APCI Insights

DISCREPANT:

HOW OIG AUDITS EXPOSED FEDERAL SUBCONTRACTOR PBMS DIVERTING HUNDREDS OF MILLIONS IN TAXPAYER DOLLARS UNDER FEHBP CONTRACTS

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Executive Summary

The Office of Personnel Management's ("OPM") Office of Inspector General ("OIG") audited prescription drug benefit administration across several plans within the Federal Employees Health Benefits Program ("FEHBP"), uncovering discrepancies totaling over half a billion dollars.

Despite operating under "pass-through" agreements, federal subcontractor pharmacy benefit managers ("PBMs") leveraged their price-setting authority to generate spread between pharmacy reimbursements and plan charges, retain unpassed pharmacy fees, and pocket manufacturer rebates and concessions intended for the plans. These findings demonstrate how PBM contractors systematically evade contractual transparency through aggregate negotiations with pharmacies and drug manufacturers at the expense of taxpayers.

Crucially, the lynchpin of this revenue capture relies on PBM methodologies that intentionally untether discounts, fees, and rebates from specific claims or plans, rendering financial concessions amorphous, obscuring true drug costs, and creating opportunities for federal subcontractor PBMs to retain taxpayer dollars. Furthermore, these same federal subcontractor PBMs act as both price setter and price taker, using administrative leverage to restrict market competition and steer federal beneficiaries toward their own affiliated pharmacies.

Allowing federal contractors to exploit price-setting authority to siphon taxpayer dollars and inflate out-of-pocket costs for federal enrollees represents an acute threat to FEHBP program integrity. For lawmakers tasked with federal fiduciary oversight, these audit findings demand decisive action to strip federal subcontractor PBMs of the mechanisms used to inflate taxpayer costs.

To put an end to these non-transparent federal subcontractor PBM tactics and restore integrity within FEHBP where OPM transparency standards have fallen short, the U.S. House Oversight Committee voted 40–2 in July 2026 to advance H.R. 6610, the Pharmacists Fight Back Act in the Federal Employees Health Benefits Program. H.R. 6610 directly resolves the abuses identified in OIG audits by replacing non-transparent, trade-secreted PBM reimbursement methodologies such as effective rate guarantees with transparent, market-based NADAC pricing derived from pharmacy reported acquisition costs, prohibiting all point-of-sale and post-adjudication pharmacy adjustments and transaction fees, banning patient steering to preserve enrollee choice and market competition, and requiring PBMs to pass all manufacturer rebates directly to beneficiaries at the pharmacy counter. Congress should prioritize its passage to restore transparency, fiscal responsibility, and market competition to FEHBP drug benefits.

FEHBP Contracted PBM Discrepancies by Plan

Over the past several years, the OPM OIG has conducted multiple performance audits of PBM practices within FEHBP plans to verify whether costs charged to the program, participating health plans, and federal enrollees complied with subcontractor contractual obligations.[1] Importantly, the underlying contracts between the health plans and their subcontractor PBMs incorporated explicit transparency standards requiring pass-through pricing to ensure that health plans and the FEHBP receive the full value of negotiated discounts, manufacturer rebates, credits, and other financial concessions.[2] Set forth in the table below are the specific billing and accounting discrepancies identified by OPM OIG auditors, totaling more than $500 million in overcharges by federal subcontractor PBMs.

[1] U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021, Report No. 2022-SAG-029 (Mar. 29, 2024) [hereinafter ESI APWU Audit]; U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017 through 2022, Report No. 2023-SAG-019 (Nov. 20, 2024) [hereinafter ESI Compass Rose Audit]; U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of the National Association of Letter Carriers as Administered by Caremark for Contract Years 2018-2023, Report No. 2024-SAG-022 (Dec. 2025) [hereinafter Caremark Letter Carriers Audit]; U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of the Blue Cross Blue Shield Association's Service Benefit Plan's Retail and Mail Order Pharmacy Programs as Administered by CVS Caremark for Contract Years 2018-2021, Report No. 2024-SAG-013 (Mar. 2026) [hereinafter Caremark BCBS Audit] (collectively hereinafter referred to as the OIG FEHBP Audits).
[2] See id.

