

Office of
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A Survey of State Entity Prescription Drug Purchasing Practices

The Office of the Legislative Auditor General was asked to conduct a survey to identify potential cost savings regarding the purchase of prescription drugs by state entities. During the survey, the audit team found that much of the data that we needed for accurate analyses was either not provided or was not verifiable due to the proprietary nature of the data. Based on our limited survey, the audit team concludes the following:

1. Due to legal issues in accessing and verifying key proprietary pharmacy cost data, we recommend not proceeding with the full audit of prescription drug purchasing practices.
2. Some state-funded entities could implement additional pharmacy cost controls. First, entities could use a drug formulary to take advantage of greater pharmacy discounts and rebates. Second, entities could implement an employee co-insurance cost-share (percentage of total cost) practice instead of an employee co-pay (fixed dollar amount) practice.
3. Our review of other states' recent pharmacy cost-control practices shows that most states had reforms principally dealing with Medicaid pharmacy costs. A few states allow state-funded entities

Due to the proprietary nature of the pharmacy cost data, key cost information cannot be provided to the audit team.

to pool pharmacy benefits together for potential cost savings, but most do not require this to happen. Utah's statute already allows state entities to pool benefits with Public Employees Health Program (PEHP).

Key Data Is Inaccessible and Unverifiable

The audit team cannot obtain reliable cost data from many state entities.

During the survey of prescription drug purchasing procedures by state entities, the audit team encountered several obstacles in acquiring proprietary data for an accurate pharmacy drug-cost study. For example, many state entities not with PEHP do not know actual pharmacy benefit costs or other details, because insurance carriers maintain this information. The audit team's right to access this data has been denied by insurance carriers.

Many state entities do not know the prescription drug benefit cost details because they are fully insured. For these fully-insured entities, insurance carriers assume the risk for extraordinary claim costs to that entity. The state entity pays a set premium to the carrier in exchange for managing the health care benefits, which include pharmacy benefits. The carriers feel that granting the audit team access to the cost data would undermine their ability to be competitive in the industry.

OLRGC says that the audit team does not have the legal right to some cost data.

Attorneys in the Office of Legislative Research and General Counsel (OLRGC) said that since the pharmacy cost data is proprietary information held by a private company and not in possession of the state entity, the audit team does not have legal authority to require the disclosure of this data. Also, PEHP's legal counsel concurs that insurance carriers may elect not to provide certain pharmacy cost information for many fully-insured state entities.

There is a possibility to legislate contract language or have an entity require contract language allowing the entity to access the data during its insurance bid process. However, based on reactions by some insurance carriers, any change requiring more data disclosure in contracts could prove problematic.

Level of Insurance Risk Impacted Access to Data

Generally, the two types of insurance risk are called self-insured and fully insured. Those entities that are fully insured have a lower insurance risk level, but also have limited access to pharmaceutical cost data, which impacted our ability to access cost data. Many state entities not with PEHP, such as most school districts and some higher education institutions, are fully insured and purchase prescription drug benefits through privately-run insurance carriers. Of the 40 school districts, 21 are fully insured or a combination of being self and fully insured and 19 are self-insured. Of the 19 self-insured entities, 16 are with PEHP. The self-insured entities purchase prescription drug benefits directly from a pharmacy benefits manager (PBM).

Self-insured entities assume the risk of extraordinary claim costs while insurance carriers assume the risk for fully-insured entities.

During the survey of six state-funded entities, the audit team was able to obtain reliable cost data from PEHP and from two other self-insured state entities. However, we were unable to obtain reliable cost data from the other three entities that are fully insured. The insurance carriers we contacted would not provide some key proprietary data which would allow the audit team to adequately compare prescription drug costs across state entities. Figure 1 demonstrates some of the differences between the two types of insured entities.

Figure 1. Differences Exist Between Self-Insured Entities and Fully-Insured Entities. Some of the key differences are due to the nature of the risk. Fully-insured entities pay an agreed upon premium, and the insurance carrier assumes the risk of extraordinary expenses.

Question	Self-Insured	Fully-Insured
Does the entity know the actual cost of prescription drugs?	Yes	No
Does the entity typically know the total actual pharmacy costs?	Yes	No
Does the entity know the pharmacy benefit manager's drug discounts?	Yes	No
How are manufacturers' rebates received?	Direct	Indirect*
Who assumes the risk?	Entity	Carrier
Who negotiates the contract for prescription drug benefits with the pharmacy benefit manager?	Entity	Carrier
Which types of entities typically use which method?	Larger	Smaller

* The audit team could not verify if any of the fully-insured entities receive rebates indirectly.

