U.S. OFFICE OF PERSONNEL MANAGEMENT

OFFICE OF THE INSPECTOR GENERAL

OFFICE OF AUDITS

Final Audit Report

Audit of the Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts

Report Number 1H-99-00-20-016

July 29, 2021

EXECUTIVE SUMMARY

Audit of the Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts

Report No. 1H-99-00-20-016 **July 29, 2021**

Why Did We Conduct the Audit?

The objective of this audit was to determine the reasonableness of each Carriers' (the BlueCross BlueShield Association, the Government Employees Health Association, the Mail Handlers Benefit Plan, the National Association of Letter Carriers, and the National Rural Letter Carriers' Association) contractual arrangements with their Pharmacy Benefits Manager (PBM) CVS Health. Additionally, our objective was to determine if the PBM is in compliance with the PBM Transparency Standards included within each plans' Federal Employees Health Benefits Program (FEHBP) contract with the U.S. Office of Personnel Management (OPM).

What Did We Audit?

The Office of Inspector General has completed a performance audit of the Carriers' pharmacy operations as administered by the PBM. Specifically, our audit consisted of a review of costs and contract arrangements related to administrative fees and manufacturer rebates, the costs reported on the Annual Accounting Statements, and claim payments from contract years 2018 and 2019. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

LEWIS PARKER

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for

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We identified two program improvement areas that, if implemented, would lead to savings for the FEHBP and the Federal subscribers.

Specifically, we identified improvement areas related to the administrative fees charged by the PBM to administer pharmacy benefits and the pricing guarantee language included in the pharmacy contracts.

All other areas reviewed and not reported herein were determined to be reasonable and in compliance with each Carriers' contract provisions relative to OPM's PBM Transparency Standards.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
AWP	**Average Wholesale Price**
Carriers	**The Carriers included in this audit:** - **BlueCross BlueShield Association,** - **Government Employees Health Association,** - **Mail Handlers Benefit Plan,** - **National Association of Letter Carriers Health Benefit Plan, and** - **National Rural Letter Carriers' Association**
Contracts	**The individual Carriers' contracts with the Office of Personnel Management**
CPO	**Chief Pharmacy Officer**
FEHBP	**Federal Employees Health Benefits Program**
HIO	**Healthcare and Insurance Office**
MAC	**Maximum Allowable Cost**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Pharmacy Benefit Manager**
PM	**Per Member**
POS	**Point of Sale**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final report details the results of our performance audit of selected Federal Employees Health Benefits Program (FEHBP) carrier's pharmacy operations for contract years 2018 and 2019. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of each of the Carrier's respective contracts with the Pharmacy Benefits Manager (PBM); Title 5, United States Code, Chapter 89; Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890); and each of the Carriers' respective contracts with the U.S. Office of Personnel Management (OPM). Specifically, the BlueCross BlueShield Association, the Government Employees Health Association, the Mail Handlers Benefit Plan, the National Association of Letter Carriers Health Benefit Plan, and the National Rural Letter Carriers' Association (hereafter referred to collectively as "Carriers") entered into separate contracts CS1039, CS1063, CS1146, CS1067, and CS1073 (Contracts), respectively. The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

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

PBMs 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 the "local" drugstore, the PBMs contract 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, PBMs offer the option of mail order pharmacies. PBMs also provide specialty pharmacy services for members with rare and/or chronic medical conditions. PBMs are used to develop, allocate, and control costs related to the pharmacy claims program.

The Carriers each individually contracted with OPM to provide health insurance benefits, including prescription drug coverage, to Federal employees and retirees, as authorized by the FEHBP Act. The Carriers' pharmacy administrative operations and responsibilities under the Contracts are carried out by CVS Health (as PBM), which is located in Scottsdale, Arizona. The Contracts include provisions that allow for audits of the program's operations.

This is the first audit of the reasonableness of selected FEHBP carrier's pharmacy benefit contracts. The results of our audit were discussed with the Carriers and PBM officials during an exit conference on December 3, 2020. Additionally, a draft report, dated January 13, 2021, was

provided to the Carriers, PBMs, and OPM for review and comments. All responses to the draft report were considered in preparing the final report and are included as appendices to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary purpose of this audit was to determine the reasonableness of the Carriers' PBM arrangements and to obtain reasonable assurance that the Carriers are complying with FEHBP contractual provisions related to OPM's PBM Transparency Standards.

SCOPE AND METHODOLOGY

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.

This performance audit included reviews of administrative fees, annual accounting statements, claim payments, and pharmacy rebates for the period January 1, 2018, through December 31, 2019.

Due to the COVID-19 pandemic we were unable to conduct site visits during the audit. Consequently, all audit fieldwork was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas from June 2020 through January 2021.

In planning and conducting our audit, we obtained an understanding of each Carriers' internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Carriers' systems of internal controls taken as a whole.

We also conducted tests to determine whether the Carriers' and/or PBM complied with their Contracts, 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 as they relate to claim payments. With respect to the items not tested, nothing came to our attention that caused us to believe that the Carriers and the PBM did not comply, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer generated data provided by the Carriers and/or the PBM. Due to time constraints, we did not verify the reliability of the data generated by the Carriers' and/or the PBM's information systems. 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.

We selected various samples of pharmacy claims to assess if the PBM complied with the OPM transparency standards. A review of these samples allowed us to gain reasonable assurance as to the reliability of the claims data. We utilized SAS software and Microsoft Excel to judgmentally select all samples reviewed. 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.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples cover the full scope of the audit, January 1, 2018, through December 31, 2019):

1. Administrative Fee Review

   - We reviewed the Carriers' administrative fee provisions within each of their PBM contracts to determine the reasonableness of those provisions and if we could identify any potential money saving options for the Carriers.

2. Annual Accounting Statements Review

   - We separately quantified all Carrier PBM invoices and reconciled the totals to each of the Carriers' Annual Accounting Statements to determine the reasonableness of the reported PBM related costs.

3. Pharmacy Claims Pricing Review

   - We reviewed the retail pharmacy claims data for the largest Carrier and identified the three highest utilized brand and generic drugs (by dollars spent) and the four most utilized retail pharmacies over the scope of the audit. We then quantified a universe of claims paid (201,816 claims, totaling $19,511,414) for those identified drugs and at the identified pharmacies in December 2019.

     For each Carrier, from each of the four highly utilized retail pharmacies, we sorted the identified claims by drug and pharmacy network and judgmentally selected every third claim for a maximum total of three claims from each network, drug, and pharmacy. This resulted in 658 claims (totaling $125,255), which we reviewed to determine if the claims were priced properly and if the OPM Transparency Standards were properly applied.

4. Drug Manufacturer Rebates Review

   - We reviewed the Carriers' drug manufacturer rebate provisions within each of their PBM contracts and drug formularies to determine the reasonableness of those provisions and if we could identify any potential improvement options for the Carriers.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The following program improvement areas represent the areas identified in our audit for which we are recommending corrective action by OPM. All other areas reviewed and not reported herein were determined to be reasonable and in compliance with each of the Carriers' contracts with the PBM and OPM. Please note that while the recommendations herein are addressed to OPM, any Carrier comments provided to the recommendations were summarized as "Carriers' Response" below.

