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PHARMACY BENEFIT MANAGERS

FEHBP Plans Satisfied With Savings and Services, but Retail Pharmacies Have Concerns



**Health, Education, and
Human Services Division**

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Congressional Requesters

The Office of Personnel Management (OPM) estimates that insurance carriers in the Federal Employees Health Benefits Program (FEHBP) covered nearly 9 million federal employees, retirees, and dependents in 1995 and that pharmacy benefit payments for its five largest plans were about \$2 billion.¹ Moreover, pharmacy benefit payments for these plans accounted for an increasing share of their total FEHBP health care costs—growing from 12 percent in 1990 to 19 percent in 1995.

Like a growing number of health insurers interested in controlling prescription drug costs, FEHBP plans have contracted with companies called pharmacy benefit managers (PBM). These companies manage pharmacy benefits on behalf of plan sponsors, such as self-insured employers and HMOs. By the end of 1995, about 58 percent of federal enrollees were covered by a PBM, according to OPM.

As PBMs have assumed a bigger role in managing pharmacy benefits for federal enrollees, questions have arisen about the effect of their cost-containment methods on the quality and availability of pharmacy services and on other segments of the health care marketplace. Accordingly, we were asked to provide information on (1) why FEHBP plans have contracted with PBMs to provide pharmacy benefits, (2) what types of services and savings the PBMs provide FEHBP plans, (3) how FEHBP plans evaluate PBM customer service, and (4) the concerns of retail pharmacists about the quality of PBM pharmacy services and the effect of some PBM practices on the retail pharmacy business.²

To address these questions, we examined three FEHBP plans that contracted with PBMs—the Blue Cross and Blue Shield Association (Blue Cross), the Government Employees Hospital Association (GEHA), and the Rural Carrier Benefit Plan (Rural). Together, these plans cover about 50 percent of all FEHBP employees and retirees, and each contracts with one of the six largest PBMs. Although the Rural plan has a relatively small enrollment compared with Blue Cross and GEHA, it is one of the few

¹OPM did not have pharmacy benefit payment data for the remaining plans, most of which were health maintenance organizations (HMO).

²For other related GAO products, see *Blue Cross FEHBP Pharmacy Benefits* (GAO/HEHS-96-182R, July 19, 1996); *Blue Cross and Blue Shield: Change in Pharmacy Benefits Affects Federal Enrollees* (GAO/T-HEHS-96-206, Sept. 5, 1996); and *Pharmacy Benefit Managers: Early Results on Ventures With Drug Manufacturers* (GAO/HEHS-96-45, Nov. 9, 1995).

fee-for-service FEHBP plans that contracts with a PBM other than Merck-Medco Managed Care, Inc., or PCS Health Systems, Inc. (These companies are referred to in this report as “Medco” and “PCS,” respectively.) We met with representatives of each plan and the PBMs they contract with, reviewed the contracts between the plans and PBMs, analyzed reports on the PBMs’ performance in meeting contract requirements, and reviewed plan customer satisfaction surveys. Appendix I contains a detailed discussion of our scope and methodology.

This report was prepared initially at the request of, among others, the former Chairman, Subcommittee on Oversight of Government Management and the District of Columbia, and the former Ranking Minority Member, Subcommittee on Post Office and Civil Service. In addition to the other initial requesters, we are addressing this report to the Ranking Minority Member, Subcommittee on Post Office and Civil Service, Committee on Government Management, and the Ranking Minority Member, Subcommittee on Civil Service, Committee on Government Reform and Oversight, because it contains information pertaining to matters under these Subcommittees’ jurisdictions.

Results in Brief

The three FEHBP plans we studied contracted with PBMs to control rapidly rising pharmacy benefit payments. The plans estimate that PBMs saved them over \$600 million in 1995 by obtaining manufacturer and pharmacy discounts and managing drug utilization. These savings reduced the pharmacy benefit costs each plan believes it would have paid without using a PBM by between 20 and 27 percent.

The PBMs met most of the performance standards in their 1995 contracts, and the plans believe that the PBMs have provided plan enrollees high-quality pharmacy service. Surveys of plan enrollees also indicate a high degree of satisfaction, with between 93 and 98 percent of respondents noting satisfaction with their pharmacy benefit services.

The plans’ decisions to use PBMs to control pharmacy benefit costs, however, can shift business away from retail pharmacies. For example, Blue Cross’s 1996 benefit change, which encouraged mail order purchases, reduced affected enrollees’ payments to retail pharmacies by 36 percent or about \$95 million. During the same period, total payments to retail pharmacies for all enrollees decreased by about 7 percent or about \$34 million. Moreover, PBM and plan officials, as well as industry experts, acknowledge that any additional efforts to control FEHBP pharmacy benefit

costs in the future might require plans to adopt more restrictive cost-containment procedures that could possibly limit enrollees' access to drugs and pharmacy services and lessen enrollees' satisfaction with their pharmacy benefits.

Background

OPM contracts with almost 400 health insurance carriers to operate the FEHBP. Under this program, health insurance carriers, including fee-for-service plans and HMOs, offer about 8.7 million federal employees, retirees, and dependents health benefit plans that include pharmacy benefits.

In the last 10 years, several FEHBP plans have contracted with PBMs to manage pharmacy benefits. Blue Cross, GEHA, and Rural have contracted with PBMs to obtain both mail order and retail pharmacy services. Blue Cross, the largest FEHBP plan, contracted with Medco in 1987 to provide mail order services and with PCS in 1993 to provide retail services. GEHA has used Medco to manage mail order services since 1990 and retail services since 1993. Rural first contracted for mail order services in 1986. It has used Caremark, Inc., to manage mail order services since 1992 and retail services since 1993.

OPM oversees all FEHBP contracts and reviews benefit change proposals to assess the changes' cost-effectiveness and possible effect on the delivery of benefits to federal enrollees. The federal health plans oversee the activities of the PBMs and report to OPM any significant problems that could affect the delivery of benefits to enrollees. OPM does not review or audit PBM savings estimates unless they are submitted as justification for a benefit change that could affect the quality of enrollees' services.

