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Health, Education and Human Services Division

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July 19, 1996

The Honorable William Cohen
Chairman, Subcommittee on Oversight
of Government Management and
the District of Columbia
Committee on Governmental Affairs
United States Senate

The Honorable David Pryor
Ranking Minority Member
Subcommittee on Post Office and
Civil Service
Committee on Governmental Affairs
United States Senate

The Honorable James Moran
Ranking Minority Member
Subcommittee on Civil Service
Committee on Government Reform
and Oversight
House of Representatives

The Honorable Benjamin Gilman
Committee on Government
Reform and Oversight
House of Representatives

The Office of Personnel Management (OPM) contracts with the Blue Cross and Blue Shield Association and almost 400 other health insurance carriers to operate the Federal Employees Health Benefits Program (FEHBP). Under this program, health insurance carriers offer about 4 million federal employees and retirees health benefit plans that include prescription drug benefits. The Association's federal employee health plan is referred to as the Blue Cross and Blue Shield Service Benefit Plan.

In recent years, prescription drug costs have accounted for an increasing share of the total benefits paid by the Blue Cross and Blue Shield Service Benefit Plan. Of approximately $6.2 billion in benefits paid by the plan in 1995, about $1.4 billion was for prescription drugs.

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Moreover, total payments for prescription drugs have risen faster than total payments for all the plan's benefits. To help control its prescription drug costs, the Association has contracted with two pharmacy benefit managers (PBM): PCS Health Systems, Inc., for retail prescription drug services, and Merck-Medco Managed Care, Inc. (referred to in this report as "Medco"), for mail order drug services.

As requested, this correspondence is an interim report on the study you requested on PBMs and the services they provide to federal employee health plans. More specifically, this letter responds to your request that we provide preliminary information on (1) the reasons the Blue Cross and Blue Shield Association made a change in pharmacy benefits, effective January 1, 1996, affecting federal retirees; (2) how the Association and Medco implemented the change; (3) concerns about the effect of the benefit change on the retail pharmacy business; and (4) the extent to which Medco and PCS have met the Association's contract requirements. We expect to complete work on our study of FEHBP carriers' use of PBMs and issue a more detailed report by the end of 1996.

To obtain information on the benefit change, we met with representatives of OPM, the Blue Cross and Blue Shield Association, Medco, PCS, the National Association of Chain Drug Stores (NACDS), and the American Pharmaceutical Association. Regarding the potential effect of the benefit change on retail pharmacies, we reviewed recent changes in the volume of prescriptions dispensed by retail pharmacies to the Association's federal enrollees. To determine the extent to which Medco and PCS met their contract requirements, we reviewed the Association's contracts with the PBMs and analyzed reports the PBMs submitted to the Association on their performance in meeting contract requirements.

We conducted our study between March 1996 and July 1996 in accordance with generally accepted government auditing standards.

SUMMARY

The Blue Cross and Blue Shield Association is trying to control its FEHBP prescription drug costs by requiring, as of January 1, 1996, coinsurance from all of its federal health plan enrollees when they purchase drugs at retail pharmacies. Before this change, the federal enrollees who

were also enrolled in Medicare part B[1] did not have copayments for drugs. The Association waives the copayment for these dual enrollees, however, for drugs purchased through Medco's mail order program. The Association and OPM expect that this change will achieve plan savings from an increase in enrollees' use of less expensive mail order services and reduced payments for prescriptions subject to copayments made by enrollees who continue to buy prescriptions from retail pharmacies. Without this benefit change, the Association advised OPM that it would have to increase monthly premiums for all of its federal enrollees with Standard Option coverage.

In early 1996, Medco experienced significant difficulty implementing the benefit change. The volume of prescriptions that shifted from the retail to mail order program was much greater and occurred more quickly than Medco or the Association had anticipated. As a result, Medco could not always meet its customer-service performance measures, particularly for prompt dispensing and delivery of prescriptions to enrollees during the benefit change's initial implementation. Medco, PCS, and the Association collaborated to respond to the increased volume of mail order prescriptions, and, by mid-March 1996, Medco was meeting its customer-service performance measures.

NACDS and other critics of the benefit change are concerned that federal enrollees' shift to the Association's mail order program will have a negative economic effect on retail pharmacies. The shift has been substantial. During the first 5 months of 1996, the total amount PCS paid retail pharmacies for prescriptions dispensed to the federal enrollees affected by the benefit change decreased by about 36 percent, or about $95 million, from the amount paid during the same period in 1995. During the same months in 1996, total payments to all retail pharmacies for prescriptions dispensed to all enrollees in the Association's federal health plan, which includes enrollees affected by the benefit change, decreased about 7 percent, or about $34 million, from the amount paid during the first 5 months in 1995.