Discrepancy	ESI APWU Audit	ESI Compass Rose Audit	Caremark Letter Carriers Audit	Caremark BCBS Audit
Pass through of retail pharmacy discounts	$12,484,472	$5,819,737	N/A	$400,739,825
Pass through of drug inventory purchasing discounts	$5,911,973	$190,134	N/A	N/A
Pass through of credits for retail pharmacy transaction fees	$2,279,264	$925,895	$6,995,072	$92,429,243
Underpayment of rebates received	$4,907,110	N/A	N/A	N/A
Pass through of drug mfg. rebates from sister company	$14,452,616	$9,524,945	N/A	N/A
Improper performance incentive paid	N/A	N/A	N/A	$23,916,120
Total principal overcharge	**$40,035,435**	**$16,460,711**	**$6,995,072**	**$517,085,188**

Overcharging Through Aggregate Discount Manipulation

Despite the existence of pass-through pricing requirements and prohibitions on "spread pricing," three of the four audits collectively uncovered over $415 million in spread pricing.[3] In uncovering these overcharges, the OIG identified that the discounts received by the plans failed to align with the deeper discounts set forth in the contracts between the federal subcontractor PBMs and the retail pharmacy contracts reviewed.[4] Importantly, federal subcontractor PBMs extracted this spread not on a drug-by-drug basis, but by implementing aggregate pricing techniques that intentionally untether discounts from specific claims.[5]

In defense of the spread identified in the ESI APWU Audit, ESI argued, amongst other things:

> ESI. . . may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes. ESI may also maintain certain preferred value or quality networks; pharmacies participating in those networks may pay or receive aggre gated payments related to these networks.

For its part, in connection with the spread identified in the Caremark BCBS Audit, Caremark argued, amongst other things:

> The complexity of managing these Overall Effective Rate arrangements across thousands of pharmacies, thousands of clients, millions of members, and hundreds of millions of claims cannot be overstated. Simply put, **there is no way to untangle the mass of claims and data down to a specific claim,** member, and/or client on the context of how the broader network was structured to operate.[6]

[3] ESI APWU Audit; ESI Compass Rose Audit; Caremark BCBS Audit.
[4] See id.
[5] See id.
[6] Caremark BCBS Audit supra note 1 (In addition, Caremark advanced several other arguments including inappropriate unfair retroactive application of OPM standards. In so doing, Caremark noted it "now maintains a separate retail network specific to the FEHBP Carriers").

The responses are instructive. They reveal that as federal subcontractors, the PBM retail pharmacy agreements were not specific to the FEHBP and that they implemented reimbursement methodologies that were not drug specific. Instead, retail pharmacy reimbursements were based on aggregate pricing methodologies that enabled federal subcontractor PBMs to fluctuate retail pharmacy reimbursement in a manner that allows them to generate backend margins, as explained by the OIG in connection with the ESI APWU Audit:

> Pharmacies allow PBMs to fluctuate the pricing of retail pharmacy claims as long as total business (all clients) equals the negotiated discount in the pharmacy agreements. The PBM's discounts given to the Carrier are not the negotiated discount, but instead are the discounts that align closest to the guarantee found in the Carrier's PBM agreement. This industry standard is used by PBMs under traditional spread pricing arrangements, not transparent pricing arrangements. [emphasis added].

In short, by utilizing non-transparent aggregate networks, federal subcontractor PBMs created an environment where true pass-through compliance was functionally impossible. What the PBMs characterize as industry-standard complexity is, in actuality, a deliberate contracting structure that allows federal subcontractor PBMs to generate unearned spread pricing at the direct expense of taxpayers and federal enrollees.

Overcharging Through Retail Pharmacy Transaction Fees

In addition to the $415-plus million in spread pricing uncovered, the OIG identified over $100 million in retail pharmacy transaction fees that were not passed back to FEHBP across the four audits.[7]

In connection with the ESI APWU Audit, ESI maintained that because these transaction fees are not tied to the price of drugs, they are not required to be passed back to the FEHBP. Similarly, in connection with the Caremark BCBS audit, Caremark took the position that "retail pharmacy 'transmission fees' are not included in Pass-Through Transparent Pricing," because transmission fees are "untethered to 'pricing based on the PBM's cost for drugs'."

These responses of the federal subcontractor PBMs further underscore how they extract revenue for themselves by untethering revenue from the price of a drug or drugs. In connection with the pharmacy reimbursements above, the ploy was aggregate discounts not tied to a specific drug or a specific plan. With regard to transaction fees, the ploy is extracting revenue not in connection with a drug itself, but rather with a transaction.

So long as federal subcontractor PBMs are permitted to extract non-drug-specific revenue from pharmacies, they will continue to shift to fee-based practices to obfuscate drug prices, evade contractual transparency, and line their own pockets at the direct expense of American taxpayers.

Overcharging Through Manufacturer Rebates and Discounts

In total, the OIG uncovered $34.9 million in drug manufacturer payments withheld from FEHBP by ESI, its offshore GPO Ascent Health Services, and affiliated pharmacies.[8] Across the APWU and Compass Rose audits, ESI diverted $28.8 million in manufacturer rebates, of which all offshore GPO rebates and a portion of traditional rebates were credited post-audit, and withheld over $6 million in drug-inventory purchasing discounts.

To justify retaining the drug-inventory purchasing discounts in connection with the ESI APWU Audit, ESI asserted that "non-specific drug discounts are received based on the total purchases made from drug manufacturers and wholesalers for the PBM's inventory."