PBMs Provide FEHBP Plans a Range of Cost-Control Services

Officials at the plans we visited said that they contracted with PBMs to help control rapidly rising pharmacy benefit payments. The use of PBMs allows the plans to pay lower prices for prescription drugs and provide a wide range of services that typically reduce pharmacy benefit costs and improve customer services, such as providing mail order drug services and checking prescriptions for adverse drug interactions. According to PBM officials, the services they offer to the FEHBP plans are generally equivalent to those offered to private industry customers.

According to Rural officials, their decision to use a PBM to provide mail order services in 1986 was directly linked to a need to contain pharmacy benefit payments that were rising faster than the increase in drug

utilization. GEHA officials also cited the need to slow the rate of increase in their pharmacy benefit payments, which they attributed to rising drug prices and utilization. Blue Cross officials also said that they expected PBM services to help them control pharmacy benefit payments, which have constituted an increasing share of total benefit payments.

The plans' PBMs provide a variety of administrative services intended to control costs. These include retail pharmacy network development, mail order pharmacy operation, formulary development, and manufacturer rebate negotiation. Table 1 describes some of the administrative services that the PBMs provide the FEHBP plans.

Table 1: Examples of PBM Administrative Services Provided to Three FEHBP Plans

Service	Description
Retail pharmacy network development	PBMs recruit pharmacies, negotiate network drug price discounts, and monitor network pharmacies' customer services.
Mail order pharmacy operation	PBMs operate mail order pharmacies that allow enrollees to obtain prescriptions, particularly maintenance prescriptions, by mail.
Formulary development	PBMs use pharmacy and therapeutics (P&T) committees ^a to help develop formularies that list drugs the plans prefer physicians to prescribe in each therapeutic category.
Rebate negotiation	PBMs negotiate and obtain rebates from drug manufacturers in return for inclusion and low-cost designation of their drugs on the plans' formularies and for formulary compliance programs that impact market share.
Claims processing	PBMs process benefit claims and prepare periodic payment and drug utilization reports for plan customers.

^aP&T committees are independent groups of health care professionals that evaluate drugs in all therapeutic categories on the basis of safety, efficacy, and substitutability.

The PBMs' mail order pharmacies and retail pharmacy networks discount prescriptions purchased by plan enrollees. The PBMs typically reimburse the retail pharmacies according to a discount formula based on an industry standard, such as the drug's usual and customary price,³ average wholesale price (AWP),⁴ or maximum allowable cost (MAC)⁵ plus a dispensing fee. The PBMs also require network pharmacies to support other cost-reduction techniques, such as substituting a less expensive generic drug for a brand-name drug when an equivalent generic drug is available.

³The usual and customary price is the price pharmacies charge cash-paying customers whose prescriptions are not covered by health insurers.

⁴Drug manufacturers suggest a list price that wholesalers charge pharmacies. The average of the list prices, collected for many wholesalers, is called a drug's AWP.

⁵MAC refers to a maximum price that retail pharmacies in plans' networks may be paid for certain generic drugs.

Pharmacies accept these levels of reimbursement and PBM cost-reduction practices to attract or retain the plans' enrollees.

Two of the FEHBP plans use the PBMs' national formularies to indicate the prescription drugs that the plans prefer enrollees to use.⁶ All of the formularies list the drugs by therapeutic class and, in some cases, relative price. The PBMs give physicians and enrollees copies of the formularies to encourage the use of lower cost formulary drugs over higher cost formulary and nonformulary drugs and to perform other formulary compliance activities (see table 2). This ability to direct market share within a therapeutic class allows the PBMs to obtain rebates from manufacturers of formulary drugs. On the basis of plan estimates, the plans we examined received over \$113 million collectively in rebates in 1995. Rebates accounted for between 2 and 21 percent of the plans' estimated savings. Because the FEHBP plans use open formularies, enrollee reimbursement is not limited to the drugs listed on the formularies.⁷

In addition to obtaining rebates and price discounts, the PBMs use other methods referred to as "interventions" to cut costs and improve pharmacy services. These interventions include activities such as drug utilization review (DUR), generic and therapeutic interchange programs, and disease management programs. Table 2 describes some of the intervention services that the PBMs provide the FEHBP plans.

⁶Blue Cross does not use its PBMs' national formularies. Rather, Blue Cross develops its own formulary with input from its two PBMs.

⁷The PBMs also offer their customers incentive-based or closed formularies. Incentive-based formularies require enrollees to pay higher copayments if their physicians prescribe nonformulary drugs. Closed formularies are more restrictive, limiting coverage to formulary drugs only.

Table 2: Physician and Pharmacist Interventions Performed for Three FEHBP Plans

Intervention	Description
DUR	DUR programs analyze patterns of drug use to prevent contraindications and adverse interactions. PBMs use this information to make prescription substitution recommendations to physicians and inform plans and physicians about physicians' prescribing patterns.
Generic substitution	Generic substitution interventions switch medications from brand-name drugs to chemically equivalent generic drugs. In some states, pharmacists can make this switch if the physician does not indicate that the prescription must be dispensed as written.
Therapeutic interchange	Therapeutic interchange interventions switch nonformulary medications to preferred formulary drugs. Therapeutic intervention programs encourage patients to use, and physicians to prescribe, less expensive brand-name formulary drugs considered as safe and effective as other, more expensive brand-name drugs.
Prior authorization	Prior authorization is required for medications that may be used to treat conditions or illnesses that are not covered by a plan, are outside the Food and Drug Administration or manufacturer guidelines, have a high potential for abuse, or are ordered in unusual quantities.
Disease management	Disease management programs try to improve the care delivered to a specific group of patients, such as those with diabetes, by recommending particular therapies or patient self-management techniques. PBMs use physician and patient education materials to emphasize shared responsibility and cost-effective approaches.