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[1]Medicare part B is a voluntary program financed by enrollee premiums and federal general revenues. It covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services.

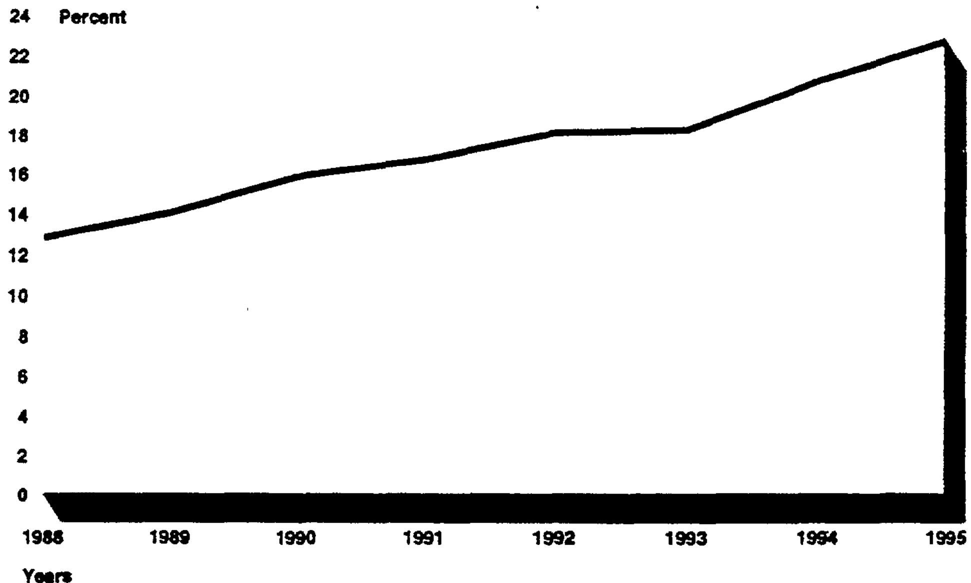
According to the Association, Medco and PCS provide valuable services to its federal employee health plan and have met most of the performance measures set forth in their contracts. These measures cover potential savings to the plan as well as customer service. So far, the PBMs' performance in meeting these measures has helped the Association control the plan's prescription drug costs.

BACKGROUND

OPM contracts with almost 400 health plans, including fee-for-service plans and health maintenance organizations, to operate the FEHBP. The Blue Cross and Blue Shield Association is the largest plan, covering in 1994 almost 42 percent of about 4 million FEHBP enrollees. The Association contracts for management of prescription drug benefits for the plan with the two largest PBMs, PCS and Medco. The Association's contract with PCS began in 1993; its contract with Medco began in 1987.

Like other PBM customers, the Association believes that the PBMs can help control its federal health plan's increasing drug costs. Between 1988 and 1995, the Association's payments for the plan's prescription drugs increased at an average annual rate of about 21 percent, compared with an average annual rate of about 12 percent for total benefit payments. Moreover, prescription drug payments have constituted an increasingly greater share of total benefit payments, rising from about 13 percent in 1988 to about 23 percent in 1995 (see fig. 1). These payment increases appear to primarily result from increases in the number of prescriptions per enrollee and the price of prescriptions.

Figure 1: Prescription Payments as a Percentage of Total Benefit Payments, 1988 to 1995



Source: Blue Cross and Blue Shield Association.

The Association also wanted to obtain the full range of PBM services that the combination of PCS and Medco could provide. Specifically, both PBMs provide claims processing for the Association's federal health plan and administer its formulary--a list of prescription drugs by therapeutic class preferred by the plan.[2] Other services provided by both PBMs include negotiating drug rebates with manufacturers, generic substitution, and drug utilization review (DUR).

In operating the retail drug program, PCS contracts with a network of pharmacies to provide the Association's federal health plan prescriptions at discounted prices. In 1996, this network included 44,751 pharmacies, about 60 percent

[2]The plan's formulary is an "open" formulary, which means that the plan pays for drugs whether they are formulary or nonformulary. Medco administers the plan's formulary for prescriptions dispensed through the mail order program, while PCS administers the formulary for prescriptions dispensed through its network of retail pharmacies.

of which were chain drug stores with the remaining 40 percent independently owned. In operating the mail order program, Medco also provides the plan prescriptions at discounted prices. Medco receives and dispenses prescriptions from pharmacies in Florida, New Jersey, Ohio, and Texas.

