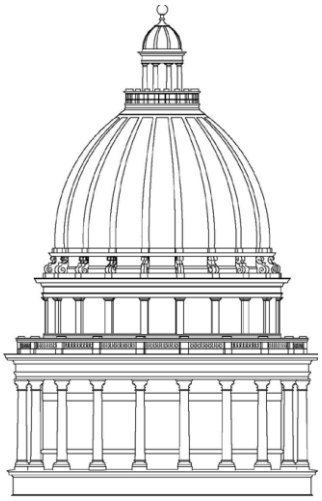
REPORT TO THE

UTAH LEGISLATURE

Number 2019-13



A Performance Audit of PEHP's Pharmacy Benefit Manager

December 2019

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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KADE R. MINCHEY, CIA, CFE
AUDITOR GENERAL

December 2019

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of PEHP's Pharmacy Benefit Manager** (Report #2019-13). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE
Auditor General

A Digest of
A Performance Audit of PEHP's
Pharmacy Benefit Manager

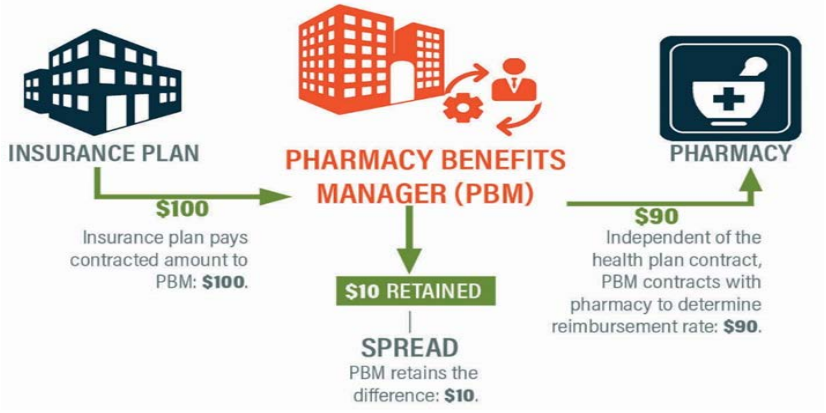
Pharmacy Benefit Managers (PBMs) act as third-party administrators for insurers whose purpose is to help control prescription drug costs. PBMs control these costs through two avenues: negotiated rebates with manufacturers and contracted reimbursement rates with pharmacies. PBMs are a central component in the prescription drug flow process. PBMs engage in financial relationships with manufacturers, pharmacies, and health care plans.

Chapter II
True Drug Costs Are Hidden by
PBM and Manufacturers' Practices

Attempting to Uncover Prescription Costs Led to Many Obstacles. Specific prescription cost data and rebates are closely held by PBMs and not easily obtained through a standard audit request. Despite our authority to conduct audits of public entities, some of the information necessary to conduct the audit resided with private entities or was controlled through legal or contractual terms. Obtaining the data required requests and negotiations with PBMs that took a great deal of time. Since no single entity has all the data necessary for a complete analysis of prescription costs, our analysis was limited until all requests were fulfilled.

Spread Pricing Is One Way PBMs Earn Profit and Is Often Misunderstood. Our analysis of one pharmacy for calendar year 2018 showed that Express Scripts, Inc. (ESI) received a spread of 24 percent on generics and 0.49 percent on brand drugs, which translates to about $6 million in spread revenue if extrapolated to all PEHP prescriptions.

Figure 1 Spread Pricing Is a Major Revenue Source for PBMs. The price difference between what the plan pays and what is reimbursed to pharmacies is the spread amount the PBMs retain as revenue.