The PBMs' retail network and mail order pharmacies use computerized systems to review enrollees' combined mail order and retail pharmacy records and detect problems with prescriptions at the point of dispensing. These concurrent activities can alert the pharmacist when a drug may adversely interact with other drugs a patient is using. They can also identify situations when a generic or formulary alternative to the prescribed drug is available or when the drug duplicates an existing prescription. If the review identifies a nonrecommended, redundant, or potentially harmful drug, a pharmacist or technician contacts the prescribing physician. Figures 1 and 2 depict the mail order and retail dispensing processes at Caremark.

Figure 1: Mail Order Prescription-Dispensing Process

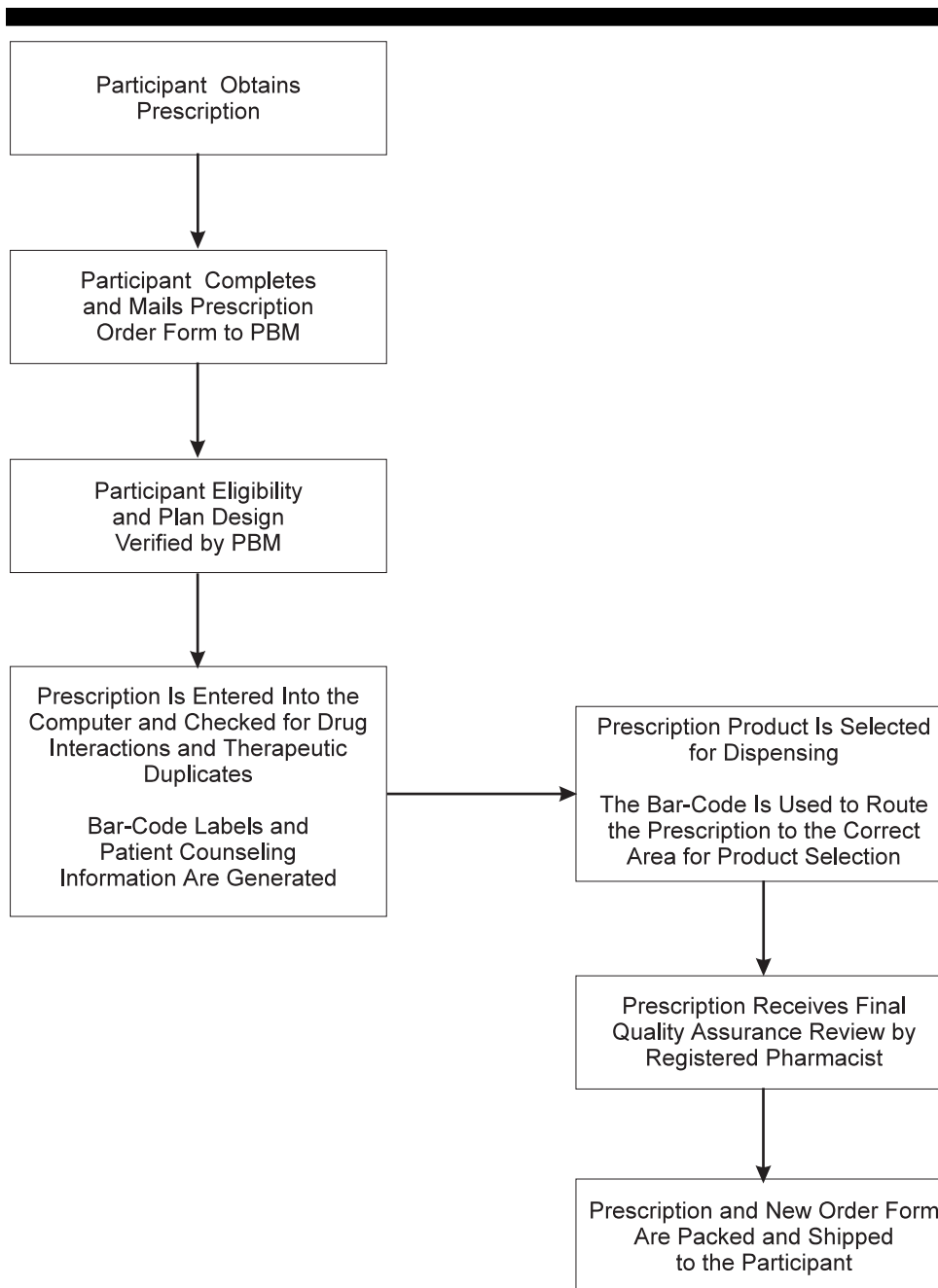
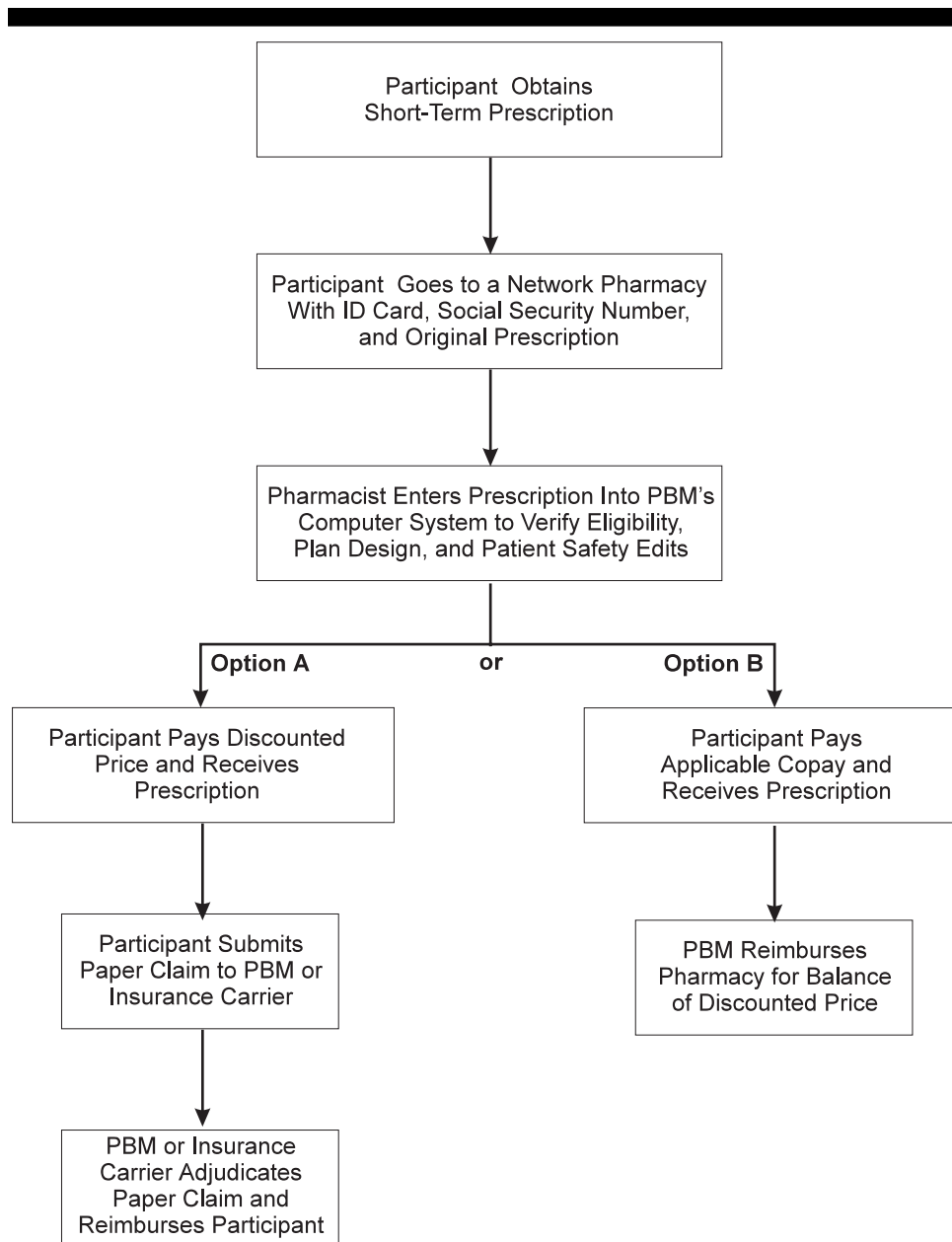