Under its FEHBP contract, the Association must submit to OPM any proposal to change benefits covered by its federal employee health plan. OPM reviews the proposal to assess its cost-effectiveness to the program and potential effect on the delivery of benefits to federal enrollees. In addition, the Association is responsible for overseeing the activities of Medco and PCS and reporting to OPM any significant problems that could affect the delivery of benefits to enrollees, such as the problems Medco initially experienced in implementing the benefit change.

BENEFIT CHANGE INTENDED TO HELP CONTROL DRUG COSTS

On May 31, 1995, the Association submitted to OPM a proposal for a benefit change to the Blue Cross and Blue Shield Service Benefit Plan effective January 1, 1996. The change was designed to control the federal plan's rising prescription drug costs while maintaining quality service for enrollees. Before the change, the approximately 800,000 people[3] insured under the Association's Standard Option Plan with Medicare part B coverage had not been paying coinsurance for prescription drugs purchased in either the retail or mail order programs. The change required these enrollees to pay 20 percent of the price of prescriptions purchased at network retail pharmacies.[4] These copayments were already required of other enrollees and were similar to those required in several other federal employee health plans. The Association continues to waive the $50 per calendar year prescription-drug deductible applicable to prescriptions filled at retail pharmacies and the copayment for prescriptions filled through the mail order program. Without the benefit change, Association officials said that an increase in premiums for all federal

[3]This number includes federal enrollees and their dependents.

[4]In 1995, federal enrollees with Medicare part B coverage paid 20 percent in coinsurance for prescriptions purchased at retail pharmacies not included in the plan's network of pharmacies. In 1996, this amount increased to 40 percent.

enrollees with Standard Option coverage would be necessary to cover the plan's prescription drug costs.[5]

PLAN DEVELOPED TO MEET INCREASE IN MAIL ORDER PRESCRIPTIONS

On August 24, 1995, Association staff met with Medco representatives to review Medco's strategy for managing the benefit change, including the anticipated increase in calls and prescriptions, without disrupting service. According to Medco officials, they estimated the size and timing of the increase in mail order prescriptions by relying primarily on their own claims experience in managing pharmacy benefits for about 50 million people, as well as data from a comparable benefit change made by Massachusetts Blue Cross and Blue Shield. Medco officials explained that the benefit change made by the Massachusetts plan also affected a retiree population and provided enrollees a financial incentive to use mail service.

The resulting Medco forecast estimated a gradual 64-percent growth in mail order prescriptions during the first year. Medco forecasted an increase from about 110,000 prescriptions a week during the last quarter of 1995 to 140,000 a week during the first quarter of 1996, 150,000 during the second quarter, 160,000 during the third quarter, and 180,000 during the fourth quarter. During 1996, Medco also planned to handle occasional surges in demand of 6 to 13 percent in excess of the forecasted number of prescriptions. Using this analysis, Medco also planned to increase its telephone capacity to respond to customer service demands.

In September 1995, OPM notified the Association that the benefit change had been approved. Both OPM and Association officials contended that the change would promote more cost-effective use of the prescription drug benefit by encouraging enrollees to get their prescriptions from the less expensive mail order program. OPM's actuarial analysis projected savings for the plan and its federal

