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

before the

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

on

"Federal Benefits: Are We Meeting Expectations?"

August 2, 2007

Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to appear before you today to discuss OPM's Office of the Inspector General's audit and investigative efforts in helping to safeguard the benefits of Federal Government employees and retirees from waste, fraud, and abuse.

The U.S. Office of Personnel Management administers benefits from its trust funds for all Federal employees and retirees participating in the Civil Service Retirement System, the Federal Employees Retirement System, the Federal Employees Health Benefits Program, and the Federal Employees Group Life Insurance Program.

These programs cover over eight million current and retired federal civilian employees, including eligible family members, and disburse approximately $91 billion annually from the program trust funds. The majority of our auditing and enforcement activities are spent in protecting these trust funds, particularly the Federal Employees Health Benefits Program (FEHBP). Since fiscal year 1997, these activities have produced over $306 million in judicially ordered recoveries and over $1 billion in recommended recoveries through our audits of the participating FEHBP health plans.

Today, I want to inform you of one of our recently concluded investigations. We participated in an eight-year investigation of Medco Health Solutions, Inc. (Medco), the largest pharmacy benefit manager (PBM) in the United States. This was a joint investigation with the U.S. Attorney's Office for the Eastern District of Pennsylvania, as well as the Offices of Inspector General at the Department of Health and Human Services (HHS OIG) and the Department of Defense.

The investigation was initiated after a former Medco employee filed a *qui tam* law suit alleging that Medco defrauded the FEHBP and other health programs. At that time Medco contracted with the FEHBP to provide mail order prescription drug benefits to Federal employees, retirees, and their eligible family members insured under the

BlueCross BlueShield Association's Federal Employees Program (FEP) and other FEHBP plans.

The joint investigation concluded that Medco:

- falsely reported their turnaround work performance agreement under the FEHBP carrier contracts;
- dispensed prescriptions without properly performing drug utilization reviews that protect the patient;
- falsified paper or electronic records relating to the dispensing process;
- improperly used pharmacy technicians and other non-pharmacist personnel to perform functions which legally must be performed by a pharmacist or under a pharmacist's direct supervision;
- billed the government for prescriptions that were never filled or ordered;
- mailed prescriptions to patients with less than the number of pills prescribed, but charged for the full amount;
- made false statements to patients that their mail order prescriptions had not been received, when in fact the prescription had been received and then cancelled in order to appear to meet contractually required turnaround times;
- favored Merck drugs over the other manufacturer's drugs in switching programs, even when the Merck drugs were more expensive; and,
- made false statements to the United States during the investigation of Medco's illegal conduct.

During the investigation, Medco and the United States Government agreed to a permanent injunction against several practices. This consent decree, which did not resolve the issue of restitution and monetary damages, was entered into on April 26, 2004.

Medco Consent Decree

Medco agreed to implement the following practices:

- Disclose to prescribers and patients the minimum or actual cost savings for health plans and the difference in co-payments made by patients;
- Disclose to prescribers and patients Medco's financial incentives for certain drug switches;

- Disclose to prescribers material differences in side effects between prescribed drugs and proposed drugs;

- Reimburse patients for out-of-pocket costs for drug switch-related health care costs and notify patients and prescribers that such reimbursement is available;

- Obtain express, verifiable authorization from the prescriber for all drug switches;

- Inform patients that they may decline the drug switch and receive the initially prescribed drug;

- Monitor the effects of drug switches on the health of patients; and,

- Adopt the American Pharmacists Association code of ethics and principles of practice for pharmaceutical care for employees at its mail order and call centers.

In October 2006, the Federal Government and Medco entered into a settlement agreement, to resolve alleged False Claims Act violations totaling $155 million. Of this amount, $137.5 million related directly to the FEHBP. The remainder involved other federal programs, including Medicare. As a result of the settlement, the FEHBP trust fund received $97 million in restitution. In addition, $40.5 million in multiple damages associated with the false claims were returned to the U.S. Treasury. This amount represents the largest single recovery by our office.