The OIG directly rejected this argument, concluding:

> The PBM would not have received these non-specific drug discounts without the FEHBP drug utilization, therefore even if these discounts may not be attributed to a certain drug, they are attributable to an entire client group.

By negotiating non-specific inventory discounts, the federal subcontractor PBM claimed the manufacturer concessions fell outside transparent pass-through obligations. However, as the OIG established, these discounts exist solely due to taxpayer-funded enrollee utilization. Reclassifying manufacturer concessions as general inventory discounts is simply another tactic used by PBMs to capture financial value generated by federal enrollees.

[7] See OIG FEHBP Audits.
[8] ESI APWU Audit; ESI Compass Rose Audit.

Market Distortion: Patient Steering and Affiliate Pharmacy Markups

Beyond financial audit discrepancies, federal subcontractor PBMs leverage their positions as price setters and price takers to distort and limit market competition by steering federal enrollees into PBM-owned mail-order and specialty pharmacies.

For example, a review of plan design and the publicly available pricing tool in one large FEHBP plan revealed the PBM-owned mail-order pharmacy was more expensive than an independent retail pharmacy on 79 of the 100 most commonly prescribed oral solid medications, with prices at the mail-order pharmacy 100 percent or more over the independent pharmacy on 34 of those drugs.[9] Not only was mail-order more expensive, but beneficiary choice was severely limited, with the PBM-owned mail-order pharmacy being required after two fills at a retail pharmacy.[10]

This disparity was even starker in specialty dispensing, where the PBM-owned pharmacy pricing revealed massive markups over the NADAC price.[11] More specifically, pricing for medications used to treat serious conditions such as cancer were observed with markups hundreds to thousands of percent over NADAC.[12] In yet another FEHBP plan, a markup for multiple sclerosis drug was observed as high as 47,000 percent above NADAC.[13]

By acting simultaneously as the network price setter and a competing price recipient through PBM affiliated pharmacies, federal subcontractor PBMs restrict beneficiary access, suppress market competition, inflate enrollee out-of-pocket costs, and capture massive profit margins at taxpayer expense.

Proposed Solution and Conclusion

The foregoing demonstrates that "transparent pass-through" contracts in the FEHBP have proven ineffective at ending PBM spread pricing and preventing PBMs from retaining revenue based on FEHBP volume by implementing practices that untether discounts, and fees from the price of a drug or a plan specifically. The result is over half a billion dollars in documented discrepancies representing massive waste of taxpayer dollars to say nothing of the downstream impact on patients and non-PBM affiliated retail pharmacies.

To eliminate PBM self-dealing, insulate federal health programs from price manipulation, and preserve enrollee choice and market competition, statutory reform should take away the ability of PBMs to set and manipulate drug prices, steer patients to PBM affiliated pharmacies, and retain drug manufacturer rebates and discounts for themselves.

To put an end to these PBM tactics and restore statutory integrity to FEHBP, the U.S. House Oversight Committee voted 40–2 in July 2026 to advance H.R. 6610, the Pharmacists Fight Back Act. H.R. 6610 directly resolves the abuses identified in OIG audits by replacing non-transparent, trade-secreted PBM reimbursement methodologies such as effective rate guarantees with transparent market-based NADAC pricing derived from pharmacy acquisition costs, prohibiting all point-of-sale and post-adjudication pharmacy adjustments and transaction fees, and banning patient steering to preserve enrollee choice and market competition.

Crucially, H.R. 6610 establishes a broad statutory definition of drug manufacturer rebates to include all fees and concessions, requiring all financial remuneration to be passed through to enrollees at the point of sale in order to lower drug prices for enrollees and to prevent PBMs from shifting revenue into offshore entities or non-client/claim specific inventory accounts.

Importantly, empirical evidence from state-level reforms validates the fiscal viability of this legislative model. In Georgia, a 2025 official retrospective claims repricing analysis conducted by the state revealed that replacing PBM spread with transparent NADAC pricing generated nearly 15 million dollars in net savings across state plans, demonstrating that eliminating PBM-affiliated pharmacy markups can more than offset transparent dispensing fee payments. Similarly, multi-year actuarial analyses and insurance reports from West Virginia demonstrated that requiring pass-through of manufacturer rebates blunted premium growth across health plans.

Congress should enact H.R. 6610 into law to eliminate non-transparent federal subcontractor PBM practices, foster fair market competition, and protect taxpayer dollars within FEHBP.

[9] APCI Insights, "American Postal Workers Union Health Plan: Mail-Order Pharmacy More Expensive Than Independent Pharmacy on 79% of Commonly Prescribed Medications Reviewed," Nov. 2024, available online at: bit.ly/apci-insights-003.
[10] Id.
[11] Id.
[12] Id.
[13] APCI Insights, "Federal Employee Health Benefits Plan: Drug Pricing Variability, Specialty Drug Markups and Steering Uncovered," September 2024, available online at: bit.ly/apci-insights-002.