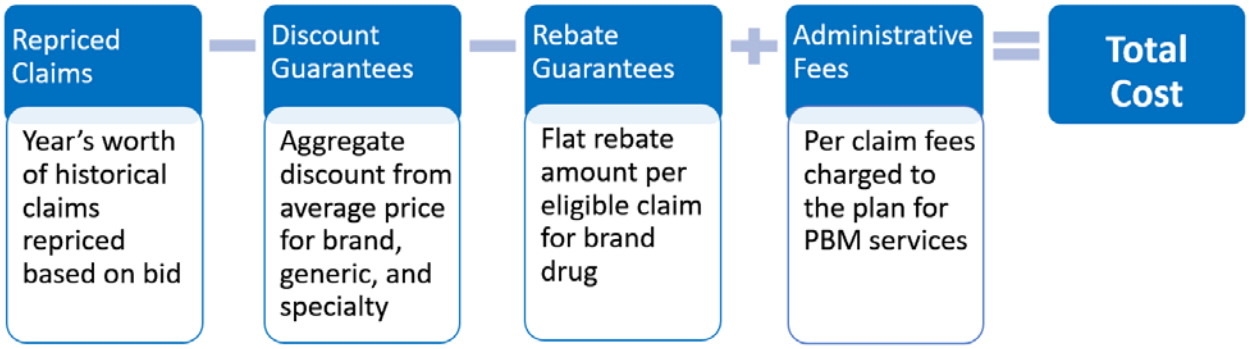
ESI Rebates Are Not Keeping Pace with Manufacturers' Price Increases. We received the list prices of drugs from various manufacturers when we visited ESI and found that average drug prices increased 8 percent from 2016 to 2017. These drug prices were consistent across all drug plans covered by ESI. During this same period, we found that overall, rebates had increased but were not keeping pace with drug prices.

Other States Are Using Audits and Legislation to Deal with Opaque PBM Process. States have addressed concerns about rebate amounts, spread pricing, wholesale acquisition costs, transparency, and administrative fees so plans can make more informed decisions.

Chapter III
PEHP Needs Transparency from ESI to Maximize Savings

PEHP Uses Competitive Bid Process to Select Most Favorable PBM Contract. We reviewed PEHP's process for selecting a PBM and pricing structure. We found they follow a competitive bid process and appropriately consider multiple factors that impact total cost.

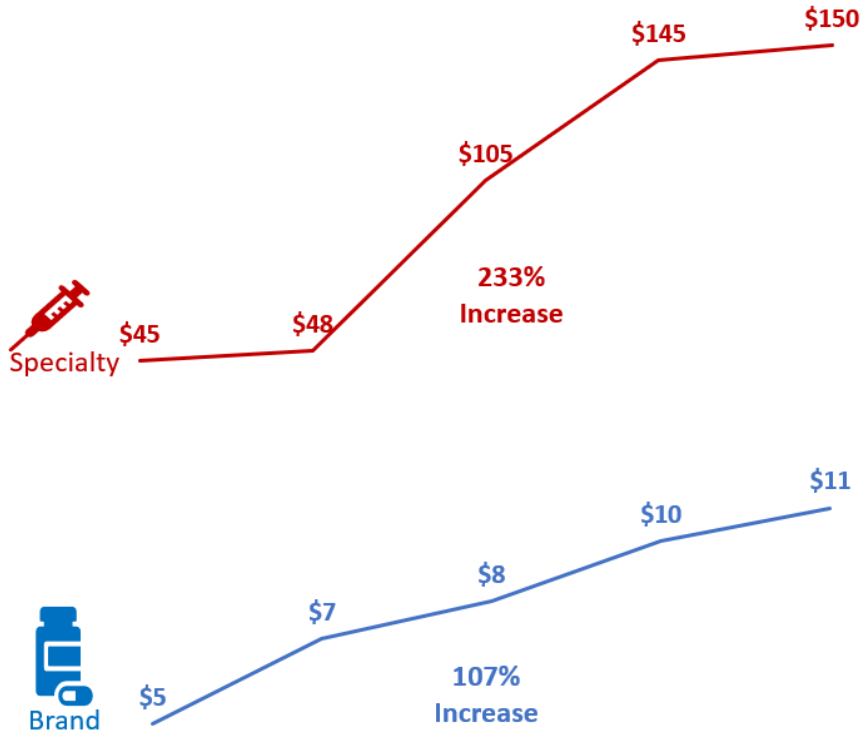
Figure 2 Criteria for Evaluation of PBM Bids. PEHP estimates total cost based on four components.



We validated that PEHP selected a traditional contract instead of a transparent contract because of lower total cost over the life of the contract. The results of the bid process showed that transparent contracts offered to PEHP are more expensive than traditional contracts due to smaller discounts, smaller rebates, and additional administrative fees.