Because of the growing importance of drug benefits to the health of FEHBP enrollees and the financial integrity of the trust fund, we pursued additional oversight. Due to the substantial impact Medco and other PBMs could have on the FEHBP, we partnered with the HHS OIG in having Medco sign a corporate integrity agreement. The HHS OIG, with our assistance, is monitoring the corporate integrity agreement with Medco. We felt this was the best and most efficient way to protect the FEHBP, in part because of the outstanding program the HHS OIG has developed to implement and monitor corporate integrity agreements.

Medco Corporate Integrity Agreement

The terms of the agreement require Medco to:

- Hire a compliance officer/appoint a compliance committee;

- Develop written standards and policies;

- Implement a comprehensive employee training program;

- Review claims submitted to federal health care programs;

- Establish a confidential disclosure program;

- Restrict employment of persons found ineligible to participate in Federal programs; and,

- Submit detailed reports to the Offices of the Inspector General at OPM and HHS, as a means of assisting them in monitoring its compliance with the corporate integrity agreement.

This is not the first PBM that our office has investigated for allegedly defrauding the FEHBP. Our office, in coordination with the HHS OIG and the U.S. Attorney's Office for the Eastern District of Pennsylvania, conducted a six-year joint investigation of the PBM AdvancePCS that administered prescription drug benefits for some FEHBP plans and Medicare Plus Choice organizations. This case was resolved in September 2005 with a civil settlement in which AdvancePCS paid $137.5 million to the Federal Government, $54.6 million of this amount was returned to the FEHBP trust fund.

The AdvancePCS civil settlement resolved False Claims Act and Public Contract Anti-Kickback Act violations arising from:

- Reimbursements and rebates by pharmaceutical manufacturers to AdvancePCS as improper rewards for favorable treatment of the manufacturers' drugs in AdvancePCS' contracts with the FEHBP and Medicare; and,

- Payments made by AdvancePCS to health insurance plans that contracted with federally-funded health care plans to ensure that it was selected or retained as the PBM for the plans.

AdvancePCS also agreed to a consent order that required them, for the five years following the settlement, to provide significant information to its client health plans, plan participants, doctors and pharmacists regarding its business practices. AdvancePCS was also required to disclose to health plans information about the payments it receives from pharmaceutical manufacturers that are in addition to rebates. Further, AdvancePCS agreed that it will not engage in drug switching that results in the health plan or plan participant paying more for a drug than the cost of the drug that the doctor originally prescribed.

Mr. Chairman this statement described in detail two of our longest and most complex health care fraud cases that not only affected the health and well being of Federal employees, retirees, and their families, but also allowed the FEHBP to recover $151.6 million. We continue to investigate a great number of complex FEHBP health care fraud cases and involve billions of dollars.

The efforts of our investigators and auditors are critical in preventing waste, fraud and abuse within OPM programs. For example, results of our past PBM audits have highlighted that much remains to be done to improve oversight and controls regarding

PBMs participating in the FEHBP. In this regard, we are working with OPM to identify methods to ensure that the FEHBP derives the safest and best possible pharmaceutical services at a fair price.

In addition, we intend to conduct more frequent audits of PBMs. For example, we will be on-site at Medco next month to begin compliance audits covering Medco's contracts with several participating FEHBP carriers. Our future audit activity will also involve detailed analysis of the 2008 FEP Pharmacy contracts recently awarded by the BlueCross BlueShield Association. Of critical importance is developing an understanding of the pricing models of both contracts and preparing a corresponding audit plan.

To further enhance our audit effort, we have begun to work with Medco to receive routine downloads of prescription drug claims data. This effort will eventually be expanded to other PBMs that participate in the FEHBP. With this information we will be able to verify contract charges, quickly determine potential program exposure in prescription drug related fraud cases and ultimately, develop analytical techniques to identify erroneous payments and potential fraud.

We feel very strongly that our rigorous, ongoing oversight of organizations participating in the FEHBP provides a sentinel effect that helps reduce erroneous and fraudulent payments in this $32.5 billion a year Federal health program. A special note is the positive and cooperative relationship between our office and OPM leadership in pursuit of trust fund integrity.

I would be glad to answer any questions you or the other Subcommittee Members may have regarding my statement.