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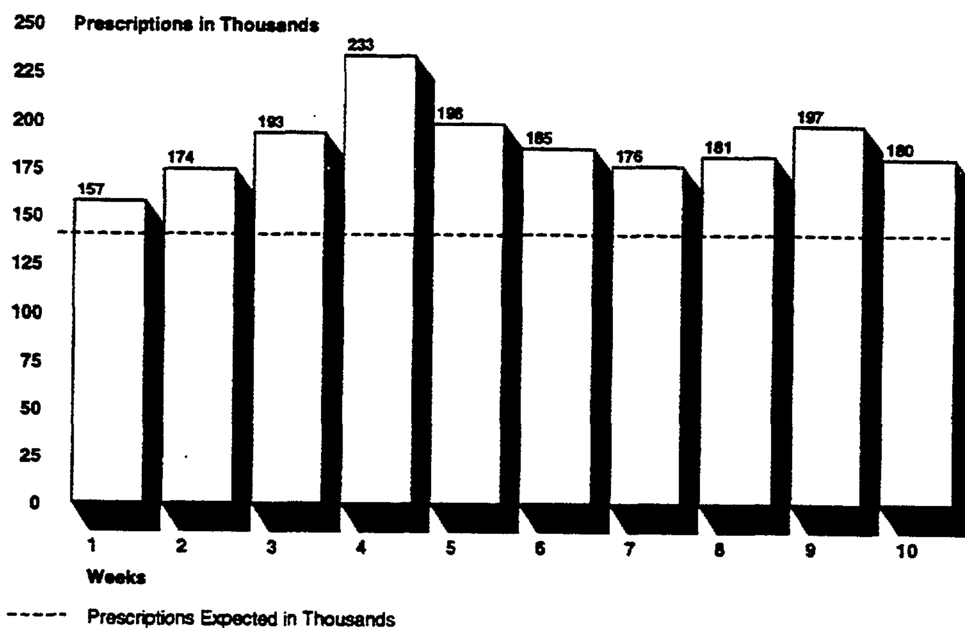
[5]OPM reported that without the benefit change the Association had proposed that 1996 monthly premiums for Standard Option increase by an additional $5.42 monthly for self-only and $12.03 monthly for self and family. In 1994, OPM reported that about 1.6 million of about 1.7 million federal active and retired enrollees covered by the Blue Cross and Blue Shield Service Benefit Plan had Standard Option coverage.

enrollees; the analysis also projected that the change would not cause the federal government to incur additional costs. According to actuarial documents, the Association expected the benefit change to save its federal employee health plan about $193 million the first year. The savings were expected to come from several sources, including the new copayments, generic drug substitution, and increased use of the mail order program.

Demand for Mail Order Service Surpassed Expectations

The number of prescriptions received by Medco quickly surpassed Medco and Association expectations. For example, during the first week of January 1996, weekly prescriptions rose to 157,000, and by the week ending January 27, 1996, rose to 233,000, or about 66 percent higher than the expected 140,000. By the week ending March 9, 1996, and continuing through the week ending April 6, 1996, Medco received between 175,000 and 187,000 prescriptions a week. Enrollees with Medicare part B benefits who shifted from using retail pharmacies to mail service accounted for most of the increase in prescriptions. About 9 percent of these enrollees' prescriptions were purchased through the mail order program in 1995, but that percentage increased to about 38 percent by February 1996. Figure 2 shows the increase in mail order prescriptions contrasted with the number of forecasted prescriptions.

Figure 2: Weekly Number of Mail Order Prescriptions Received, Week Ending January 6, 1996, to Week Ending March 9, 1996



Source: Medco.

Medco's processing capacity could not absorb this increase. In particular, the capacity Medco had planned to support the benefit change could not handle the steep increase in prescriptions received in January 1996. As a result, the number of pharmacists was insufficient to handle orders for prescriptions, and many enrollees did not get their prescriptions filled promptly. During the last week of January 1996, OPM informed Association officials of its disappointment with the customer service being provided to enrollees using the mail order program.

Medco's contract with the Association for the federal employee health plan requires that Medco dispense or return 99 percent of the prescriptions it receives daily within 5 business days after the date received. Medco reported that the 5-day performance measure was met about 87 percent of the time in January 1996 and about 94 percent of the time in February 1996.

In addition, many customer calls were delayed or went unanswered during January and February 1996. During these

2 months, Medco received an average of about 106,000 customer calls a week. Medco's contract with the Association for the federal employee health plan specifies that no more than 2 percent of customer calls a week will receive a busy signal (call blockage) or result in a customer hanging up after waiting on the phone (call abandonment). For the 2-month period, the call blockage rate averaged 1.8 percent a week; the call abandonment rate averaged 1.7 percent a week. However, about 8 percent, or 11,000 calls, received a busy signal during the week ending January 20, 1996, and about 5 percent, or 6,000 callers, hung up before reaching a Medco customer service representative during the week ending February 3, 1996.

Actions Restored Service

Medco responded to the unanticipated demand and associated service problems by moving quickly to increase processing capacity. For example, during the week ending January 20, 1996, Medco officials expanded operations at the company's Florida and New Jersey pharmacies from a 5-1/2-day schedule to 7 days a week, with operating hours expanded from 15 hours to 19 hours daily. Medco also reassigned pharmacists who normally performed other Medco jobs to confirm phone and fax prescription orders. Medco officials also brought pharmacists and support personnel from their pharmacies across the country to one of their pharmacies in Tampa, Florida, to increase processing capacity.