Figure 2: Retail Network Pharmacy-Dispensing Process



The PBMs' retrospective DUR programs study the combined retail and mail order drug utilization patterns of the plans' enrollees to identify other

instances in which physicians may have prescribed inappropriate medications or enrollees may not be using prescribed drugs properly. When retrospective DUR activities identify inappropriate prescribing or drug usage, such as incorrect dosages or durations of therapy, PBMS typically contact the physicians and encourage the use of more cost-effective drugs or appropriate therapies.

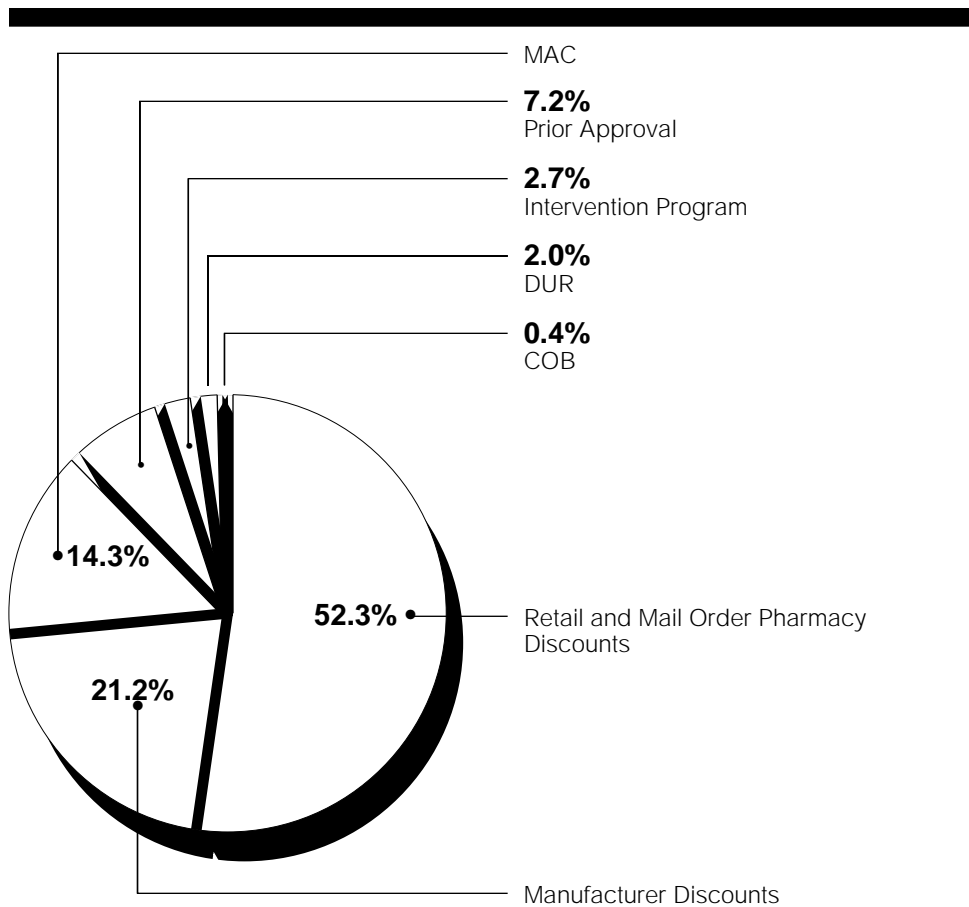
The PBMS also try to help the plans contain spending for chronic conditions, such as asthma and diabetes, by developing disease management programs to manage the care of enrollees with specific illnesses. For example, two PBMS indicated that they notify enrollees and their physicians about the method they consider most effective for treating asthma. Such disease management activities try to educate both enrollees and their physicians about more cost-effective treatments and monitor compliance with the interventions. The treatment programs are intended to help reduce the risk of complications and costly additional care, such as unnecessary diagnosis-related emergency room visits.