A. Program Improvement Areas

1. Pooling of Carrier Contracts **Procedural**

Based on discussions with the PBM and our overall review of each carrier's expenses related to the PBM's administration of pharmacy benefits, we believe it would lower FEHBP pharmacy costs if the carriers pooled their resources in a common PBM agreement.

The FEHBP could potentially save millions of dollars if its health plans consider pooling their resources.

Currently, each carrier separately contracts with the PBM to provide its members with pharmacy benefits. Discussions with the PBM disclosed that, understandably, the carrier's size (lives covered and pharmacy spend) is a major driving factor in the administrative fee rates and pharmacy discounts made available. Simply stated, the smaller carriers pay higher administrative fees and receive lower discounts.

Exhibit 1 – Total Administrative Fees

Contract Year	Carrier 1	Carrier 2	Carrier 3	Carrier 4*	Carrier 5
Total Headcount Per Carrier					
2018					
2019					
Total Admin Fees					
2018	$	$	$	$	$
2019	$	$	$	$	$
Average Admin Fee Per Member					
2018	$	$	$	$	$
2019	$	$	$	$	$
** = Carrier entered into a new contract with the PBM in CY 2019*					

The administrative fees for the four smaller Carriers reviewed in our audit totaled $67,875,986 for 2018 and 2019 (See Exhibit 1 above). If these Carriers pooled their resources into a common contract, we conservatively estimate that it could result in an approximate 28 percent savings in administrative fees, equating to potential savings to the FEHBP of over $9.5 million annually (See Exhibit 2 below). Additionally, we anticipate that

much larger claims savings could potentially result if an across the board increase in pricing discounts was made available (we are unable to project that savings amount at this time).

Exhibit 2 - Potential Savings Calculation for Carriers 2 -5 if Headcount Combined

Total Headcount, carriers 2 - 5 - 2018 & 2019	2,439,777
New admin fee PM based on estimated 15 percent savings on Carrier 2s 2019 admin fee resulting from over 70 percent increase in headcount if combined (.85*$24)	$20
Projected Admin Fees at $20 PM 2018 & 2019	$48,795,540
Actual Admin Fees 2018 & 2019	$67,875,986
2 year savings	$19,080,446
Potential Savings Per Year	$9,540,223
Average actual Admin Fees paid - 2018 & 2019	$33,937,993
Percentage Savings Per Year	28%

Recommendation 1

We recommend that the Contracting Officer direct its carriers to consider pooling their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members.

OPM Response:

OPM stated that it has never precluded FEHBP carriers from pooling resources into a common agreement, nor has it ever received a proposal by any carrier to do so in the past. It said that it would consider such a proposal if received in the future.

OIG Comments:

The OIG's recent Management Advisory Report on the FEHBP's Prescription Drug Benefit Costs (Report Number 1H-01-00-18-039, dated March 31, 2020) expressed concerns that "OPM may not be obtaining the most cost-effective pharmacy benefit arrangements under the FEHBP," and "that OPM should consider all possible options … to gain additional savings and maximize cost containment efforts …." The above-mentioned program improvement recommendation is just one example of an "option" that may be considered as part of this effort, and we find it concerning that OPM simply dismisses considering the option because the carriers have never proposed it.

We believe that the FEHBP carriers have never proposed pooling their combined resources in the past because it does not fit the FEHBP competitive model of separate carriers and it doesn't serve their purposes. It is also our opinion that the FEHBP's competitive model of separate carriers, especially as it pertains to pharmacy costs, is out of date in today's health care marketplace where size and volume of the purchaser drives down the costs. The FEHBP model effectively splits its purchasing power among many carriers for pharmacy benefits, while other employers are pooling their entire books of business under one pharmacy contract. We agree that allowing carriers to contract separately with PBMs drives competition, likely lowers cost to some degree, and ensures that the entire FEHBP population has access to quality health coverage. However, it is also highly likely that taking advantage of the FEHBP's purchasing power, by limiting the number of pharmacy contracts with the PBMs, would drive additional cost savings for the FEHBP population while still maintaining access to quality care. Consequently, we believe that, although a daunting task, OPM should consider expressly directing its carriers to consider pooling their resources into a combined agreement.

Carriers' Response:

The Carriers stated that the pooling together of resources under a common agreement would not allow consideration of individual Carrier requirements, which essentially maximizes competitive value at a contracting level. They also stated that such standardization would eliminate variety of options for Federal employees based on their needs.

OIG Comments:

We understand that the concept introduced by the recommendation is foreign to the carriers and that undergoing such a change would require sacrifices on any parties that consider pooling resources. However, just as PBMs began with the idea that their buying power would reduce health care costs, the concept of pooling carrier resources would potentially give the carriers similar buying power when negotiating with the PBMs. We also believe that, as part of this process, each of the carriers could work with the PBMs to differentiate certain offerings within the joint contract to separate itself in regards to other carriers if necessary.

2. Inappropriate Application of Transparency Standards **Procedural**

Our review of claims from the five nation wide Carriers found that the PBM's contracting practices with the carriers and pricing and payment of retail pharmacy claims do not appear to meet the PBM transparency standards as established by OPM in 2011. Specifically, the PBM's interpretation of transparency is to pass through to the carriers and the FEHBP the price that it pays to the retail pharmacies at the time the prescriptions are processed. However, its contracting practices with individual carriers allow it to manipulate the generic and brand name drug price paid at point of sale (POS), allowing the PBM to profit from what is paid for these drugs in a non transparent manner.

The PBM does not pass through the full value of the PBM's negotiated discounts, rebates, credits, or other financial benefits to the FEHBP.

The current transparency standards state that for retail pharmacy claims, the PBM agrees to provide pass through transparent pricing and charge the carrier the amount paid to the pharmacy for each drug plus a dispensing fee. These standards are incorporated into each of the carrier's contracts with the PBM and are required to be followed.

For the five Carriers reviewed, we identified the six most highly utilized drugs (three generic and three brand) dispensed and paid in December 2019 to the four most highly utilized retail pharmacies. We then reviewed the resulting claims and pharmacy contracts to determine if the final payment to the pharmacies appeared to meet the above requirements.

Our review found that, although the PBM does pass through the amount paid to the retail pharmacy at POS to the carriers, how it gets to that final POS price does not meet the definition of "pass through transparent pricing" as defined by OPM. Pass through transparent pricing is defined as drug pricing "in which the Carrier receives the value of the PBM's negotiated discounts, rebates, credits, or other financial benefits." However, we found that the POS amount paid for the same drugs, at the same pharmacy, at the same time differed for each carrier (i.e., the pharmacies are accepting varying amounts for the same drugs depending on the carrier).

The pricing variations that we identified can be traced to the PBM's contracts with the carriers. The PBM contracts typically include claim pricing guarantee language that sets a ceiling for the carrier's claim liability. The risk for this ceiling is completely on the PBM; if the carrier's claim cost exceeds the guarantee, the PBM reimburses the carrier and the FEHBP. No additional payment is due from the carrier and the FEHBP if the claim cost is less than the guarantee.

Discussions with the PBM determined that it places the carriers into internal networks based on the carriers' size (overall lives covered) and that these networks are geared toward

meeting the guarantee built within each carrier's contract. Our review of the carrier contracts found the variance in the brand name drug pricing to be the discount applied to the drug's average wholesale price (AWP). However, our review also identified actual pricing inconsistencies for the generic drugs, which make up the overwhelming majority of the claims processed and paid.

