PBM to the Carrier were in accordance with the Agreement.

B. Annual Accounting Statements Review

The results of our review showed that the amounts stated in the 2016 through 2019 annual accounting statements were accurately reported.

C. Claims Pricing Review

1. Mail Order and Specialty Drug Pricing $2,327,880

The PBM did not provide pass-through transparent pricing for drugs filled by its own mail order warehouses and specialty pharmacies based on the actual acquisition cost AAC) plus a dispensing fee, resulting in a $2,219,164 overcharge to the FEHBP for CYs 2016 through 2019. Additionally, $108,716 is due to the FEHBP for lost investment income ($2,327,880 in total).

The PBM overcharged the Carrier on the price for drugs filled by its own mail order warehouses and specialty pharmacies.

Section 1.28(a)(2) of Contract Number CS 1058 (Contract) between OPM and the Carrier states, "The PBM agrees to provide pass-through transparent pricing based on the PBM's cost for drugs (as described below) . (ii) The PBM shall charge the Carrier the cost of drugs at mail order pharmacies based on the actual cost, plus a dispensing fee. Costs shall not be based on industry benchmarks . ."

Additionally, section 3.4 e) and (f) of the Contract states that "Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income producing investments and accounts shall be paid from the date the funds should have been invested or appropriate income was not credited and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision. . The Carrier shall credit the Special Reserve for income due in accordance with this clause. All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods in which the amount becomes due..... "

During pre-audit, we requested the PBM's AAC summary reports for the scope of our audit to ensure that pass-through transparent pricing was given to the Carrier. The PBM disclosed that $2,219,164 is due back to the FEHBP for transparent pricing once it realized that the

PBM erroneously processed the Carrier's mail order and specialty drug claims using traditional pricing (based on carrier guarantees with spread pricing) instead of the lower pass-through transparent pricing (based on the actual cost for drugs at invoice price plus dispensing fees). The PBM stated that there was a "fundamental misunderstanding" between Caremark and the Carrier as to what pricing terms were requested. Once we verified that the transparent pricing should have been implemented beginning in 2013, the PBM and the OIG agreed that the FEHBP was overcharged $2,219,164 for CYs 2016 to 2019 because of this finding, in addition to $108,716 for Lost Investment Income (LII). The Carrier has since been moved to transparent pricing so that the FEHBP receives AAC based on the PBMs average moving cost for drugs filled by its mail order warehouses and specialty pharmacies.

Recommendation 1

We recommend that OPM's Contracting Officer verify that the Carrier returns $2,327,880, including LII, to the FEHBP for overcharges related to the PBM's actual acquisition cost of mail order and specialty drugs from 2016 through 2019.

Carrier's Response:

The Carrier agreed with our finding and reported a payment of $2,327,880 back to the FEHBP on August 11, 2021.

2. Retail Generic Drug Pricing Guarantee $2,508,534

The Carrier did not return $2,302,623 in retail generic pricing guarantees that were paid by the PBM to the Carrier for the 2016 pharmacy claims. Additionally, $205,911 is due to the FEHBP for LII ($2,508,534 in total).

The Carrier did not credit the FEHBP for retail generic pricing guarantees that were paid by the PBM to the Carrier.

Section 1.28 of the Contract lists transparency standards that the PBM and Carrier must follow, to include pass-through pricing of all negotiated discounts, rebates, credits, and other financial benefits. The PBM contract provided a series of drug pricing guarantees that are payable to the Carrier for its pharmacy claims. When the aggregate for each category of the Carrier's pharmacy claims are paid at a lesser discount than the guarantee, the PBM pays the Carrier a true-up amount to meet the guarantee. These refunds are due the FEHBP based on section 2.3(i) of the Contract which states, "All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier."

Additionally, section 3.4 e) and (f) of the Contract states that "Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income

producing investments and accounts shall be paid from the date the funds should have been invested or appropriate income was not credited and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3 the date of the Contracting Officer's Final Decision. . The Carrier shall credit the Special Reserve for income due in accordance with this clause. All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621 a)(2) applicable to the periods in which the amount becomes due..... "

As part of our audit, we reviewed the PBM's pricing guarantees and end of the year true-ups to ensure that the Carrier's pharmacy claims were priced at the lower of pass-through pricing or the Carriers guaranteed discounts for each category of drug and distribution type. The PBM provided year-end true-up calculations showing what pricing guarantees were paid to the Carrier during the scope of our audit. We traced these true-up amounts back to the LOCA and found that the Carrier never returned credits it received for retail generic pricing guarantees in 2016. The Carrier stated that this mistake occurred due to "human error coupled with a lack of end-to-end oversight ." The Carrier is now in the process of updating its policies to reduce the risk of this error reoccurring. We verified that all subsequent pricing guarantees paid by the PBM to the Carrier for CY 2017 through 2019 pharmacy claims were returned to the LOCA. As a result of the Carrier failing to return the 2016 retail generic pricing guarantees back to the LOCA, the FEHBP was overcharged $2,302,623.