FEHBP Plans Report That PBM Services Yield Substantial Savings

The three FEHBP plans estimate that the PBMS saved their plans over \$600 million in pharmacy benefit costs in 1995. Although each of the plans used different approaches to estimate savings and in some cases may have defined savings sources differently, the savings for all three plans are based on the plans' estimates of what they would have paid for prescription drugs and related services without a PBM. The estimates were prepared by plan or PBM officials using PBM savings data. Although two plans told us that they validated some of the PBM data, none of the methodologies used to estimate savings has been examined by independent auditors. Moreover, according to OPM officials, OPM does not review or audit the savings unless they relate to plan benefit changes that could affect enrollee services.

Blue Cross estimated that its 1995 FEHBP pharmacy savings totaled about \$505 million. Pharmacy benefit payments in 1995 totaled about \$1.4 billion. Figure 3 shows the percentage of total savings that Blue Cross attributed to different PBM services.

Figure 3: 1995 Blue Cross FEHBP Pharmacy Savings



Source: Blue Cross and Blue Shield Association.

The following describes the savings that Blue Cross attributed to PBM services:

- Retail and mail order pharmacy discounts accounted for about \$264 million in savings.⁸ For retail, total savings resulted from the difference between the reimbursement amount PCS paid pharmacies for individual prescriptions and the drugs' usual and customary prices. Mail

⁸Retail pharmacy savings do not include savings from the use of generic drugs for which PCS has set a maximum reimbursement limit for pharmacies.

order savings resulted from discounts off AWP that Blue Cross negotiated with Medco.

- MAC savings accounted for approximately \$72 million in savings. These savings resulted from the difference between the reimbursement amount PCS paid the pharmacies for certain generic drugs and the drugs' usual and customary prices.⁹
- Manufacturer rebates accounted for about \$107 million in savings and represent the guaranteed manufacturer discounts that PCS and Medco negotiated with drug manufacturers for including their products on their formulary. Blue Cross 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.
- DUR accounted for about \$10 million in savings that resulted from clinical activities the PBMS performed. Savings include the sum of the prices of prescriptions reversed or denied because of DUR alerts.¹⁰
- Medco's intervention program accounted for about \$13.5 million in savings, which were derived, in part, from the use of less expensive brand-name drugs.
- The prior approval program accounted for about \$36.5 million in savings. Blue Cross determined savings from this program by calculating the cost of prescriptions denied reimbursement or never filled by enrollees who received a prior approval form.¹¹ This program covers 13 drugs that require Blue Cross approval before dispensing.
- The coordination of benefits (COB) program accounted for about \$2 million in savings. Blue Cross computed savings from this program by determining the total reductions in the amount Blue Cross was responsible for paying for claims that were also covered in part by other insurers. COB is an industrywide method used to avoid paying duplicate benefits to an individual covered by another insurer.

GEHA estimated that its 1995 FEHBP pharmacy savings totaled about \$85 million. Prescription drug payments in 1995 totaled about \$226 million.

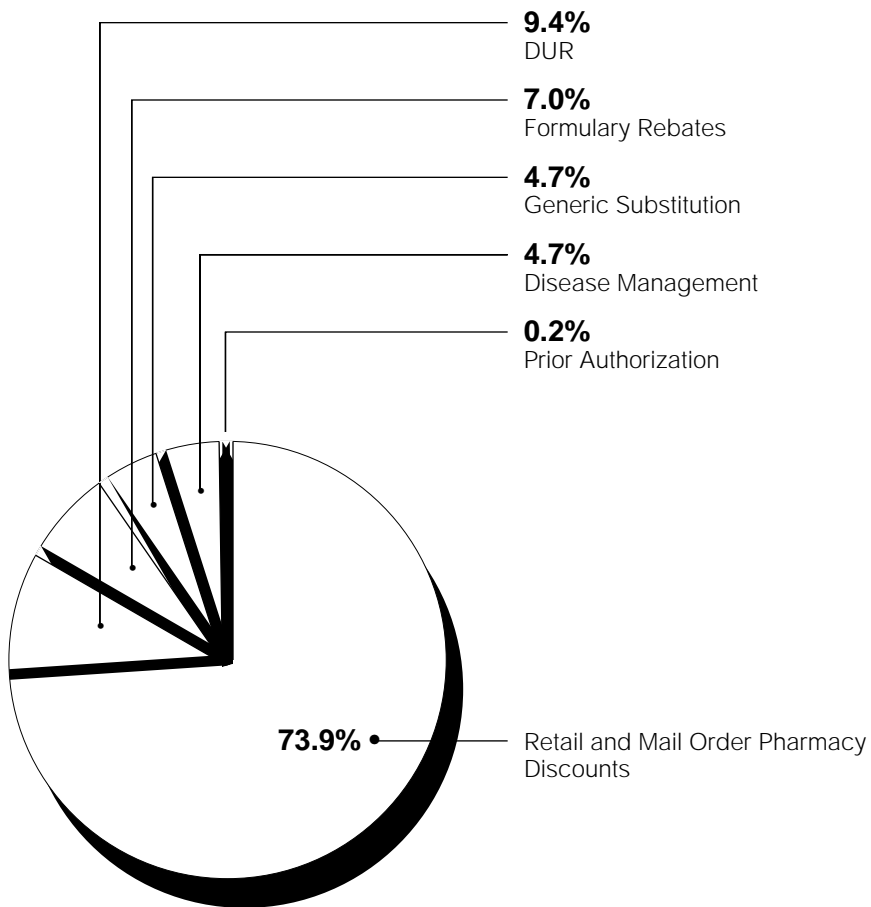
⁹MAC savings include about 73 percent of all generic drugs dispensed by retail pharmacies that are reimbursed by Blue Cross. The remaining 27 percent represent generic drugs for which Blue Cross, at PCS' recommendation, does not pay retail pharmacies incentives to encourage substitution because (1) they have such narrow therapeutic ranges that variations among them could affect a patient's response or (2) generically available products with reliable suppliers and low cost are insufficient to justify such incentives.