The cause of the inconsistencies was the maximum allowable cost (MAC) pricing utilized. The MAC price is set internally by the PBM, and this pricing varied across all carriers reviewed, resulting in different amounts paid by each carrier for the same drugs to the same pharmacies in the same time period. MAC prices, like the discounts and administrative fees noted earlier, are set by the PBM based on the carrier's size. This price manipulation also allowed the PBM to ensure that each carrier's total claim cost comes close to but does not exceed their contracts' pricing guarantees.

As part of previous PBM audits, we have consistently requested full copies of the retail pharmacy contracts. However, we have only ever received copies of the audited carrier's pricing sheets (setting the brand discount that the PBM applies to the carrier's claims). As our current audit consisted of multiple carriers, however, we were able to view the pricing sheets for the various networks that each carrier was placed into by the PBM and, for the first time, saw the variations in network discounts applied to each network. Generally, we found that the carriers with the largest number of covered lives received the greater discounts off of AWP for brand name drugs and lower MAC pricing for generic drugs.

Based on our prior PBM audit experience, we are confident that the processed drug cost (less member copay or coinsurance) is passed on to the FEHBP. However, as stated above, our audit shows that the POS price for like drugs at the same pharmacy in the same time period varied by carrier. This leads us to the question of why the retail pharmacies would accept varying prices for the same products. It is our opinion that a reasonable business would not accept varying prices for the same product because the claims were from different insurance carriers unless there was an overall payment guarantee within the PBM/retail pharmacy contract.

A recent OPM Office of the Inspector General audit of this PBM revealed that at least some of its retail pharmacy contracts include such language. Specifically, the contract provides for an annual reconciliation and true up to ensure that the retail pharmacy target guarantee rates are met. However, the PBM maintains that it is entitled to keep any FEHBP monies that exceeded the final amount paid to the retail pharmacies. This additional amount above the overall payment guarantee, known as spread, is something the Transparency Standards hoped to eliminate by tying the PBM's profit solely to the administrative fees - thus making the pharmacy payment transparent.

Consequently, we do not believe that the PBM Transparency Standards set by OPM in its carrier contracts are being applied as intended by the PBM. This misapplication of the standards potentially allows the PBM to profit on the sale of retail pharmacy drugs and thereby overcharge the FEHBP by the amount of profit.

Recommendation 2

We recommend that the Contracting Officer complete a data analysis of the claims pricing for all FEHBP carriers who contract with the PBM to determine if the transparency standards are being implemented as intended.

OPM's Response:

OPM stated that, as it does not have access to claims data or resources to conduct such work, and the requested analysis would essentially be a contract compliance audit, they feel this recommendation would be best achieved via an OIG audit of FEHB carriers.

OIG Comments:

As the administrator of the FEHBP, OPM should have hands on knowledge and understanding of the program's operations based on the guidance it provides. While we agree that oversight of OPM and OPM programs is our responsibility, this does not absolve OPM from conducting its own oversight and other analyses on issues identified by the OIG. Our concerns with how the transparency standards have been implemented by the PBMs will require corrective actions by OPM. In order to develop the corrective actions, it is incumbent upon OPM to obtain a better understanding of the concern, which the recommended analysis would provide.

Recommendation 3

We recommend that the Contracting Officer require the carrier contracts to include a true up to ensure that each carrier receives the full value of all discounts, rebates, credits, or any other financial guarantees or adjustments included within the PBM's contracts with pharmacies. The true ups should ensure that only the final costs paid to the pharmacies and/or drug suppliers (including any post POS reconciliations or true ups) are passed on to the FEHBP.

OPM's Response:

OPM stated that they have addressed this issue as part of the 2021 amendments to the FEHB contracts; specifically, clauses section 1.28(a)(5) and section 1.28(b)(2)(iv).

OIG Comments:

OPM's response assumes that transparency will be achieved by carriers with PBM agreements that include aggregate pharmacy claim discount guarantees that are reconciled at least annually. Under that assumption, transparency would ensure that all carriers would receive the same guarantees. The only differences between carriers would be based on estimate volume. However, that is not the case.

As mentioned in our description of the issue, the PBM clearly stated to us in meetings that the guarantees proposed to carriers are based on their unique population and estimated claim spend. These guarantees are set up to place a hard floor to the overall discounts received by the carriers for drugs. If the PBM fails to meet the discount guarantee, then amounts sufficient to meet the overall discount are returned to the carrier. This rarely happens because the PBM strategically prices retail claims so that the guarantee is achieved and does not base the prices on its contracts with the individual pharmacies.

Simply relying upon an annual reconciliation of the discount guarantee will not ensure transparency. Instead, it may allow the PBM to benefit from the spread pricing mentioned above. Consequently, the true up that our recommendation is focused on is not a reconciliation to the discount guarantees (which are already part of the carrier contracts with the PBM), but on ensuring that the carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments that are included in the PBMs agreements with retail pharmacies (which may exceed the overall discount guarantee to the carrier) after the POS.

If OPM believes that the true up referred to in the recommendation is already required by section 1.28(a)(5) of the carrier contract's transparency standards, we disagree. This language remains unchanged from the standards in place prior to the 2021 amendments and such a true up is not a part of the PBMs standard procedures for FEHBP carriers. Therefore, we feel that standards should be updated to clearly state that such a true up should be done. At the least, OPM should clarify the intent of that section of the standards to its carriers (and through them to the PBM) and direct the carriers to ensure that such language is enforced in their PBM contracts. Specifically, that direction should be that the PBM perform true ups for all of its pharmacy contracts to ensure that the FEHBP receives its proportionate share of any monies returned to the PBM after the POS.

Carriers' Response:

The Carriers' state that they oppose the proposed changes to transparency standards in recommendation 3 and stated such changes would result in various complexities as well as increased costs for both Carriers and OPM. Additionally, the carriers stated that different pharmacies within the PBM network require different pricing terms depending on various factors, thus resulting in varying reimbursement rates.

Furthermore, the carriers stated that if the PBM were required to perform a true-up to ensure pass-through pricing at a client-specific level, there is a risk that could result in the Carrier paying a different, potentially higher, amount than initially paid at POS at the pharmacy. If the PBM was made to perform reconciliation and make true-up payments, the PBM would likely increase administrative fee rates to offset costs or require Carriers to participate in such reconciliations to pay their share of true-up obligations directly to pharmacies.

OIG Comments:

It should be noted that recommendation 3 is not a change to the transparency standards, because what is suggested is already part of the standards. The recommendation has been made because the PBM has not fully adhered to the requirements of the standards and has not passed back to the FEHBP all monies recovered as a result of true ups with contracted pharmacies.

As part of doing business with any organization, a PBM sets pricing guarantees within its respective contracts. These pricing guarantees, more than anything else, dictate the cost for drugs that is ultimately paid by the purchaser. Consequently, we believe there is little to no risk of the carriers paying more than what was paid at POS to the PBM for the actual cost of drugs as the risk shifts to the PBM when these actual costs exceed the guarantees built within the PBM contract. Instead, the two most likely outcomes are 1) administrative fees may increase as a result of the PBM completing the true ups; and 2) the PBM potentially owing monies to the FEHBP to ensure that the FEHBP receives the full value of discounts and adjustments included in the pharmacy contracts which are not currently accounted for by the PBM.