OPM and the Association agreed that Medco would send medications by overnight mail to customers who would not otherwise receive them within 5 business days. Between the weeks ending January 6, 1996, and April 27, 1996, Medco sent approximately 160,000 prescription packages by overnight mail at a cost of almost $1 million.[6] In February 1996, OPM also agreed that the Association should arrange through PCS for mail order customers whose prescriptions were delayed and who needed their medications immediately to get up to a 21-day supply from PCS retail network pharmacies. This ad hoc arrangement required PCS to adjust quickly to serve over 5,000 enrollees who used this service and did not have to pay the 20-percent

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[6]As of July 2, 1996, the Association and Medco had not resolved which company would pay these overnight mail costs under their contract. A Medco official estimated the actual cost to be about $542,000, considering the cost Medco would have incurred by using the regular mail service.

coinsurance required for retail purchases.[7] The coinsurance for over 10,000 retail prescriptions dispensed to these enrollees would have amounted to approximately $291,000.

Although Medco continued to use extra means to deliver prescriptions to enrollees through the last week of April 1996, Association data show that the mail order program began to meet performance expectations for turning around prescriptions within 5 days during the week ending March 16, 1996. Medco began to consistently meet performance expectations for customer service calls during the week ending February 10, 1996.

The difficulties enrollees had with the mail order program during early 1996 were reflected in the Association's most recent customer satisfaction survey of mail order customers. Quarterly averages for 1994 indicated that about 95 percent of enrollees surveyed were satisfied, with about 85 percent very satisfied; in 1995, about 94 percent were satisfied, with about 84 percent very satisfied. Customer satisfaction with the program fell, however, during the first quarter of 1996, with about 81 percent of those surveyed indicating that they were satisfied with services, and about 66 percent responding that they were very satisfied. The greatest change in customer satisfaction concerned the time it took to fill prescriptions. About 75 percent responded that their prescriptions were filled promptly, down from quarterly averages of 94 percent in 1994 and 92 percent in 1995.

CONCERN ABOUT THE EFFECT OF THE BENEFIT CHANGE ON RETAIL PHARMACIES

The 1996 copayment change in pharmacy benefits raised concerns from NACDS and many chain and independent pharmacies about its effect on the retail pharmacy business. As a result of the change's incentive to use mail service, retail pharmacies foresee the shifting of millions of dollars in prescription drug sales to the mail order program. Because of this shift in dollars and other issues concerning the benefit change, representatives of NACDS and many pharmacies have contended that the Blue

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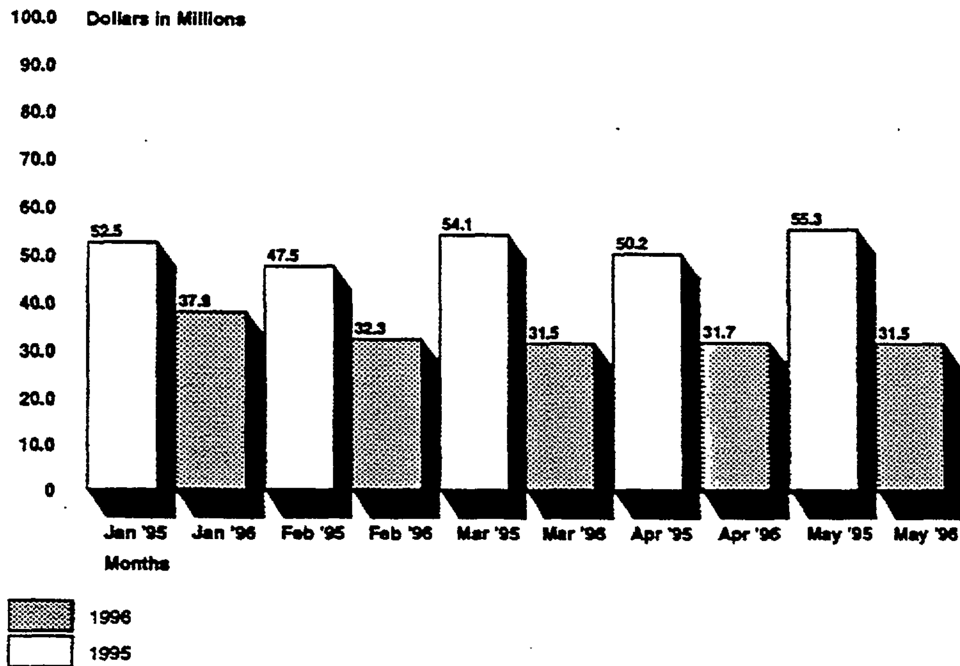
[7]PCS officials noted that although PCS was not contractually required to implement this policy change, the company developed procedures for it and implemented it within 1 week of learning of the problem.