¹⁰A DUR alert could occur for several reasons, including one or more of the following: rejects for early refill and maximum daily dose and reversals based on screens for drug interaction, duplicate therapy, drug allergy, drug and pregnancy, drug and disease, drug and gender, drug and age, under-minimum daily dose, and underuse.

¹¹Savings calculations involved determining the number of months for which a specific drug is usually prescribed.

Figure 4 shows the percentage of total savings that GEHA attributed to different PBM services.

Figure 4: 1995 GEHA FEHBP Pharmacy Savings



Source: GEHA.

The following describes the savings that GEHA attributed to PBM services:

- Retail and mail order pharmacy discounts accounted for approximately \$63 million in savings. Total savings resulted from the difference between

the AWP that GEHA would have paid for retail and mail order drugs and what GEHA did pay for these drugs because of the negotiated discounts.

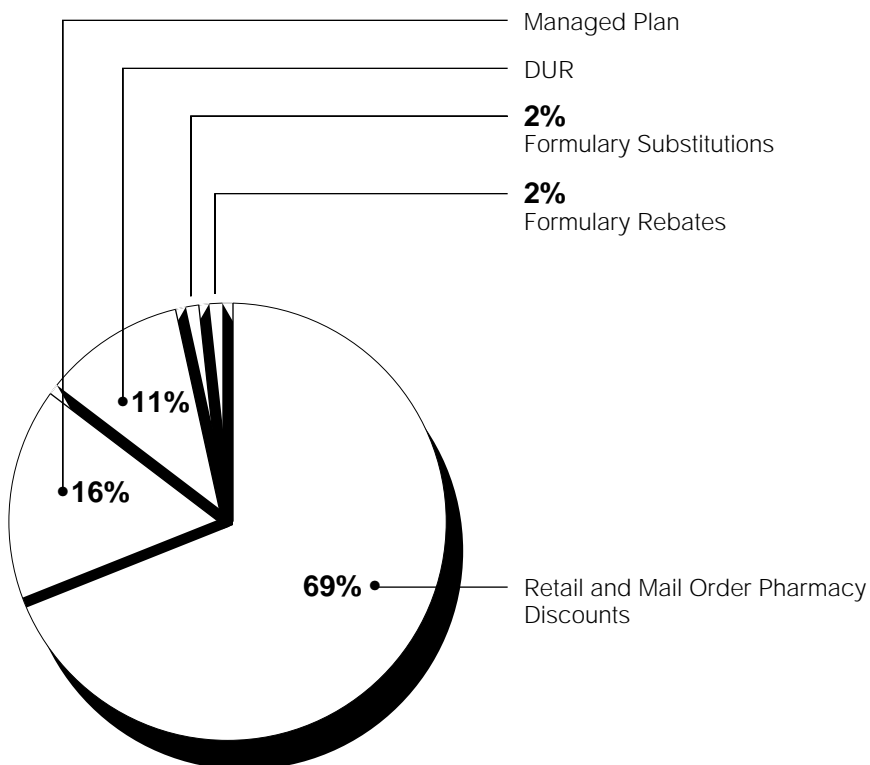
- DUR accounted for about \$8 million in savings, which resulted from the concurrent clinical activities the PBM performed. For drugs receiving a DUR alert, savings include the sum of the prices of prescriptions reversed or denied before dispensing.
- Formulary rebates accounted for approximately \$6 million in savings. Under the retail and mail order programs, Medco receives discounts from certain drug manufacturers for including the manufacturers' products on Medco's national formulary. In 1995, GEHA retained 80 percent of total rebates due to the dispensing of each manufacturer's formulary drugs under GEHA's program. GEHA had a guaranteed formulary savings of 3 percent of the total ingredient cost of brand-name drugs dispensed through the mail.
- Generic substitution accounted for about \$4 million in estimated savings. Although GEHA did not have a guaranteed generic substitution rate in 1995, its substitution rate was higher in 1995 than 1994. The savings represent the difference between the 1994 and 1995 generic savings. In other words, in 1994, where applicable, generic equivalents were substituted for brand-name drugs 68 percent of the time and, in 1995, about 77 percent of the time. GEHA's 1995 savings represent the difference between brand-name and generic prices for 9 percent of the drugs dispensed at both retail and mail order pharmacies.
- Disease management accounted for approximately \$4 million in savings. Savings resulted from multiplying a PBM-determined savings per patient per year in overall health care costs by the number of patients enrolled in GEHA's diabetes program.¹²
- Prior authorization accounted for about \$200,000 in savings, which were determined by calculating the cost of a prescription drug that was denied reimbursement or never filled by enrollees who received a prior authorization form.¹³

Rural estimated that its 1995 FEHBP pharmacy savings totaled about \$11.6 million. Prescription drug payments in 1995 totaled about \$46 million. Figure 5 shows the percentage of total savings that Rural attributed to different PBM services.

¹²Because GEHA chose not to provide medical claims data to the PBM, the PBM relied on its experience with another client who was enrolled in its diabetes disease management program to estimate overall savings per patient.

¹³According to GEHA officials, they only required prior authorization for one drug in 1995.

Figure 5: 1995 Rural FEHBP Pharmacy Savings



Source: Caremark.

The following describes the savings that Rural attributed to PBM services:

- Retail and mail order pharmacy discounts accounted for approximately \$8 million in savings. These savings resulted from price discounts off drugs' AWP for brand-name and AWP or MAC for generic pharmaceutical products at mail order and retail pharmacies.
- DUR accounted for about \$1.3 million in savings, which occurred when Caremark did not fill prescriptions due to routine DUR alerts such as drug allergy, patient not covered, or duplicate claim.
- Managed plan activities accounted for about \$1.9 million in savings. These savings resulted from instances when Caremark pharmacists contacted physicians and obtained permission to substitute a generic drug for a brand-name drug that was prescribed "Dispense as Written." Other savings

resulted from clinical interventions, such as recommendations for more appropriate drug regimens or duration of drug therapy.