Pharmacy Costs Are Increasing Despite PEHP's Proactive Efforts. Pharmacy costs per member after rebates increased 8 percent from calendar year 2014 to calendar year 2018 despite PEHP's efforts to lower costs. PEHP's control over its formulary is central to cost-reduction efforts because it incentivizes members to use generics over brands. However, prices of prescription drugs continue to rise. Specialty drugs in particular are driving up total costs for PEHP, as shown in Figure 3.

Figure 3 Average Price Per Unit for Brand and Specialty Drugs Before Rebates. Specialty drugs represented less than 1 percent of all prescriptions but accounted for 40 percent of brand costs from 2014 through 2018.



Legislative Action to Require Rebate Transparency Would Bolster PEHP's Efforts to Negotiate Better Contract Terms. We found that ESI does not allow PEHP access to claim-level rebate information through regular reporting or auditing. While we verified that ESI passed through 100 percent of rebate payments from manufacturers in 2016 and 2017, PEHP cannot verify this data for itself due to ESI's protocols, which require a third-party, on-site audit. We found that, in addition to better oversight, improved access to claim-level rebate information can help PEHP identify opportunities for negotiation. Although PEHP should try to negotiate access to its rebate data, we believe legislative action may be necessary before PBMs will share this information with their clients.

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A Performance Audit of PEHP's Pharmacy Benefit Manager

December 2019

Audit Performed By:

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Chapter I
Introduction

Pharmacy Benefit Managers (PBMs) act as third-party administrators for insurers whose purpose is to help control prescription drug costs. PBMs control these costs through two avenues: negotiated rebates with manufacturers and contracted reimbursement rates with pharmacies. PBMs are used by the Public Employees Health Program (PEHP) and Medicaid's four Accountability Care Organizations (ACOs). Medicaid's fee-for-service plan manages prescription benefits without a PBM.

We were asked by the Legislature to audit the pricing structures of PBMs to PEHP and Medicaid ACOs as well as oversight of PBM charges by PEHP and the Utah Department of Health (UDOH). The focus of this audit report will be the relationship between PEHP and its PBM, Express Scripts, Inc. (ESI). We will release a companion audit report in the first half of 2020 that will address the impact of PBMs on the ACOs and the oversight provided by the UDOH.

We were asked to audit the pricing structure and oversight of PBM contracts for PEHP and Medicaid ACOs.

PEHP currently covers more than 154,000 members in various risk pools including state of Utah employees and employees of local governments and multiple school districts.[1] In 2018, the pharmacy benefit comprised 14 percent of PEHP's total expenses, totaling $85 million.