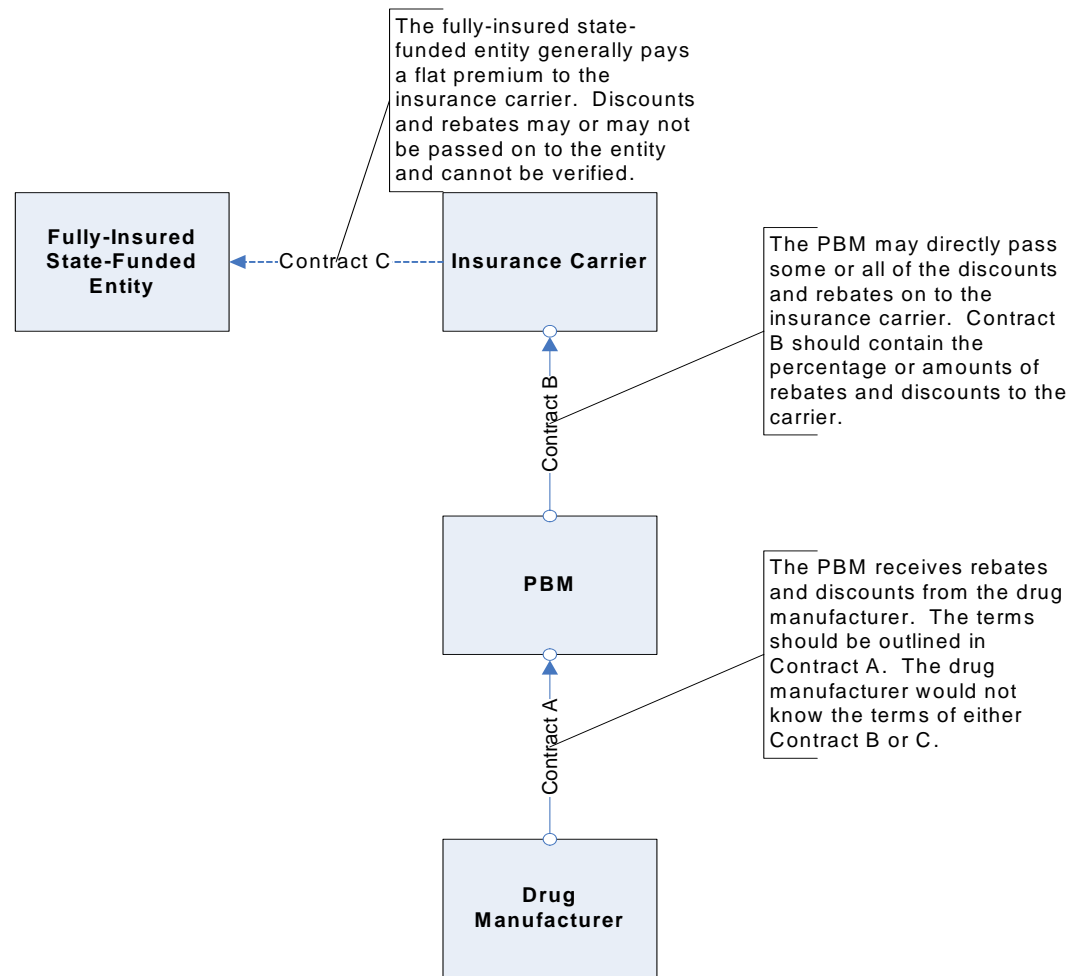
The main difference between the two types of insurance coverage is the self-insured entity would assume the risk of extraordinary claim costs while the insurance carrier would assume the risk of extraordinary claim costs for the fully-insured entity. Many state entities are fully insured and purchase health care benefits independently because they are too small to accept the risk of being self-insured.

In addition, fully-insured entities do not have access to or receive certain information relating to drug costs. This information is typically considered proprietary between the insurance carrier and the pharmacy benefit manager (PBM). Furthermore, fully-insured entities typically do not know the cost breakout of pharmacy benefits because they are usually combined with the medical benefit costs. Insurance carriers of fully-insured entities have refused to provide the total pharmacy costs to state entities.

Fully-insured entities typically do not know the actual cost of prescription drug benefits because the costs are combined with medical benefit costs.

Because insurance carriers purchase drugs from the PBM in behalf of certain state entities, these carriers will not share key information, such as drug discounts and rebates, which is needed to make an accurate comparison of prescription drug costs among state entities. The carriers claim that the entity itself has no right to this information because it involves an agreement between two private companies, the PBM and the insurance carrier. This relationship is illustrated in Figure 2.

Figure 2. Certain Proprietary Cost Data Resides with the PBM and Insurance Carriers for Fully-Insured State Entities. The fully-insured state-funded entity is not privileged to know the specifics of the insurance carrier’s contract with the PBM.