To remedy this finding, the Carrier agreed to return $2,508,534 to the FEHBP, which includes $205,911 for LII in accordance with section 3.4 of the Contract. The Carrier also reported that it will "immediately take steps to remediate this process by identifying an accountable resource to oversee this multi-departmental process. We will update and/or create policies and procedures and engage our Internal Audit department to test the policies and procedures. We will closely monitor this process for a minimum of one-year to ensure there are no gaps in our process."

Recommendation 2

We recommend that OPM's Contracting Officer ensure that the Carrier returns $2,508,534, including LII, to the FEHBP for CY 2016 retail generic drug pricing guarantees that were paid by the PBM to the Carrier.

Carrier's Response:

The Carrier agreed with our finding and reported a payment of $2,508,534 back to the FEHBP on April 26, 2021.

Recommendation 3

We recommend that OPM's Contracting Officer verify that the Carrier implemented new controls to ensure that pricing guarantees and other credits that include FEHBP pharmacy claims are properly returned to the LOCA.

Carrier's Response:

The Carrier agreed with our recommendation and stated that it's "in the process of implementing new controls to ensure the pricing guarantees and other credits that include FEHBP are properly and timely returned to the LOCA."

D. Claims Eligibility Review

1. Continued Coverage of Ineligible Dependents $6,808

Our review identified 63 pharmacy claims for 17 dependents, age 26 and older, who were ineligible for coverage at the time their claims were processed. This resulted in $6,581 of overcharges to the FEHBP for 2019. Additionally, $227 is due to the FEHBP for LII $6,808 in total).

The Carrier did not remove child dependents in a timely manner once turning age 26.

Carrier Letter 2015-16 states that "For covered family members, terminations are typically based on a loss of eligibility such as, in the case of a child, turning age 26; or, in the case of a spouse, a divorce. When an enrollee switches a covered family member due to a termination, the family member whose enrollment has been terminated is eligible for the 31-day extension of coverage." The Carrier's benefit brochure states that family member coverage is for natural, adopted children, stepchildren, and certified foster children who are eligible for coverage until their 26th birthday.

Additionally, children who are incapable of self-support due to mental or physical disability that began before age 26 are eligible for continued coverage. Title 5, Code of Federal Regulations, Section 890.302 allows dependent children under the age of 26, and dependents age 26 or older who are incapable of self-support due to a disability, to be covered by the enrollment of a Federal employee or annuitant in the FEHBP. The regulation also requires certification from a physician and a decision by the Federal employment office showing that the dependent is incapable of self-support due to a disability in order for the Carrier to continue providing coverage to that member beyond their 26th birthday.

Furthermore, section 2.3(g) of the Contract states that "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program." Section 2.3(g)(12) of the Contract states, "In compliance with the provisions of the Contracts Dispute Act, the Carrier shall return to the Program an

amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment ....."

Finally, section 3.4(e) and (f) of the Contract states that "Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income producing investments and accounts shall be paid from the date the funds should have been invested or appropriate income was not credited and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3 the date of the Contracting Officer's Final Decision. . The Carrier shall credit the Special Reserve for income due in accordance with this clause. All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621 a)(2) applicable to the periods in which the amount becomes due..... "

Using the most recent year of our audit scope, we reviewed all 2019 pharmacy claims to determine if any child dependents remained enrolled in the FEHBP 31 days beyond their 26th birthday. Our review found 17 dependents who were not identified as being disabled and incapable of self-support yet continued to have claims paid 31 days after their 26th birthday. In total, we identified 63 pharmacy claims paid for these 17 dependents during the period in which they were ineligible for coverage. Further review showed that 3 of the 17 dependents were still enrolled at the time of this audit. The other 14 dependents were terminated after the Carrier received a Standard Form (SF) 2809 several months or years beyond their ineligible date. Most of these SF 2809s were not retro-active nor were any of the overpayments recovered. When we asked the Carrier why the 17 dependents were not terminated 31 days after turning age 26, it responded, "In accordance with FEHBP Program Carrier Letter No. 1999-034, changes that affect premium withholdings, i.e., changes from self only to self and family or vice versa, the disenrollment is initiated upon receipt of a completed SF 2809 Health Benefits Election form or requisite agency verifications."

We discussed this issue with OPM and confirmed that the Carrier is misinterpreting OPM's guidelines. Carriers are required to terminate coverage for overage dependents after turning age 26, regardless of the enrollee's premium level, since that dependent is no longer eligible for coverage. By not terminating dependents 31 days after turning age 26, the Carrier continued to pay claims for ineligible dependents resulting in $6,581 of improper pharmacy payments for 2019, plus $227 in LII.