Cross and Blue Shield Association should change the benefit again to restore incentives for enrollees to use retail pharmacies. Moreover, several chain pharmacies encouraged the affected enrollees to express their concerns about the change to members of the Congress and the Association.

Because the benefit change is recent, we could not determine how many federal enrollees affected by the change have shifted to using primarily the mail order program and will continue to use primarily the mail order program. Therefore, determining the benefit change's effect on retail pharmacies' sales is difficult. Nevertheless, payments to retail pharmacies for prescriptions dispensed to enrollees affected by the change decreased substantially from 1995 to 1996, according to our analysis of PCS payments to retail pharmacies.[8] This analysis included prescriptions dispensed to federal enrollees with both Standard Option and Medicare part B coverage. (See fig. 3.)

Figure 3: Payments to Retail Pharmacies for Prescriptions Dispensed to Enrollees With Standard Option and Medicare Part B Coverage, January to May, 1995 and 1996



Source: PCS.

[8]All analyses of payments to retail pharmacies included copayments and deductibles paid by enrollees.

Figure 3 shows that between January and May 1995, total prescription payments to retail pharmacies for prescriptions dispensed to enrollees affected by the benefit change were about $259.6 million, compared with about $164.9 million between January and May 1996--a decrease of about 36 percent.

Retail pharmacies serving the largest percentages of the Association's federal enrollees affected by the benefit change experienced similar percentage decreases in prescription payments following the change, according to PCS data. These pharmacies include Walgreens, Rite Aid, CVS, Revco, and Wal-Mart. We determined the change these pharmacies experienced in total payments between January and May in 1995 and 1996 for prescriptions dispensed to enrollees in the Association's federal health plan who had Medicare part B coverage, as well as total payments for prescriptions dispensed to all enrollees in the plan. Between 1995 and 1996, these specific pharmacies had, on average, a 41-percent decrease in total retail payments for prescriptions dispensed to the enrollees with Medicare part B coverage, and a 14-percent decrease in total payments for prescriptions dispensed to all plan enrollees.

Total payments to all retail pharmacies for prescriptions dispensed to all enrollees in the Association's federal health plan also decreased between 1995 and 1996. This total includes payments for enrollees affected by the benefit change. PCS data indicate that between January and May 1995, total payments were about $473.3 million, compared with about $439.8 million between January and May 1996--a decrease of about 7 percent.

PBMS MET MOST BLUE CROSS 1995 PERFORMANCE MEASURES

The Blue Cross and Blue Shield Association's contracts with Medco and PCS include annual performance measures that focus on two areas--savings and customer service. In each area, the contracts provide financial incentives for exceeding certain performance measures and penalties for not meeting them. According to information from Association officials, in 1995, Medco met its savings and customer-service measures for the Blue Cross and Blue Shield Service Benefit Plan. PCS, on the other hand, incurred penalties for not meeting some savings and customer-service measures.