- Substitution of formulary drugs for nonformulary drugs by the mail order pharmacy accounted for about \$200,000 in savings.
- Formulary rebates accounted for approximately \$200,000 in savings. Caremark pays Rural an annual rebate based on a percentage of the prior year's drug costs.

FEHBP Plans Report That PBM Customer Services Meet Performance Standards

The FEHBP plans evaluate PBM customer service by determining the extent to which the PBMS meet the annual performance standards in their contracts. The performance standards are intended to ensure quality service, and they focus on factors such as mail order turn-around time and access to counseling and retail pharmacy services. According to plan data, the PBMS met most of each plan's customer service performance standards in 1995. Furthermore, enrollees in all three plans reported high levels of satisfaction with the quality of PBM services.¹⁴

All of the PBM contracts include performance standards for customer services provided to the FEHBP plans and their enrollees. The mail order contracts typically specify acceptable time frames for telephone responses and prescription dispensing. For example, two of the plans' contracts require their PBMS to answer a specified percentage of the customer service telephone calls to each plan's mail order pharmacy within 20 seconds. All of the contracts also require the PBMS to dispense between 90 and 99 percent of all mail order prescriptions within 2 to 7 business days.

Regarding retail network access, one plan's contract specifies that a network pharmacy be located within 5 miles of 98 percent of the plan's enrollees. Although the other two 1995 contracts did not specify pharmacy distances, one plan's retail network had a pharmacy within 5 miles of 92 percent of the plan's enrollees, and the other plan's PBM was required to contract with retail pharmacies in "agreed-upon locations."

All of the plans use customer surveys to assess enrollees' satisfaction with their pharmacy benefits. In addition to reviewing the performance reflected in the PBMS' operating reports, the survey addresses specific

¹⁴Blue Cross contracts with the Gallup Organization to conduct quarterly retail and mail order customer satisfaction surveys. GEHA receives the results of semiannual retail and mail order customer satisfaction surveys from Medco. Caremark contracts with Walker Research to conduct annual customer satisfaction surveys. The Caremark survey population is not limited to Rural enrollees, but Caremark and Rural use the results as a performance indicator because Rural enrollees account for a large proportion of those served. None of the plans has audited the survey results.

issues, such as whether the enrollees felt the time their calls were on hold was reasonable, and more general issues, such as enrollees' overall satisfaction with program performance.

In 1995, the plans' surveys typically reflected high levels of enrollee satisfaction. For example, an average of 94 percent of those who responded to Blue Cross's 1995 quarterly pharmacy program surveys indicated that they were either "satisfied" or "very satisfied" with their mail order prescription service.¹⁵ According to Caremark, 95 percent of those who responded to its annual customer satisfaction survey described their experiences purchasing long-term prescriptions through Caremark's mail order service as "good," "very good," or "excellent."¹⁶ Caremark reported that 93 percent of those responding indicated similar satisfaction with their retail services. GEHA's 1995 biannual patient satisfaction survey results showed that about 98 percent of enrollee responses indicated their overall level of customer satisfaction with retail and mail order services as "satisfied" or "very satisfied."

PBM Practices Concern Retail Pharmacies

The FEHBP plans we studied are satisfied with the savings and quality of services provided by the PBMs, and enrollees have reported a high degree of satisfaction with PBM pharmacy services. The National Association of Chain Drug Stores (NACDS) and retail pharmacists, however, have raised questions about the effect of PBM use on retail pharmacies and the quality and availability of pharmacy services. The pharmacists' concerns typically focus on three areas—access to retail pharmacy services, quality of mail order pharmacy services, and reduced reimbursement for drugs dispensed by retail pharmacies.

Although retail pharmacists contend that FEHBP plans' use of PBMs can limit enrollees' ability to obtain prescriptions at their local retail pharmacies, plan data indicate that enrollee access to retail pharmacy services has not been substantially limited. For example, in 1995, enrollees could purchase discounted prescriptions at between 44,000 and 55,000 retail network pharmacies, or between 80 and 97 percent of pharmacies nationwide, and obtain mail order services particularly valued by enrollees who do not live near a retail pharmacy. Furthermore, they could purchase regularly priced prescriptions at any retail pharmacy.

¹⁵Blue Cross's customer survey for its retail pharmacy program did not contain a comparable measure for its retail pharmacy services.

¹⁶Although Caremark's survey does not specifically target Rural enrollees, Rural officials believe that the results are indicative of Rural enrollees' experience.

Retail pharmacists also have raised questions about the quality of mail order services because mail order pharmacists cannot provide face-to-face counseling to patients and lack access to information about all the medications an enrollee is using. We found, however, that although mail order pharmacists at the plans we studied do not provide face-to-face patient counseling, they do provide telephone counseling 24 hours a day.

In addition, both retail network and mail order PBM pharmacists for these plans have access to integrated drug utilization records that include all the prescriptions each enrollee has received through the plans' retail network and mail order pharmacies. As a result, pharmacists at these locations appear equally able to detect potentially adverse drug interactions or inappropriate prescriptions before dispensing a drug. In addition, both of the mail order pharmacies we observed use a variety of quality assurance processes to ensure that enrollees receive the correct drug and number of prescriptions. These processes include automated scans that match prescriptions to drug quantities, names, and mailing labels. Typically, these and most other pharmacy activities are performed by pharmacists or trained pharmacy technicians supervised by pharmacists.

Lastly, retail pharmacists contend that FEHBP plans' use of PBMs can affect retail pharmacies' business in two ways. First, plan designs can provide enrollees with financial incentives to use mail order services. Second, cost-containment strategies can rely too heavily on retail pharmacy discounts.