PBMs Are a Central Figure In the Prescription Drug Cycle

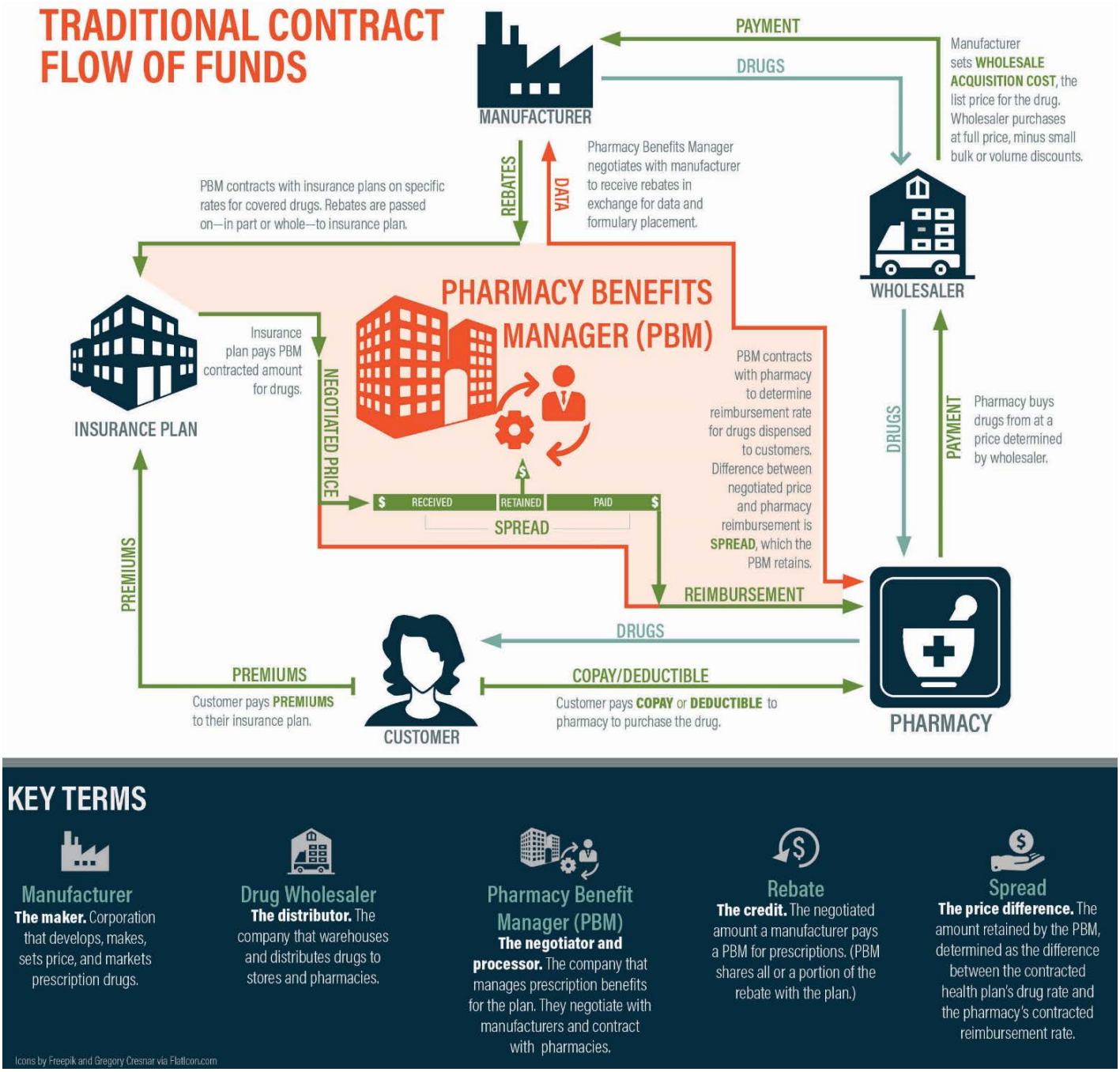
PBMs are a central component in the prescription drug flow process. Health care plans (plans) typically enter into one of two types of contracts known as traditional or transparent. PEHP and one of the ACOs have a traditional contract, whereas two ACOs have transparent contracts. The fourth ACO operates an internal PBM that allows for full transparency. We will discuss the difference between a traditional and transparent contract later in this chapter; further discussion of ACO contracting will occur in the forthcoming companion audit

PEHP and one of the four ACOs have a traditional PBM contract.

[1] This enrollment total excludes Medicare Part D members as we did not include the Medicare supplement plan in analyses for this report.

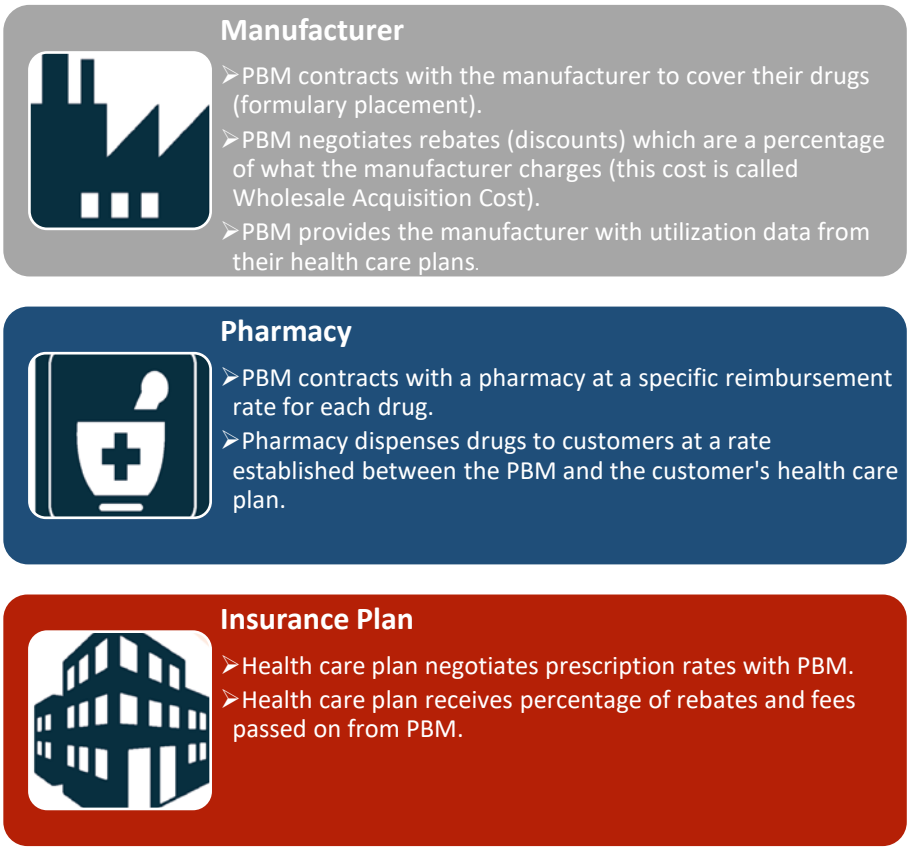
report. PBMs engage in financial relationships with manufacturers, pharmacies, and health care plans. Figure 1.1 illustrates the centrality of the PBM in this process.