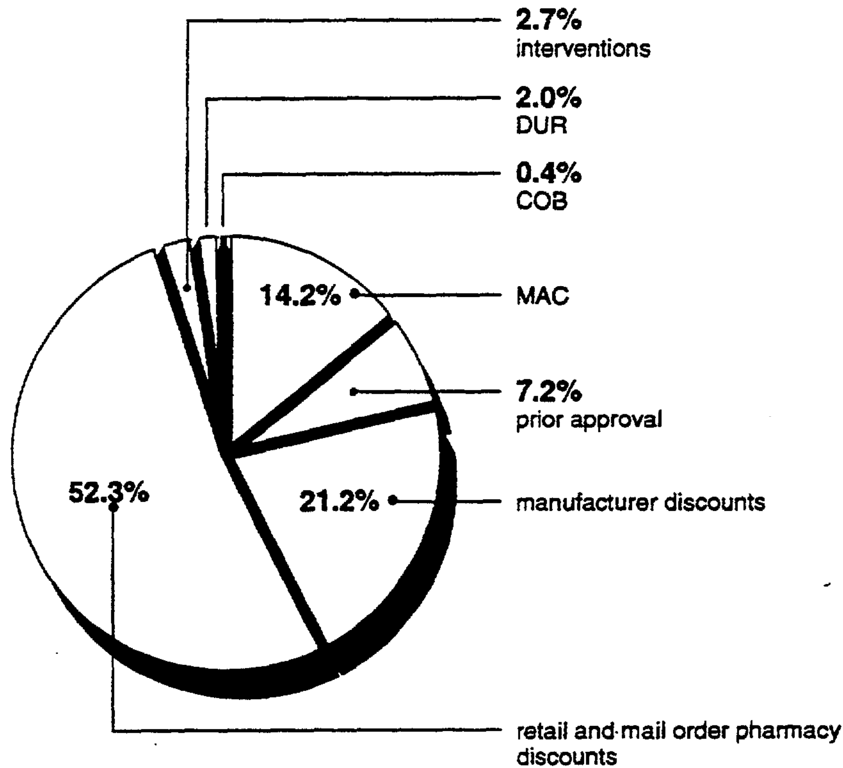
PBM Performance Produced Savings in 1995

The Blue Cross and Blue Shield Association estimated that its two PBMs saved the plan about $505 million in 1995. These savings were about 54 percent higher than they were the year before. Association officials indicated that these savings are used to support the pharmacy benefit plan, as well as to contain enrollee premiums, deductibles, and copayments and enhance the plan's overall benefit package.

Savings in 1995 resulted from seven categories of PBM services, according to Association estimates. These savings were based on what the Association estimated it would have paid for prescription drugs and related services had it not contracted with the PBMs. The Association developed this methodology, which represents one way to determine potential savings from PBM services. We plan to evaluate the soundness of this methodology and compare it with methodologies developed by other federal health plans for our final report.

Figure 4 shows the percentage of total savings each of the seven service categories represents.

Figure 4: 1995 Blue Cross FEHBP Pharmacy Savings



Source: Blue Cross and Blue Shield Association.

-- Retail and mail order pharmacy discounts accounted for about $264 million in savings.[9] For retail, total savings resulted from the difference between the reimbursement amount PCS paid pharmacies for all individual prescriptions[10] and the drugs' usual and

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[9]Retail pharmacy savings do not include savings from the use of generic drugs for which PCS has set a maximum reimbursement limit to pharmacies.

[10]PCS negotiated this reimbursement amount with individual pharmacies, which is based on a percentage discount off a drug's average wholesale price (AWP) plus a dispensing fee. The AWP is the list price drug manufacturers suggest that wholesalers charge pharmacies, and is an average of list prices collected for many wholesalers.

customary prices.[11] Mail order savings were derived from discounts off drugs' average wholesale prices (AWP) that the Association negotiated with Medco.

-- Maximum allowable cost (MAC) savings accounted for approximately $72 million in savings. MAC refers to the maximum price that retail pharmacies in PCS' network may be paid for certain generic drugs. Savings resulted from the difference between the reimbursement amount PCS paid the pharmacies for these generic drugs and the drugs' usual and customary prices.[12]

-- Manufacturer discounts in the form of rebates accounted for about $107 million in savings. These were guaranteed discounts to the plan that PCS and Medco negotiated with drug manufacturers for prescriptions dispensed through retail or mail order pharmacies. The plan received 90 percent of the total rebates, and the PBMs retained the remaining 10 percent as an administrative fee and incentive to increase the amount of discounts. PCS did not meet its rebate guarantee in 1995 and, as a result, incurred a penalty.

-- DUR accounted for about $10 million in savings that resulted from clinical activities the PBMs performed and fall into two categories: concurrent and retrospective DUR. Concurrent DUR is performed before dispensing a drug and is designed to prevent drug interactions, therapeutic duplications, early and late

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[11]The usual and customary price is what each pharmacy charges its cash-paying customers whose prescriptions are not covered by health plans.