A pharmacy benefit change instituted by Blue Cross in 1996 illustrated the retail pharmacists' concerns. This change affected the way many federal enrollees obtain prescription drugs. Blue Cross's attempt to increase savings by encouraging mail order purchases produced an unexpectedly rapid increase in mail order prescriptions, resulting in a 36-percent reduction or about \$95 million in payments for affected enrollees to retail pharmacies during the first 5 months of 1996. Total payments to all retail pharmacies for prescriptions dispensed to all enrollees in Blue Cross's federal health plan, including those affected by the benefit change, decreased about \$34 million or about 7 percent during that period. Rural experienced a similar shift when the plan implemented a comparable benefit change in 1989. According to Rural officials, this change also resulted in an immediate and substantial increase of between 35 and 40 percent in the number of prescriptions filled by mail order. Nevertheless, in 1995, over two-thirds of all prescriptions at the Blue Cross and GEHA federal health plans continued to be filled by retail pharmacies.

However, payments to retail pharmacies differed between the two plans. About 70 percent of Blue Cross's prescription payments¹⁷ went to its retail network pharmacies; over two-thirds of GEHA's prescription payments went to its mail order pharmacy.

Concerns about the size and effect of PBM pharmacy discounts are reflected in reports that pharmacy profit margins are decreasing as PBMs and managed care organizations account for a greater share of pharmacy business. Moreover, an industry trade publication reported that the number of independent pharmacies decreased by 1,800 or about 7.2 percent in 1995.¹⁸ However, the publication also notes that many of these pharmacies were purchased by major drug chains and then absorbed into the chains' nearest pharmacies.

Although the future impact of PBM use on federal enrollees and retail pharmacies is unclear, additional efforts to control FEHBP plans' pharmacy benefit costs could affect retail pharmacies and federal enrollees. For example, if the number of retired FEHBP enrollees continues to grow, payments for maintenance drugs might increase and the plans might decide to provide additional incentives to use mail order services for maintenance prescriptions. This type of benefit change could allow the plans to take further advantage of large mail order discounts but could also result in further declines in the plans' payments to retail pharmacies. Moreover, if plans adopt additional actions to control pharmacy benefit costs, such as adopting restrictive formularies and more aggressive therapeutic interchange programs or reducing reimbursement rates and the size of the retail network, these actions could affect enrollees' access to drugs. Such actions could also affect enrollees' satisfaction with their pharmacy benefits as well as the retail pharmacies' business.

Agency and Other Comments

We obtained comments on a draft of this report from OPM, Blue Cross, GEHA, Rural, Medco, and Caremark. We also obtained comments from NACDS on the section of the report that addressed the concerns of retail pharmacies. In general, they found the report to be accurate and complete and provided specific technical comments, which we incorporated into the report where appropriate.

¹⁷Unlike GEHA's payments, the Blue Cross payments do not include the copayments that patients paid to retail pharmacies for their prescription drugs.

¹⁸Marie Griffin, "Showing Strength, Back-to-Basics Approach Enables Drug Chains to Reach New Heights," Drug Store News, April 29, 1996, p. 59.

Copies of this report will be made available to the Director of OPM; officials of Blue Cross, GEHA, Rural, Medco, PCS, and Caremark; and others upon request.

This report was prepared by John C. Hansen, Assistant Director; Jennifer Weil Arns, Evaluator-in-Charge; and Mary W. Freeman. Please call Mr. Hansen at (202) 512-7105 if you or your staff have any questions.

A handwritten signature in black ink that reads "Bernice Steinhardt". The signature is written in a cursive style with a large initial 'B' and a long, sweeping tail.

Bernice Steinhardt
Director, Health Services Quality
and Public Health

List of Requesters

The Honorable Joseph Lieberman
Ranking Minority Member
Subcommittee on Post Office
and Civil Service
Committee on Governmental Management
United States Senate

The Honorable John L. Mica
Chairman
The Honorable Tim Holden
Ranking Minority Member
Subcommittee on Civil Service
Committee on Government Reform
and Oversight
House of Representatives

The Honorable Barbara A. Mikulski
United States Senate

The Honorable Benjamin Gilman
House of Representatives

The Honorable James Moran
House of Representatives

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Abbreviations

AWP	average wholesale price
COB	coordination of benefits
DUR	drug utilization review
FEHBP	Federal Employees Health Benefits Program
GEHA	Government Employees Hospital Association
HMO	health maintenance organization
MAC	maximum allowable cost
NACDS	National Association of Chain Drug Stores
OPM	Office of Personnel Management
PBM	pharmacy benefit manager
PCS	PCS Health Systems, Inc.

Scope and Methodology

To understand why the FEHBP plans we studied had contracted with PBMS for pharmacy benefit services, we met with representatives of OPM, Blue Cross, GEHA, and Rural to discuss their reasons for contracting with PBMS and the goals they hope to achieve through PBM contracts. We also obtained prescription and total benefit payment data from the plans and OPM.

To identify PBM services, we reviewed recent PBM contracts, OPM open season benefit brochures, and plan and PBM benefit literature. We also observed operations at Medco's Tampa, Florida, and Caremark's Richmond, Virginia, mail order pharmacies and met with plan and PBM officials to discuss these services in detail. To determine the means used to assess PBM performance, we examined contracts and planning documents to identify performance standards such as telephone response times and time required to fill prescriptions. We also interviewed plan and PBM officials to discuss PBM performance assessment, and we reviewed activity reports to determine whether the PBMS are meeting performance requirements.

Regarding concerns about the effect of PBM use, we met with plan officials to discuss their satisfaction with PBM savings and obtain savings estimates. We also obtained copies of customer surveys and questions used to assess enrollee satisfaction. However, the reported results of these customer satisfaction surveys have not been verified by the plans or OPM. We met with representatives of NACDS to discuss their views on the effect of PBMS on retail pharmacies. In addition, we reviewed the Health Care Financing Administration's report, Assessment of the Impact of Pharmacy Benefit Managers, dated September 30, 1996. We also examined Blue Cross prescription utilization and drug payment data to determine the effects of the 1996 pharmacy benefit change on payments to retail pharmacies.

Because much of the information contained in the PBM contracts is proprietary and confidential, we have not specified individual manufacturer discounts and rebates. Moreover, because actual drug prices are proprietary, we did not compare mail order and retail drug prices.

We conducted our study between March 1996 and January 1997 in accordance with generally accepted government auditing standards.

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