Figure 1.1 PBMs Play a Central Role in the Pharmacy World. PBMs negotiate rebates with manufacturers and then pass all or a portion of those rebates to the insurance plan.



Spread is the price difference between what the plan pays the PBM and what the PBM reimburses the pharmacy.

Figure 1.1 is an example of the flow of prescription drugs, payments, and data for a traditional contract, which allows spread pricing. Spread is defined as the price difference between what the plan pays the PBM and what the PBM reimburses the pharmacy. We will discuss spread pricing in more depth in Chapter II. The relationships between the PBM and the manufacturer, pharmacy, and the plan are shown below:

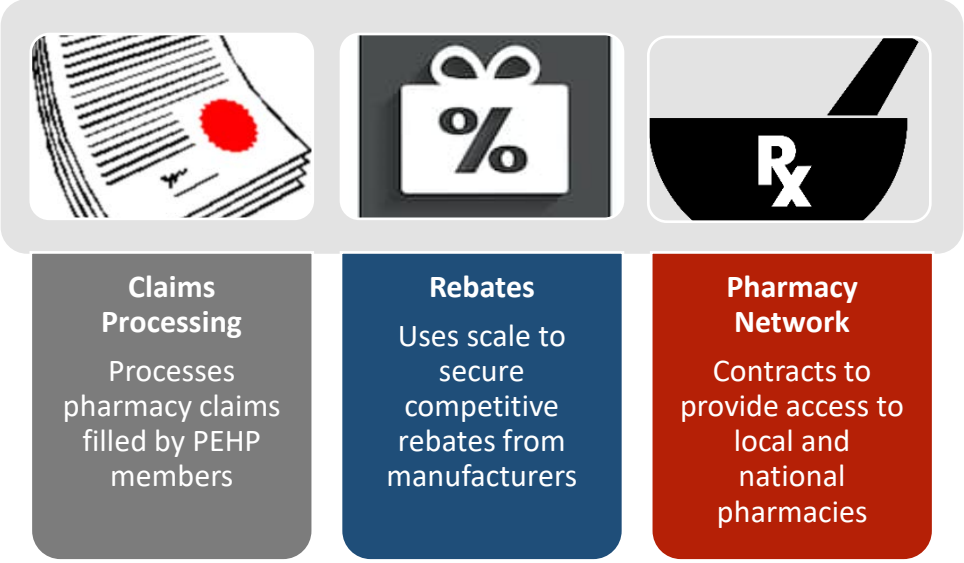


ESI Provides Value to PEHP in Different Ways

ESI is one of the three largest PBMs and has more than 100 million members.

ESI is one of the three largest PBMs in the industry, which together control roughly two-thirds of the PBM market. ESI covers more than 100 million members and has been PEHP's PBM since 2001. Like other large PBMs, ESI operates its own mail-order pharmacy as well as a specialty pharmacy, Accredo, which ships expensive medications that require special handling to patients' homes. Nearly all specialty prescriptions are filled through Accredo

pharmacies. As the PBM for PEHP, ESI performs various services, as shown below:



Unlike other medical claims, pharmacy claims are processed in real-time while the customer is in the pharmacy. Claims processing takes into account the member's deductible and copay, the drug's status on PEHP's formulary and different pricing indicators for the drug. Rebates are available for some brand and specialty drugs. PBMs typically negotiate agreements with manufacturers that offer different rebates for various types of plans instead of negotiating a separate agreement for each plan. For example, health care plans following ESI's national formulary will get certain rebates, while health care plans with their own custom formularies may receive smaller rebates.