Conclusion:
Discount and rebate information is contained in Contracts A and B and not Contract C. The audit team does not have access to any agreements besides Contract C.

Figure 2 shows there are typically three contracts involved in the purchase of prescription drug benefits for fully-insured entities. Contract C is the agreement between the state-funded entity and the insurance carrier which the audit team can access. Contract B is the agreement between the insurance carrier and the PBM. Contract A is the agreement between the PBM and the drug manufacturer. In its contract with the PBM (Contract B), the insurance carrier generally agrees to keep discounts and rebates confidential to all parties. For this reason, the state entities typically are not able to receive this information.

Commonly-used insurance carriers have said that the Legislature would not be able to obtain this information because the carriers are bound by their contracts with their PBMs to keep it confidential. For example, when we sought data from one insurance carrier, the chief financial officer responded with the following:

In both our contractual relationship with this group [state entity] and our PBM vendor provider [PBM] we have obligations which either do not compel us to provide this key competitive information, or specifically prevent us from disclosing our cost information as a contract term as is the case with [the PBM].

In contrast, the audit team was able to obtain information for self-insured entities because the information was more readily available to them. As shown earlier in Figure 1, state entities that are self-insured are entitled to know the drug discount rates given to them, the costs of drugs, the manufacturers' rebates, and total pharmacy costs. However, fully-insured state entities are not entitled to this proprietary information because of the nature of the contractual relationship.

Obstacles Prevented a Full Audit of Prescription Drug Costs

Figure 3 shows a summary of the issues that prevented the audit team from conducting a more in-depth study of prescription drug costs among state-funded entities.

Data from self-insured entities can be verified and is considered more reliable.

Figure 3. Obstacles that Prevented a Full Audit of Prescription Drug Costs. The lack of accessible data among fully-insured state-funded entities prevented the audit team from gathering data for a full audit.

Information Not Accessible	Reason Information Is Not Accessible	Effect on Audit
Actual cost for prescription drug benefits for those fully-insured state-funded entities that are not with PEHP.	Many fully-insured entities contract with the insurance carrier to provide both the prescription drug and medical benefits. The entity does not generally know the cost breakout of the individual benefits.	We cannot accurately determine the cost for prescription drug benefits.
Employee pharmacy cost share and dispensing fee costs per member per month (PMPM) for fully-insured state-funded entities not with PEHP.	Proprietary information between the insurance carrier and PBM.	We cannot accurately compare prescription drug benefit costs among state-funded entities.
The amount of selected drug discounts applied to the average drug wholesale price (AWP) for fully-insured entities that are not with PEHP.	Proprietary information between the insurance carrier and PBM.	We cannot accurately show a difference in the actual cost of specific drugs.
Rebates from drug manufacturers received by the insurance carriers of fully-insured state-funded entities that are not with PEHP.	Proprietary information between the insurance carrier and PBM.	We cannot verify that rebates received by the insurance carrier are being passed on to the state-funded entities through lower premiums.

Based on the issues in Figure 3, the audit team could only compare the cost of prescription drug benefits among self-insured entities because these entities know the actual prescription drug benefit costs and interface directly with the PBM. In contrast, fully-insured state-funded entities could only estimate the cost for prescription drug benefits. These cost estimates cannot be verified and thus should not be considered reliable.

Contract Reform Could Be Problematic

The Legislature could require state entities to only purchase prescription drug benefits from insurance carriers who would provide key pharmaceutical cost data to the entities. The entity could require that the contract between the entity and the insurance carrier include language allowing access to specific cost information. However, some insurance providers have said they would not provide this information under any circumstances, because it would limit their ability to be competitive. The audit team found no legal precedent on this issue as to whether it is legal to require insurance carriers to provide this cost data for fully-insured entities.

Opportunities Exist for State Entities to Reduce Pharmacy Costs

While we were unable to obtain sufficient cost data to perform a reliable comparison, we did learn of some cost-saving efficiencies. According to individuals in the pharmacy industry, an entity could reduce costs by implementing either a drug formulary and/or requiring the members of the benefit plan to pay co-insurance for pharmacy drugs instead of a co-pay.

These common cost-saving practices should be utilized; however, our initial survey of six state entities found two entities that did not use co-insurance and one entity that did not use a drug formulary. Further research of state entities that were not part of our sample found at least one other entity that does not use a formulary and six other entities that use co-pays instead of co-insurance. Therefore, at least some other non-PEHP insured state entities also have not implemented these cost-saving tools.

Formularies Can Reduce Plan Costs

Drug formularies can lower costs to an entity. A formulary is designed to give members desired choices in prescription drugs while maintaining the lowest possible cost. Generally, formularies with more drug choices will cost more to the entity and its members than formularies with fewer drug choices. Drug formularies are created by

medical and pharmacy professionals with the objective of creating the plan with the most value for its members.