IV. ADDITIONAL OPM COMMENTS

In addition to its comments to the audit report recommendations, OPM provided additional comments regarding the overall audit and audit process which will be addressed below.

OPM Comment:

OPM stated that prior to the audit the OIG had agreed to allow its Chief Pharmacy Officer (CPO) to be actively involved in the audit as findings were developed in order to provide greater insight into some of the challenges and implications regarding the recommendations proposed.

OIG Response:

OPM is correct that we agreed to allow its CPO to attend the planned on site portions of the audit, including all of our pre audit meetings. Once the COVID 19 pandemic struck, we had to pivot to a virtual audit with no on site visit. When this was done, the CPO, and other OPM personnel, were invited to all of our virtual meetings (including our entrance and exit conferences). However, at no point did the OIG agree that OPM's CPO would be "actively involved" in our audit or participate in the development of our findings. In addition to our comments here, we also directly responded to this comment via a memorandum to OPM's HIO dated May 4, 2021.

OPM Comment:

OPM stated that as the recommendations from the audit are characterized as "Program Improvement Areas" that it would strongly prefer that they not be conveyed in an audit report, but in another vehicle (Management Challenge or Management Advisory Report) that does not compel carrier review and afford insight into internal issues identified by the OIG. Inclusion of the recommendations as part of an audit report invites carriers into processes or decisions that OPM may not want to be made public. Additionally, OPM also stated that it would like the recommendations of the report to be redacted from the report.

OIG Response:

The objectives of our audit were to determine the reasonableness of each plans' contractual arrangements with the PBM and to determine whether the FEHBP contract's transparency standards were being applied appropriately. Accomplishing these objectives required the gathering of evidentiary support at the carrier level. Therefore, our results are being conveyed as they would be with any other audit. It is also important to note that whether the recommendations are conveyed in an audit report, a Management Challenges letter, a Management Advisory Report, or any other type of internal publication, the resulting document would still be posted to our webpage.

As for OPM's request to have the recommendations redacted, the OIG has mechanisms in place for the consideration of redactions, and OPM is aware of this process. If OPM has specific

concerns related to the release of information under the Freedom of Information Act or due to the proprietary and confidential nature of the information, then it should have formerly made those specific concerns known to the OIG's legal team, along with what qualified the information for redaction. The OIG's legal team would then determine if those concerns were legitimate and if redactions were appropriate. However, OPM did not follow this guidance at the draft report stage, and therefore, this request was not considered in the preparation of our final report. That being said, as per our normal processes OPM will have an additional opportunity to propose redactions prior to the release of this report.

APPENDIX A

February 12, 2021

Stephanie M. Oliver
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RE: OPM OIG DRAFT AUDIT REPORT NO. lH-99-00-20-0l6: AUDIT OF THE REASONABLENESS OF SELECTED FEHBP CARRIERS' PHARMACY BENEFIT CONTRACTS

Below is the Aetna management response, as Mail Handlers Benefit Plan ("MHBP") administrator, to the above-referenced U.S. Office of Personnel Management Office of Inspector General ("OPM OIG") Draft Audit Report dated January 13, 2021 (the "Draft Report"). Aetna welcomes the opportunity to discuss the contents of the MHBP's response further with the OPM OIG at its convenience, and to this audit's prompt and mutually satisfactory resolution.

REDACTED BY THE OIG - NOT RELEVANT TO THE FINAL REPORT

B. Program Improvement Areas

1. Pooling of Carrier Contracts ***Procedural***

Recommendation 2

We recommend that the Contracting 0fficer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members.

Aetna Response: The OIG's recommendation that OPM allow carriers to pool their resources together into a common PBM agreement fails to take into account each FEHB plan carrier's separate and distinct priorities, which reflects itself in each carrier's respective plan as a mix of various features including, but not limited to: formulary, plan design, network design, utilization, drug mix, brand/generic pipeline, program elections, brand/generic effective rate guarantees, specialty guarantees, rebate guarantees, performance guarantees, and client credits. These features taken in their entirety permit each carrier individually to maximize the competitive value of its PBM contracting

process, and collectively to offer individual federal employees the opportunity to choose the FEHB plan that best suits their particularized health care needs. To truly obtain any potential volume discounts, all carriers would need to have uniform pharmacy benefit plan designs, features, and levels of support, such as designated or dedicated call center and account management resources which, though they may achieve some administrative fee savings, would eliminate carriers' ability to customize and differentiate their individual offerings and thereby provide federal employees with the real choice in health benefit plan envisioned in the FEHBP.

For these reasons, the OPM OIG should withdraw its Recommendation 2.

2. Inappropriate Application of Transparency Standards **Procedural**

Recommendation 3

We recommend that the Contracting 0fficer complete a data analysis of the claims pricing at the PBM to determine if the transparency standards are being implemented as intended.

REDACTED BY THE OIG - NOT RELEVANT TO THE FINAL REPORT

Recommendation 5

We recommend that the Contracting 0fficer require the carrier contracts to include a true-up to ensure that only the final costs paid to the pharmacies and/or drug suppliers are passed on to the FEHBP carriers for contracts that include guarantees.

Aetna Response: The changes to transparency standards for retail pharmacies that the OPM OIG proposes in Recommendations 3-5 are very problematic, and would create significant complexity and administrative costs, member disruption and, likely, increased costs to carriers and OPM. Different retail pharmacies that participate in a PBM's retail pharmacy network demand different pricing terms based on a variety of factors, including whether they are a chain or independent, the services they offer, and their geographic location. Accordingly, the overall reimbursement rate a PBM is contracted to pay a retail pharmacy often will vary from pharmacy-to-pharmacy. Furthermore, PBMs generally will apply maximum allowable cost ("MAC") pricing for multi-source generic drugs dispensed through retail pharmacies. This MAC pricing approach creates a ceiling on what the PBM will reimburse a retail pharmacy for a drug, regardless of that drug's undiscounted Average Wholesale Price ("AWP") value, thus incentivizing the retail pharmacy to "shop around" for the lowest cost generic drug supplier. This in turn reduces the PBM clients' drug spend. While MAC pricing is a very effective tool for controlling retail drug costs, inherently it will result in variable drug reimbursement rates, as illustrated here:

> For example, if one generic drug (Generic A) has an AWP of $50 and an equivalent generic drug (Generic B) has an AWP of $45, and both have a PBM-imposed MAC price of $15, the adjudicated effective AWP discount of Generic Drug A is AWP-70% (1-$15/$50), and the effective AWP discount of Generic Drug B is AWP-67% (1-$15/$45). Therefore, depending on the retail pharmacy at issue (which the plan member alone selects), and the specific manufacturer of the generic drug that the pharmacy purchases, a PBM client can be charged the exact same price for two different but generically interchangeable drugs, but the effective AWP discount for those drugs at a claim-specific level can be materially different. In this example, if the PBM had contracted with two different pharmacies, but one pharmacy purchased only Generic Drug A, and the other purchased only Generic Drug B, the PBM would have two materially different overall reimbursement rates with the two pharmacies for those interchangeable drugs, despite having reimbursed both retail pharmacies for them in the exact same dollar value (as well as cost to the carrier, and, ultimately, OPM).