Recommendation 4

We recommend that OPM's Contracting Officer require the Carrier to return $6,808, including LII, to the FEHBP for improper pharmacy claim payments incurred by the 17 ineligible dependents in CY 2019.

Carrier's Response:

The Carrier agreed with our finding and reported a payment of $6,581 back to the FEHBP on May 24, 2021, plus an additional $227 credited for LII on June 1, 2021.

Recommendation 5

We recommend that OPM's Contracting Officer continue working with the Carrier to identify and recover all health benefit charges (both medical and prescription drugs) related to ineligible dependents that were erroneously paid during the scope of our audit.

Carrier's Response:

The Carrier agreed with our recommendation and returned an additional $24,258[2] to the FEHBP (including LII) for medical and prescription drug charges that it identified as improper payments during the scope of our audit related to ineligible dependents.

Recommendation 6

We recommend that OPM's Contracting Officer verify that the Carrier improve its controls for terminating dependent children 31 days after turning age 26 to ensure that claims are not paid for ineligible dependents.

Carrier's Response:

The Carrier agreed with our recommendation and will improve its controls to ensure that ineligible dependents are not covered beyond the 31-day extension of coverage period, regardless of premium level.

E. Drug Manufacturer Rebates Review

The results of our review showed that the PBM correctly billed and credited drug manufacturer rebates to the Carrier, which were returned to the FEHBP.

F. Fraud and Abuse Program Review

The results of our review showed that the Carrier and the PBM had sufficient policies and procedures in place to help prevent fraud and abuse.

[2] This amount was not included in the finding since the improper payments were identified and disclosed by the Carrier after the draft audit report and included corresponding medical claims outside of our audit scope.

G. Performance Guarantees Review

The results of our review showed that the PBM's performance guarantees were accurately reported and credited to the Carrier and the FEHBP.

Appendix

August 13, 2021

Attn: W. Rick Davis, AIC &
Luke Z Johnson
Special Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, PA 16066

RE: Audit of Hawaii Medical Service Association's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Caremark for Contract Years 2016 through 2019 (Report Number 1H-02-00-20-033)

Dear Mr. Davis:

This letter is in response to the above-referenced U.S. Office of Personnel Management OPM) Draft Audit Report, issued on July 15, 2021, detailing the results of the limited scope audit of the Federal Employee Health Benefits Program FEHBP) Pharmacy Operations administered by Caremark. Our comments regarding the findings in the report are as follows:

C. Claim Pricing Review

1. **Mail Order and Specialty Drug Pricing** **$2,219,164**

The PBM did not provide pass-through transparent pricing for drugs filled by its own mail order warehouses and specialty pharmacies based on the actual acquisition cost (AAC) plus a dispensing fee, resulting in a $2,219,164 overcharge to the FEHBP for contract years (CY) 2016 through 2019.

Recommendation 1

We recommend that OPM's Contracting Officer require the Carrier to collect $2,219,164 from the PBM and return the funds to the FEHBP for overcharges related to mail order and specialty drug pricing from 2016 through 2019.

Carrier's Response

Per the OIG finding, HMSA will request that CVS reimburse HMSA for the amounts due for applicable mail order and specialty pharmacies from 2016-2019. HMSA's contract with OPM stated in 2014, Section 1.28 (a) (2) (ii), "*The PBM shall charge the Carrier the cost of drugs at mail order pharmacies based on the actual cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition*

***Cost (AAC) or Wholesale Acquisition Cost WAC)*." In 2020, the OPM contract was amended to add specialty pharmacies, Section 1.28 b) 2) (ii), "*The PBM shall charge the Carrier the cost of drugs dispensed by a specialty and/or a mail order pharmacy that is owned by the PBM based on the pharmacy's actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC)*." HMSA interpreted the original OPM contract language to not include specialty pharmacies until the language was inserted into the OPM 2020 contract amendment. Based on the auditors' clarification that the intent of the original contract language with OPM was to include both mail order and specialty pharmacies owned by the PBM, HMSA will make a payment in the amount due of $2,219,163.69, with interest in the amount of $108,716.70. The total amount of $2,327,880.39 was transmitted to FEHBP on August 11, 2021 as referenced in *Table 1*. Payment confirmation document is submitted as Appendix A.**

Table 1

Amount Due for Mail Order & Specialty Pharmacies CYs 2016-2019	Prior Settlement Paid to FEHBP in 2018	Summary of Balance Due	Interest Due CYs 2016-2019	Total Payment transmitted to FEHBP on 8/11/2021
$,2,376,205.55	($157,041.86)	$2,219,163.69	$108,716.70	$2,327,880.39

2. Retail Generic Drug Pricing Guarantees $2,302,623

The Carrier did not return to the FEHBP $2,302,623 in retail generic pricing guarantees that were paid by the PBM to the Carrier for 2016 pharmacy claims.