Drug manufacturers encourage PBMs to include their drugs on a formulary by offering rebates and deeper discounts. PBMs receive rebates from the drug manufacturer and can choose to pass all or part of the rebates to the purchasing entity. A carrier is the purchasing entity for a fully-insured state entity, while a self-insured state entity purchases the drugs directly from the PBM. A formulary can reduce the net cost of prescription drugs to an entity by providing greater rebates in exchange for inclusion of a drug on an entity's formulary.

Drug formularies encourage members to use lower-cost generic drugs instead of brand-name drugs.

In addition to providing greater rebates, formularies can persuade members to purchase lower-cost generic drugs instead of more expensive brand-name drugs. Individuals in the pharmaceutical industry say that the use of a formulary can significantly lower brand-name drug utilization, which can lower the overall costs of an entity's pharmacy benefit plan.

Co-Insurance Usage Has Benefits Over Co-Pays

Co-insurance requires members to share in the cost of increasing prescription drug prices.

Two of the six state-funded entities surveyed choose to use a flat co-pay while others use co-insurance. Further research found at least six other state entities that also use co-pays. A co-pay is a flat amount that the member pays to purchase a prescription drug, and the benefit plan pays the remainder of the cost. A member who has co-insurance pays a percentage of the drug cost instead of a flat rate. Individuals in the pharmaceutical industry say that members who pay co-insurance are more cognizant of actual prescription drug costs and are more likely to use generic drugs than brand-name drugs. An employer can reduce costs when its members purchase generic drugs instead of brand name drugs.

Co-insurance also allows members to share in the cost of increasing prescription drug prices and is more responsive to changes in drug prices. If a plan uses a co-pay employee cost-share plan, the entity must bear the burden of increased drug prices on its own or raise the co-pay periodically. Entities often elect not to raise co-pay amounts because members typically do not respond well to a publicized increase in their cost share. If an entity chooses not to raise the co-pay, it must find other methods to pay for the increase of prescription drug costs

Members who pay co-insurance typically understand the actual costs of prescription drugs better than those who pay a flat co-pay.

Nineteen states attempted legislation to pool/bulk purchase prescription drugs for all state entities.

The State of Utah requires all state agencies to purchase benefits through PEHP.

by either raising the employees' benefit premiums or funding the increases on its own.

One PBM spokesperson said that members respond more favorably to small, frequent cost-share increases rather than larger increases. Employees may notice small increases in their co-insurance for certain drugs over time; however, the increases will not be as drastic or as publicized as an increase in their co-pay.

Few States Mandate State Entities to Bulk Purchase Their Prescription Drugs

In a final survey area, we reviewed some of the more recent trends in other states' prescription drug purchases. In 2005, all 50 states attempted legislation to improve prescription drug purchasing plans in some form. These bills addressed concerns such as regulation, affordability, payment, and general policies regarding prescription drugs. Most bills addressed changes to prescription drug purchasing for Medicaid; however, 19 states attempted to pass legislation concerning interagency or multi-state bulk purchasing of prescription drugs. Six states enacted new laws concerning interagency or multi-state prescription bulk purchasing. Bulk purchasing can reduce costs.

Washington was the only state that enacted a bill that pertains to this audit survey in determining cost savings by bulk purchasing prescription drugs by pooling state-funded entities under the same pharmacy benefit plan. This new law in Washington requires that all state agencies purchase prescription drug benefits through a newly-organized state drug-purchasing consortium. Programs could be exempt from this requirement if they could demonstrate that they could receive greater cost savings through another drug-purchasing agreement.

According to *Utah Code* 49-20-201, all state agencies in Utah are already required to purchase their health care benefits through PEHP. Educational institutions and political subdivisions are also eligible to purchase benefits through PEHP; however, they are not required to do so by statute. Most educational institutions request bids for health care through PEHP as well as other commonly-used carriers. Currently PEHP provides health care benefits to several state entities

including 16 school districts, five applied technology colleges, and three state colleges.

Some other carriers have provided pharmaceutical benefits to some state-funded entities at a lower cost than PEHP which may be attributed to a more restrictive formulary. A more restrictive formulary has fewer drugs on the preferred drug list, which enables the carrier to more accurately predict and contain costs.

Recommendations

1. We recommend the Office of the Legislative Auditor General not proceed with a full audit of prescription drug purchasing because of our inability to legally access the proprietary data.
2. We recommend that the Legislature encourage all state-funded entities to consider using a formulary in order to receive greater rebates and discounts, thus reducing overall costs.
3. We recommend that the Legislature encourage all state-funded entities to consider implementing an employee co-insurance cost-share practice for prescription drug purchasing instead of an employee co-pay practice.