Moreover, FEHB plan carriers demand minimum pricing discount guarantees regardless of the PBM's overall reimbursement rate to the retail pharmacy. If, in the above example, the PBM's pricing commitment to the carrier for generic drugs was AWP-70%, the PBM would meet its pricing guarantee to the carrier if that carrier's members favored pharmacies that purchased Generic Drug A, but would miss its pricing guarantee if that carrier's members favored pharmacies that purchased Generic Drug B – *even though in each case* the carrier would be charged the same dollar amount per prescription.

The scenario plays out literally millions of times over the course of a year across a PBM's entire book of business, and the PBM has to manage MAC pricing to meet its commitments both to retail pharmacies and to plan sponsor clients. If the PBM was required to manage a true-up between commitments to retail pharmacies and pass-through pricing to clients at the plan sponsor-specific level, where the volume of claims is but a tiny fraction of the overall number of claims the PBM processes in a year, the risk is significantly heightened that the overall effective rate of the PBM's reimbursements to a specific pharmacy or pharmacy chain will not match the overall effective rate of the amounts charged to the client, even though in actuality the PBM both (i) charged the client the exact amount it remitted to the retail pharmacy on a claim-by-claim basis, and (ii) met its overall pricing guarantee made to that client. If the PBM were required to make true-up payments to individual plan carrier clients resulting from each and every such mismatch, the PBM would need not only to (i) increase administrative fee rates to offset this risk, but (ii) require, contractually, that the carrier participate in this annual reconciliation with the retail pharmacy and pay its proportionate share of that true-up

payment obligation to those pharmacies, so as to enable the PBM to avoid the risk of operating at a loss on its FEHBP business.

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

In short, OPM's adoption of Pass-Through Transparent Pricing at the retail pharmacy level as the OPM OIG proposes redefining it in the Draft Report likely will result in increased complexity, additional costs and member disruption, while providing the FEHB Program with no clear advantage to the current pass-through transparency standards requiring PBMs to pass through to FEHB plan carriers the actual amounts the PBM pays to retail pharmacies.

For these reasons, the OPM OIG should withdraw its Recommendations 3, 4 and 5.

The MHBP thanks the OPM OIG for this opportunity to respond to the recommendations contained in the Draft Report. Please do not hesitate to contact me via e-mail or at 240-418-8970 if you have any questions or require any additional information regarding this response prior to issuance of the Final Report.

Sincerely,

Scott R. Jamison
Senior Director, Federal Government Relations
Aetna Federal Plans

cc: Nina Gallauresi, Executive Director, MHBP
Stephanie Thompson, OPM Contracting Officer

APPENDIX B

1310 G Street, N.W.¶
Washington, D.C. 20005¶
202.626.4800¶
www.BCBS.com¶

February 12, 2021

Ms. Stephanie Oliver, Group Chief
Claims Audit and Analysis Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: **Audit of the Reasonableness of Selected FEHBP Carrier's Pharmacy Benefit Contracts**
Audit Report No. 1H-99-00-20-016
(Dated January 13, 2021)

Dear Ms. Oliver:

Thank you for the opportunity to provide responses from the Blue Cross and Blue Shield Service Benefit Plan (BCBSA) to the above-referenced Audit Report. We have read the Office of Inspector General's (OIG) draft audit report, and held a conversation about the draft recommendations with Michael Esser, Assistant Inspector General, Lewis Parker, Deputy Assistant Inspector General, and Michael Weaver, Sr. Team Leader on February 9, 2021.

REDACTED BY THE OIG - NOT RELEVANT TO THE FINAL REPORT

OIG Recommendation 2

We recommend that the Contracting Officer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members.

BCBSA Response

Per discussions between BCBSA and the Office of Inspector General on February 9, 2021, BCBSA notes that this recommendation does not pertain to BCBSA, but is a policy recommendation for the OPM Contracting Office. As such we are not responding directly to this finding, but will share our thoughts on the underlying policy issue, if any, with the OPM Contracting Officer.

OIG Recommendation 3

We recommend that the Contracting Officer complete a data analysis of the claims pricing at the PBM to determine if the transparency standards are being implemented as intended.

BCBSA Response

Per discussions between BCBSA and the Office of Inspector General on February 9, 2021, BCBSA notes that this recommendation does not pertain to BCBSA, but is a recommendation for the OPM Contracting Office. As such we are not responding directly to this finding, but will share our thoughts on the underlying policy issue, if any, with the OPM Contracting Officer.

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

OIG Recommendation 5

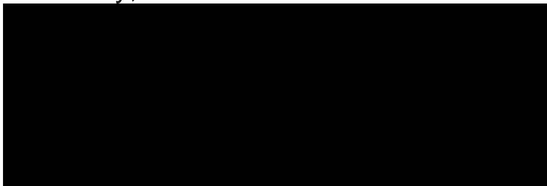
We recommend that the Contracting Officer require the carrier contracts to include a true-up to ensure that only the final costs paid to the pharmacies and/or drug suppliers are passed on to the FEHBP carriers for contracts that include guarantees.

BCBSA Response

Per discussions between BCBSA and the Office of Inspector General on February 9, 2021, BCBSA notes that this recommendation does not pertain to BCBSA, but is a policy recommendation for the OPM Contracting Office. As such we are not responding directly to this finding, but will share our thoughts on the underlying policy issue, if any, with the OPM Contracting Officer.

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

Sincerely,



APPENDIX C

February 12, 2021

Stephanie M. Oliver
Group Chief
Claim Audit and Analytics Group
U.S. Office of Personnel Management
1900 E Street NW
Washington, DC 20415

Dear Ms. Oliver,

We appreciate the opportunity to review the PBM Network Draft Audit Report and to provide comments to the recommendations listed in the report. The following are our comments to the recommendations:

Recommendation 2

We recommend that the Contracting Officer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members.

> GEHA Comment: The proposed change for Carriers to pool together into a common PBM agreement does not consider the unique requirements of each Carrier, including: formulary, plan design, network design, utilization, drug mix, brand/generic pipeline, program elections, brand/generic effective rate guarantees, specialty guarantees, rebate guarantees, performance guarantees, and client credits. These unique requirements allow Carriers to maximize competitive value during contracting and offer federal employees variety/choice in their pharmacy benefit. To truly obtain volume discounts as suggested, all Carriers would need to have a uniform pharmacy benefit. While implementing such levels of uniformity could drive some administrative fee savings, it would eliminate the Carrier's ability to differentiate their offerings and provide federal employees with choice in their benefit plan.

Recommendation 3

We recommend that the Contracting Officer complete a data analysis of the claims pricing at the PBM to determine if the transparency standards are being implemented as intended.

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

Recommendation 5

We recommend that the Contracting Officer require the carrier contracts to include a true-up to ensure that only the final costs paid to the pharmacies and/or drug suppliers are passed on to the FEHBP carriers for contracts that include guarantees.

GEHA Comment: The proposed changes to the transparency standard for retail pharmacies is problematic, creating significant complexity and administrative costs, as well as increased costs to Carriers and OPM.