Recommendation 2

*We recommend that OPM's Contracting Officer ensure that the Carrier returns $2,302,623 to the FEHBP for CY 2016 retail generic drug pricing guarantees that were paid by the PBM to the Carrie*r.

Carrier's Response

HMSA agrees with the finding. The monies HMSA received from Caremark for the CY2016 retail generic drug pricing guarantees in the amount of $2,302,623.05 were transmitted for payment to FEHBP on April 26, 2021.

Recommendation 3

We recommend that OPM's Contracting Officer ensure that the Carrier returns $205,911 to the FEHBP for LII related to the retail generic drug pricing guarantees finding.

Carrier's Response

HMSA agrees with the recommendation. HMSA has transmitted payment of $205,911.28 to FEHBP on April 26, 2021.

Recommendation 4

We recommend that OPM's Contracting Officer verify that the Carrier implemented new controls

to ensure that pricing guarantees and other credits that include FEHBP pharmacy claims are properly returned to the LOCA.

Carrier's Response

HMSA performed a root cause analysis and determined that human error coupled with a lack of end-to-end oversight caused this error. During the period when HMSA received the HMSA retail generic drug pricing guarantees from Caremark, the roles and responsibilities were being shifted internally creating unclear accountability for ensuring appropriate tracking and follow up. HMSA has taken steps to remediate this by identifying an accountable resource to oversee this multi-departmental process. HMSA is in the process of implementing new controls to ensure the pricing guarantees and other credits that include FEHBP are properly and timely returned to the LOCA.

D. Claim Eligibility Review

1. Continued Coverage of Ineligible Dependents $6,581

Our review identified 63 pharmacy claims for 17 dependents, age 26 and older, who were ineligible for coverage at the time their claims were processed resulting in $6,581 of overcharges to the FEHBP for 2019.

Recommendation 5

We recommend that OPM's Contracting Officer require the Carrier to return $6,581 to the FEHBP for improper pharmacy claim payments incurred by the 17 ineligible dependents in CY 2019.

Carrier's Response

HMSA agrees with the finding. HMSA returned the $6,581 to FEHBP on May 24, 2021 for improper pharmacy claim payments incurred by the 17 ineligible dependents in CY 2019. An additional $227.23 in interest was also paid to FEHBP on June 1, 2021.

Recommendation 6

We recommend that OPM's Contracting Officer continue working with the Carrier to identify and recover all health benefit charges (both medical and drug) related to ineligible dependents that were paid during the scope of our audit.

Carrier's Response

HMSA has identified additional health benefit charges (both medical and drug) related to ineligible dependents that were paid during the scope of the audit. Additional payments were made to FEHBP during the month of June as referenced in *Table 2*.

Table 2

Description	Refund Amount	Interest Amount	Refund Memo Date	Transfer Amount to Fed 87	Transfer Memo Date
Refund of medical claims paid to ineligible members plus interest	$6,171.59	$160.96	6/4/2021 & 6/11/2021	$6,332.55	6/11/2021
Refund of 235 drug claims paid to ineligible members plus interest	$17,769.57	$238.86	6/22/2021 & 6/25/2021	$18,008.43	6/25/2021
Refund of 5 drug claims paid to ineligible members plus interest	$135.75	$0.06	6/23/2021 & 6/25/2021	$135.81	6/25/2021
Refund of medical claims paid to ineligible members plus interest	$6,302.21	$60.00	6/25/2021	$6,362.21	6/25/2021
			Total		**$30,839.00**

Recommendation 7

We recommend that OPM's Contracting Officer require the Carrier to improve its system controls for terminating dependents upon turning age 26 to ensure that ineligible dependents are not covered beyond the 31-day extension of coverage period.

Carrier's Response

Based on the clarifying information received during the audit, a systematic report of dependents turning age 26 in 2021 was generated specifically to update the dependents termination date in accordance with Carrier Letter 2015-16 to ensure that ineligible dependents are not covered beyond the 31-day extension of coverage period. HMSA will terminate coverage for dependents after turning age 26, regardless of the enrollee's premium level, since the dependent is no longer eligible for coverage. Going forward, HMSA will be systematically running a monthly report to capture dependents turning 26. The report will be used to monitor and subsequently manually update the termination date to ensure the ineligible dependents are not covered beyond the 31-day extension of coverage period.

HMSA appreciates the opportunity to provide our responses to the draft audit report and request that our comments be included in the Final Audit Report. Thank you for the opportunity to better serve our FEHBP members.

[redacted]
Executive Vice President
Hawaii Medical Service Association

Report No. 1H-02-00-20-033

Report Fraud, Waste, and Mismanagement

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