[12]MAC savings include about 73 percent of all generic drugs dispensed by retail pharmacies that are reimbursed by the Association. The remaining 27 percent represent generic drugs for which the Association, at PCS' recommendation, does not pay retail pharmacies incentives to encourage substitution because (1) they have such narrow therapeutic ranges that variations among them could affect a patient's response to the drug or (2) there is an insufficient number of generically available products with reliable suppliers and low cost to justify such incentives.

refills, and excessive doses.[13] Retrospective DUR is a special program PCS conducts to identify enrollees who have received particular drugs or combinations of drugs and to advise the enrollees' physicians on the clinical and economic implications of various treatment alternatives, including drug selection and dosing. PCS encourages the physicians to use the most cost-effective drugs and regimens to optimize their patients' drug therapies.[14]

-- Medco's intervention program accounted for about $13.5 million in savings.[15] The program encourages patients to use, and physicians to prescribe, less expensive brand-name drugs considered as safe and effective[16] as other, more expensive brand-name drugs.[17]

-- The prior approval program accounted for about $36.5 million in savings. This program covers 13 drugs that require Association approval before dispensing.[18] The Association determined savings from this program by

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[13]Concurrent DUR savings equal the sum of the prices of prescriptions reversed before dispensing for drugs receiving a DUR alert.

[14]PCS performs retrospective DUR for both the retail and mail order pharmacy benefit programs. Since PCS does not have access to mail order drug prices, it estimates retrospective savings for mail order drugs.

[15]PCS plans to begin a similar FEHBP intervention program in the retail setting in August 1996.

[16]Medco uses an independent group of health care professionals, known as a Pharmacy and Therapeutics Committee, to evaluate drugs in all therapeutic categories and evaluate them on the basis of safety, efficacy, and substitutability.

[17]Medco officials noted that this program helps to manage use of the plan's formulary and ensure the plan continued manufacturer rebates by increasing market share for particular drugs.

[18]Prior approval is required for medications that may be used to treat conditions or illnesses that are not covered by the Association, are outside the Food and Drug Administration or manufacturer guidelines, or have a high potential for abuse.

calculating the cost of prescriptions that were denied reimbursement or never filled by enrollees who received a prior approval form.[19]

-- The coordination of benefits (COB) program accounted for about $2 million in savings. COB is an industrywide method used to avoid paying a claim when another insurer has primary liability and to prevent duplicate benefits to an individual covered by another insurer. The Association computed savings from this program by determining the total reductions in the amount the Association was responsible for paying for claims also covered in part by other insurers.

Performance Measures Focus on Providing Quality Customer Service

The Association's contracts with its PBMs also specify performance measures for the quality of customer service provided to the federal plan and its enrollees. For example, both PBMs are required to answer customer calls and respond to inquiries within a specific time frame. In addition, Medco's contract requires that its pharmacy dispense all of its prescriptions annually with less than a .005-percent error rate.[20] Further, PCS' contract has several guarantees for the accuracy and timeliness of prescription claims submitted by enrollees for reimbursement. In two instances, PCS did not meet claims timeliness guarantees and therefore incurred minor penalties.[21]

PCS' contract also guarantees that it provide plan enrollees convenient access to its network pharmacies. The guarantee states that a network pharmacy be located within 5 miles of 98 percent of the enrollees. PCS data indicate

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[19]Savings calculations involved determining the number of months that a specific drug is usually prescribed.

[20]Errors occur when a drug other than the one prescribed by the physician is dispensed or the prescribed drug is dispensed with inappropriate dosage instructions. Errors are those reported by plan enrollees or other non-Medco personnel.

[21]According to PCS officials, neither instance disrupted service to enrollees and the company was within 4 days of meeting the performance measure.

that this guarantee was met in 1995 and was met as of April 1996.

AGENCY AND OTHER COMMENTS

We obtained comments on a draft of this correspondence from OPM, the Blue Cross and Blue Shield Association, Medco, and PCS. In general, their comments were technical in nature and helped to provide additional clarification. Where appropriate, the correspondence was modified to reflect their comments.

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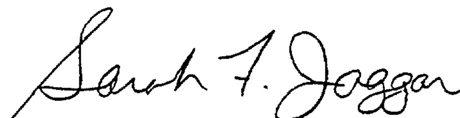
As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this correspondence until 30 days after its issue date. At that time we will make copies available to the Chairman and Ranking Minority Member of the Subcommittee on Civil Service, House Committee on Government Reform and Oversight; other congressional committees; the Director of OPM; and officials of Blue Cross, Medco, PCS, and others upon request.

The information in this correspondence was prepared by John Hansen, Assistant Director; Joel Hamilton; Jennifer Arns; Mary Freeman; Jonathan Blum; and Kristin Sosinski. Please call Mr. Hansen at (202) 512-7105 if you or your staff have any questions.



Sarah F. Jaggar
Director, Health Financing
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