Different retail pharmacies participating in the PBM's retail pharmacy network demand different pricing terms based on a variety of factors, including whether they are a chain or independent, the services they offer and their geographic location. Accordingly, reimbursement rates with a retail pharmacy will often vary from pharmacy to pharmacy. To ensure low costs with these different reimbursement arrangements, PBMs will generally apply maximum allowable cost (MAC) pricing for multi source generic drugs dispensed through retail pharmacies. This MAC pricing approach creates an upper limit on the reimbursement the PBM will pay a retail pharmacy for a drug, regardless of the undiscounted Average Wholesale Price (AWP) value for a drug, which incents the retail pharmacy to "shop around" for the lowest cost generic drug supplier, saving the Carrier money. While MAC pricing is a very effective tool for controlling retail drug costs, it will inherently result in variable drug reimbursement rates.

For example, if one generic drug (Generic A) has an Average Wholesale Price (AWP) of $50 and an equivalent generic drug (Generic B) has an AWP of $45, and both have a PBM imposed MAC price of $15, the adjudicated effective AWP discount of Generic Drug A is AWP-70% (1-$15/$50), and the effective AWP discount of Generic Drug B is AWP 67% (1-$15/$45). Therefore, depending on the pharmacy at issue (which is selected by the plan member), and the specific manufacturer of the generic drug that pharmacy purchases, a PBM client can be charged the exact same price for two different generically interchangeable drugs, yet the effective AWP discount for the drugs, at a claim specific level, can be materially different. In this example, if the PBM had contracted with two different pharmacies, but one pharmacy purchased only Generic Drug A, and the other purchased only Generic Drug B, the PBM would have two materially different overall reimbursement rates with the two pharmacies for these interchangeable drugs, despite having reimbursed them both at the exact same dollar value (and cost to OPM and the Carrier).

In addition, Carriers demand minimum pricing discount guarantees, regardless of the PBM's overall reimbursement rate to the retail pharmacy. If, in the example above, the PBM's pricing commitment to the Carrier for generic drugs was AWP-70%, the PBM would meet its pricing guarantee to the Carrier if that Carrier's members favored

pharmacies purchasing Generic Drug A, but would miss its pricing guarantee to the Carrier if that Carrier's members favored pharmacies purchasing Generic Drug B, despite the fact that in either case the Carrier would be charged the same dollar amount per prescription.

Chart breakdown:

	Generic Drug A	Generic Drug B	Notes:
AWP	$50	$45	
MAC	$15	$15	MAC pricing creates consistent reimbursement rate due to "upper limit" of payment
Guarantee	AWP 70%	AWP 67%	Difference in discounts creates materially different reimbursement rates for guarantees
Guarantee met	YES	NO	

If the PBM were required to manage a true up between commitments to retail pharmacies and pass through pricing to clients at a client specific level, there is a significantly increased risk of the overall effective rate of the PBM's reimbursements to any specific pharmacy or pharmacy chain not matching the overall effective rate of the amounts charged to the client, despite the fact that the PBM (i) charged the client the exact amount it remitted to the retail pharmacy on a claim by claim basis and (ii) met the overall pricing guarantee made to the client. If the PBM were required to make true up payments to Carrier client based on any such mismatch, the PBM would likely need to (a) increase administrative fee rates to offset this risk, or (b) require, contractually, that the Carrier participate in this annual reconciliation with the retail pharmacy and pay its proportionate share of the annual true up payment obligation to such pharmacies, in order to avoid the risk of operating at a loss on OPM Carrier business.

<u>REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT</u>

In conclusion, the application of Pass Through Transparent Pricing for network pharmacies, as OIG proposes to redefine it, will create significant complexity and added costs. Upon review, there are no clear benefits over the current pass through transparency requirement for retail pharmacies, where the PBM is obligated to pass through to the Carrier the actual amount the PBM pays to the retail pharmacy.

Thank you for the opportunity to provide comments. If you have any questions or would like to discuss, please don't hesitate to contact me.

Sincerely,

David W. Koenig

Chief Member & Operations Officer

Cc:	Laurie E. Bodenheimer	OPM
	Edward M. DeHarde	OPM
	Janet L. Barnes	OPM
	Lloyd V. Williams	OPM
	Stephanie D. Thompson	OPM
	Richard Bierman	GEHA
	Andrea Dorsey	GEHA

NATIONAL ASSOCIATION OF LETTER CARRIERS

HEALTH BENEFIT PLAN

20547 Waverly Court, Ashburn, Virginia 20149 ● (703)729-4677 or 888-636-NALC (6252)

Fredric V. Rolando, President ● Stephanie **M. Stewart,** Director

February 12, 2021

Stephanie M. Oliver
Group Chief
Claim Audits and Analytics Group
United States Office of Personnel Management
Office of the Inspector General

Re: Audit of the Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit

Dear Ms. Oliver:

In response to your letter dated January 13, 2021, the NALC Health Benefit Plan, respectfully submits the following comment regarding Recommendation 2 of the Draft Report of the above referenced audit.

In Recommendation 2 of the Draft Report, OIG recommends "that the Contracting Officer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members." We sincerely appreciate OPM OIG's offer of flexibility to carriers in exploring different options that may be beneficial to the FEHB Program and its enrollees. With respect to this particular recommendation, however, we believe that the differences in carriers' arrangements with PBMs and the effective dates of contracts could present obstacles to carriers coalescing to negotiate a common PBM agreement. In addition, different plan designs and programs are a benefit to FEHB Program enrollees and having a single agreement would limit the variety of offerings to members.

If you should have any questions, please feel free to contact me at (703) 729-8101 or Helen Ferris at (703) 729-8102.

Sincerely,

Bernard Perlmutter
Administrator
NALC Health Benefit Plan

NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

1630 Duke Street Alexandria, Virginia 22314-3467 Phone: (703) 684-5545

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February 12, 2021

Ms. Stephanie Oliver
Group Chief
Claim Audits and Analytics Group
Office of Inspector General
U.S. Office of Personnel Management
Washington, DC 20415

Delivered by email

Re: Draft Audit Report Number 1H-99-00-20-016

Dear Ms. Oliver:

The following is the National Rural Letter Carrier Association ("NRLCA") response to OPM Inspector General's ("OIG") Draft Audit Report Number 1H-99-00-20-016, titled "Audit of the Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts," dated January 13, 2021.

While the report did not include any audit findings against NRLCA, we submit, at your invitation, this response in order to address certain Inspector General's recommendations made in the Program improvement section of the draft audit report.

<u>Introduction</u>

The Federal Employees Health Benefits Program ("FEHB") has unique demographics. Over one-third of our membership are annuitants with primary coverage from Medicare Parts A and B. Consequently, Medicare bears financial responsibility for this cadre's hospital and medical expenses and our FEHB plan bears primary responsibility for their prescription drug expenses. The fact that our plan accounting does not reflect this Medicare financing skews our drug spending as a percentage of total benefit expenses much higher than reality. When Medicare financing is considering, our plan's drug spending is in line with commercial plans (roughly 16.4% before manufacturer payments). See HCCI 2018 Health Care Cost and Utilization Report, at 3 (available at https://healthcostinstitute.org/images/pdfs/HCCI_2018_Health_Care_Cost_and_Utilization_Report.pdf)

We nevertheless realize that prescription drugs are a significant part of our plans benefit spend. With the support of our Rx benefit consultant Axia, our independent medical director, Terry Flander, D.O, and our actuary Oliver Wyman, we place a great deal of focus and effort into controlling prescription benefit expenses, and we believe that we do a good job on our own.

Our ongoing diligence in this area includes competitive marketing/RFP every three years, annual market checks to negotiate improved pricing and contract terms, quarterly monitoring of financial guarantees and annual claims audits. Our efforts are confirmed by our service charge letter from OPM and our health plan accreditation from AAAHC.

NRLCA Response to OIG Recommendations 2-5

Here are our specific responses to the Inspector General's recommendations that are relevant to our FEHB plan. We have developed these responses in consultation with our independent medical director, our PBM CVS Health, and our consultant Axia:

OIG Recommendation 2

We recommend that the Contracting Officer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also to its Federal members.

NRLCA Response to OIG Recommendation No. 2:

We do not concur with this recommendation. The proposed change to allow Carriers to pool together resources into a common PBM agreement does not consider the unique requirements of each Carrier, including the following: formulary, plan design, network design, utilization, drug mix, brand/generic pipeline, program elections, brand/generic effective rate guarantees, specialty guarantees, rebate guarantees, performance guarantees, and client credits. These unique requirements, which are addressed in their independent PBM contracts, allow the Carriers to maximize the competitive value of the contracting process with the PBM and to offer federal employees a variety of choices. Having our own PBM contract also allows the NLRCA to address unique cost containment and quality issues confronting the Plan and its members, e.g., our concentration of rural residents.

To truly obtain any potential volume discounts, all the Carriers would need to have uniform pharmacy benefit plan elections and levels of support, such as designated or dedicated call center and account management resources. While implementing such levels of uniformity could drive some administrative fee savings, it would also eliminate the Carrier's ability to differentiate their offerings and provide federal employees with real choice in their benefit plan as the FEHB Act requires.

OIG Recommendation 3

We recommend that the Contracting Officer complete a data analysis of the claims pricing at the PBM to determine if the transparency standards are being implemented as intended.

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

OIG Recommendation 5

We recommend that the Contracting Officer require the carrier contracts to include a true-up to ensure that only the final costs paid to the pharmacies and/or drug suppliers are passed on to the FEHBP carriers for contracts that include guarantees.

NRLCA Response to Recommendations 3, 4, and 5:

NRLCA along with the other experience rated members of the AFHO trade association objected to OPM's revisions to the transparency language in Section 1.26 of the Standard Contract which OPM added to the Standard Contract for 2021 with the earlier effective date of 2022. We plan to renegotiate these terms for 2022 principally to preserve the status quo. Accordingly, we do not concur with these recommendations.

CVS Health has provided us with the following detailed explanation behind our contract position:

> The recent changes to the transparency standard for retail pharmacies are very problematic, creating significant complexity and administrative costs, as well as member disruption and, likely, increased costs to our FEHB plan and other experienced rated plans.[1] Different retail pharmacies that participate in a PBM's retail pharmacy network demand different pricing terms based on a variety of factors, including whether they are a chain or independent, the services they offer and their geographic location. Accordingly, the overall reimbursement rate for which the PBM has contracted with a retail pharmacy will often vary from pharmacy to pharmacy. Furthermore, PBMs will generally apply maximum allowable cost (MAC) pricing for multi-source generic drugs dispensed through retail pharmacies. This MAC pricing approach creates an upper limit on the reimbursement the PBM will pay a retail pharmacy for a drug, regardless of the undiscounted Average Wholesale Price (AWP) value for a drug, which incents the retail pharmacy to "shop around" for the lowest cost generic drug supplier, saving the PBM's clients money. While MAC pricing is a very effective tool for controlling retail drug costs, it will inherently result in variable drug reimbursement rates, as illustrated here:
>
> For example, if one generic drug (Generic A) has an Average Wholesale Price (AWP) of $50 and an equivalent generic drug (Generic B) has an AWP of $45, and both have a PBM imposed MAC price of $15, the adjudicated effective AWP discount of Generic Drug A is AWP-70% (1-$15/$50), and the effective AWP discount of Generic Drug B is AWP-67% (1-$15/$45). Therefore, depending on the pharmacy at issue (which is selected by the plan member), and the specific manufacturer of the generic drug that pharmacy purchases, a PBM client can be charged the exact same price for two different generically interchangeable drugs, yet the effective AWP discount for the drugs, at a claim-specific level, can be materially different. In this example, if the PBM had contracted with two different pharmacies, but one pharmacy purchased only

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[1] It is worth noting that the same objectionable pricing rules apply to mail order or special pharmacies not owned by the PBM.

Generic Drug A, and the other purchased only Generic Drug B, the PBM would have two materially different overall reimbursement rates with the two pharmacies for these interchangeable drugs, despite having reimbursed them both at the exact same dollar value (and cost to the FEHB contract and the Carrier).

Moreover, Carriers [including NRLCA] demands minimum pricing discount guarantees, regardless of the PBM's overall reimbursement rate to the retail pharmacy. If, in the example above, the PBM's pricing commitment to the Carrier for generic drugs was AWP-70%, the PBM would meet its pricing guarantee to the Carrier if that Carrier's members favored pharmacies purchasing Generic Drug A, but would miss its pricing guarantee to the Carrier if that Carrier's members favored pharmacies purchasing Generic Drug B, despite the fact that in either case the Carrier would be charged the same dollar amount per prescription.

The scenario plays out millions of times over the course of a year across a PBM's entire book of business and the PBM has to manage MAC pricing to meet its commitments to retail pharmacies and clients. If the PBM were required to manage a true up between commitments to retail pharmacies and pass-through pricing to clients at a client-specific level, where the volume of claims is a fraction of the overall number of claims the PBM processes in a year, there is a significantly increased risk of the overall effective rate of the PBM's reimbursements to any specific pharmacy or pharmacy chain not matching the overall effective rate of the amounts charged to the client, despite the fact that the PBM (i) charged the client the exact amount it remitted to the retail pharmacy on a claim-by-claim basis and (ii) met the overall pricing guarantee made to the client. If the PBM were required to make true-up payments to Carrier client based on any such mismatch, the PBM would likely need to (a) increase administrative fee rates to offset this risk, or (b) require, contractually, that the Carrier participate in this annual reconciliation with the retail pharmacy and pay its proportionate share of the annual true-up payment obligation to such pharmacies, in order to avoid the risk of operating at a loss on OPM Carrier business.

<u>REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT</u>

In short, the application of Pass-Through Transparent Pricing, as OPM OIG proposes to redefine it in the draft audit report, to the PBM's retail pharmacy network will create significant complexity, added costs and member disruption, with no clear benefits over the current pass-through transparency requirement for retail pharmacies, where the PBM is obligated to pass through to the Carrier the actual amount the PBM pays to the retail pharmacy.

<u>Summary</u>

For the foregoing reasons, we ask the Inspector General to withdraw Recommendations 2 through 5 inclusive because if implemented those recommendations would have a detrimental impact on our prescription drug benefit program and our members. For nearly a decade, carriers and their PBMs have complied with OPM's request for transparent pricing. The Inspector General now unnecessarily seeks to transform transparent pricing to uniform pricing / benefit design across carriers which is anti-

competitive and would impair health plan quality and benefit cost containment efforts, thereby conflicting with the FEHB Act and our contract with OPM.

We are willing, of course, to discuss these comments with the OIG. We recognize that the final audit report will be a publicly available document. We have no Freedom of Information Act retraction requests with regard to that document.

Sincerely,

Cameron Deml

cc: Ronnie Stutts, NRLCA, President
Clifford Dailing, NRLCA, Secretary/Treasurer
Dr. Terry Flander, NRLCA, Medical Director
Laura Birkel, Axia Strategies, Vice President
Lauren Kovalik, Axia Strategies, Director of Account Management
Jack Gierat, CVS Health, Director
David Ermer, Ermer and Suter, Attorney

Healthcare and Insurance

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, NW, Washington, DC 20415

APPENDIX F

DATE: March 10, 2021

MEMORANDUM FOR: Stephanie G. Oliver
Group Chief
Office of Inspector General

FROM: Edward M. DeHarde
Assistant Director
Federal Employee Insurance Operations

SUBJECT: Response to Draft Audit Report No. 1H 99 00 20 016 on the Reasonableness of Selected Federal Employees Health Benefits (FEHB) Program Carriers' Pharmacy Benefit Contracts

This memorandum is in response to the above subject audit and includes points discussed in our February 24, 2021 meeting. This Audit focused on the Pharmacy Benefit Manager (PBM) contracts from five large carriers: Blue Cross Blue Shield Association (BCBSA), Government Employees Health Association (GEHA), Mail Handlers Benefit Plan, the National Association of Letter Carriers (NALC), and the National Rural Letter Carriers' Association.

Thank you for meeting with the Contracting Office to explain the audit process and your findings and recommendations in this draft report. Prior to this audit we agreed that Healthcare and Insurance's (HI) Chief Pharmacy Officer (CPO) would be actively involved in this audit as the OIG's findings were developed to provide greater insight into some of the challenges and implications you would consider in implementing some of the recommendations. We believe this was a lost opportunity to benefit from her experience and expertise, especially for future PBM work the IG might contemplate.

While a few FEHB Carriers provide pharmacy benefits in house, the vast majority obtain PBM services via competitive procurement. OPM provides oversight of these procurement actions, under the large provider provisions of FEHB Program regulations. While there has been market consolidation in this space, PBMs do vigorously compete for FEHB Carrier business, resulting in unique contract arrangements between the Carriers and their selected PBM, which administer unique pharmacy benefits specific to each Carrier. A change to this market based structure could well result in administrative costs that might outweigh any benefits realized, resulting in higher premium. Carriers also compete with each other; the pharmacy benefits each plan option includes are an important component of the market dynamics of the FEHB Program. To fully evaluate all the implications of imposing such a

novel scheme upon the carriers would require access to data and significant analysis that is beyond HI's current resources.

HI/Federal Employee Insurance Operations (FEIO) has taken action to control drug spending in the FEHB Program, which was acknowledged by OIG. Examples of this action include adding and expanding drug management programs that control costs and improving quality and patient outcomes; establishing better formulary management techniques; selective pharmacy network contracting based on costs and quality criteria; and a formulary exception process. We also continue to note that the percentage of drug expenditure versus overall costs in the FEHB is skewed due to the inclusion of federal retirees and their families, which comprise a large percentage of the FEHB Program. For retirees, FEHB Program carriers pay for the entire prescription drug coverage instead of Medicare. It is critically important to realize that this artificially inflates the percentage of FEHB Program spending dedicated to pharmacy benefits.

FEHB Carriers leverage their entire purchasing power to negotiate drug pricing for their respective PBM contracts. This then benefits the FEHB population. Finally, prescription drug spending is largely driven by new, high cost drugs, which in many cases represent significant advances in care or even cures that drive down overall medical spend.

With respect to this Draft report, FEIO requests removal of Recommendations 2 5 from the final audit report.

Recommendation Responses

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

Recommendation 2: We recommend that the Contracting Officer allow carriers to pool together their resources into a common PBM agreement, which could potentially not only lower costs to the program but also its Federal members.

FEIO and its COs have never precluded carriers from pooling together their resources into a common PBM agreement, nor has OPM ever received such a proposal. The CO's duty is to consider proposals put forth by the carriers, and then approve or disallow the benefits and plan design factors from those proposals based on their merits following negotiation. Therefore, a CO would consider a carrier's proposal to pool their resources with other carriers into a common PBM agreement, but discretion cannot be exercised until such a proposal is received. Any further action on this recommendation would be outside the scope of our CO's duties.

If this recommendation is not removed as requested, OPM urges the removal of Exhibit 1 Total Administrative Fees, page 3 of the report, due to the ability to identify both the carrier and its administrative amounts. Additionally, each carrier which addressed this

recommendation in its response, requested that it be removed, thereby also requesting to redact the findings and recommendation for this entire section.

Recommendation 3: We recommend that the Contracting Officer complete a data analysis of the claims pricing at the PBM to determine if the transparency standards are being implemented as intended.

This recommendation asks the CO to perform Program wide data analysis of claims pricing, which would be an examination of various, different Carrier PBM contractual arrangements. HI has neither the claims data or the resources to complete such an analysis. Furthermore, the analysis would not compare like arrangements, as each carrier PBM contract is unique. FEIO views this recommendation as one best achieved via OIG audit of individual carriers, versus Program office "data analysis." This analysis would effectively constitute a contract compliance audit, which FEIO might otherwise seek to have the OIG perform as a function of its annual schedule of audits of HI's benefit programs.

REDACTED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT

Recommendation 5: We recommend that the Contracting Officer require the carrier contracts to include a true-up to ensure that only the final costs paid to the pharmacies and/or drug suppliers are passed on to the FEHBP carriers for contracts that include guarantees.

OPM has already addressed the issue this recommendation would be aimed toward in its 2021 amendments to the FEHB contracts. Please refer to the following contract clauses.

§1.28(a)(5):

> "Pass Through Transparent Pricing" means drug pricing in which the Carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments including any true up or reconciliation.

§1.28(b)(2)(iv), which states in part:

> The PBM must commit to minimum annual aggregate pharmacy claim discount guarantees, based on Average Wholesale Price (AWP) or other recognized industry benchmark, and maximum annual aggregate dispensing fee guarantees. *PBM must reconcile Carrier claim costs to these guarantees no less frequently than annually.* PBM must pay to the Carrier any shortfall in meeting these pricing guarantees, with the Carrier receiving any payment for under performance of the pricing guarantees to credit its' FEHB Program reserves.

FEIO recognizes that the recommendations in this draft audit report fall under 'Program Improvements' for management's consideration. In that vein, we would strongly prefer

recommendations for Contracting Officer or Program Office action be conveyed via Management Challenge, Management Advisory Report or other internal audit vehicle that does not compel carrier review and affords insight into internal OPM deliberations between HI and OIG. The OIG's inclusion of FEHB Program recommendations in carrier audits invites carriers into what may be processes or decisions that OPM may appropriately desire not be made public. It also has the potential to hold open a carrier audit report, as OIG and the FEHB Program office work to resolve audit findings, where the carrier(s) may have no control.

Thank you again for taking the time to meet with us and reviewing our response. We urge you to consider our request that Recommendations 2 through 5 be removed from this audit. Consider this also a request that if they are not removed, they be redacted. You may contact Sean McGrath at Sean.McGrath@opm.gov for any further questions or follow up on this response, and Dele Solaru at Dele.Solaru@opm.gov for additional Pharmacy or PBM technical assistance as you transition from the Draft Audit stage to the Final Audit stage.

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