PBMs negotiate manufacturer agreements that offer different rebates depending on the type of plan.

Health care plans typically use a PBM-provided pharmacy network and do not contract with pharmacies directly, although plans have the option to negotiate their own pharmacy networks. ESI maintains a broad pharmacy network through a contracting process separate from its contracts with plans. PEHP uses ESI's broadest network which includes major and regional chains as well as most independent pharmacies.

PEHP has opted to do some of the work traditionally done by PBMs, such as formulary management and prior authorizations. While these activities increase the work that PEHP's pharmacy staff must complete, PEHP reports they help to reduce overall pharmacy costs. These internal processes are discussed in Chapter III.

PEHP performs many pharmacy benefit management tasks internally.

PEHP reports that use of a PBM helps reduce pharmacy costs.

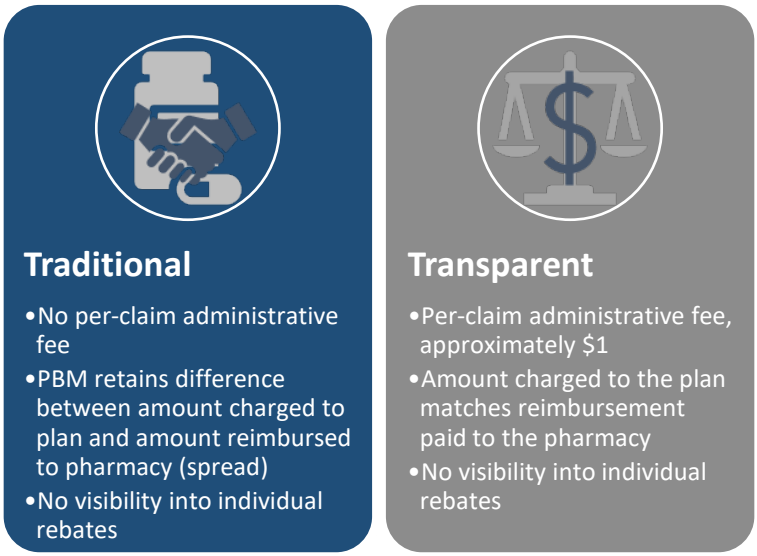
Despite recent scrutiny of PBMs, PEHP reports that it is an important contractor. Although PBMs profit from the services they provide, these services can help health care plans reduce their pharmacy costs. Health care plans also benefit from not having to process their own pharmacy claims. There are different financing models that PBMs use to obtain payment for their services. PEHP's contract with ESI is under a "traditional financing model," which is described in more detail in the next section.

Transparent Contracts Provide Minimal Additional Information to Plans

Health care plans decide between transparent and traditional contracts.

Health care plans typically select either a traditional or transparent (also called pass-through) pricing structure when they contract with a PBM. Figure 1.2 shows the differences between these options.

Figure 1.2 Contract Models. Although transparent contracts guarantee that the insurance plan's cost matches the pharmacy's reimbursement, they do not necessarily offer transparency into rebates.



Transparent contracts provide assurance that spread pricing is not occurring.

As shown in Figure 1.2, a transparent contract provides a health care plan with assurance that spread pricing is not occurring, but at an additional administrative cost to the plan. In neither contract does the plan necessarily have visibility into the specific individual rebates being paid by the PBM. Health care plans we examined receive only

aggregate rebate amounts, not claim-level detail. This level of detail was available only through an on-site audit conducted by a third party.

During our audit, we reviewed both traditional and transparent contract models. Our analysis of PEHP's pricing structure is found in Chapter III.

Audit Scope and Objectives

We were asked to review the effect that pharmacy benefit managers have on prescription costs for PEHP and determine whether spread pricing is occurring and, if it is occurring, determine its effect:

- Chapter II: True Drug Costs Are Hidden by PBM and Manufacturers' Practices
- Chapter III: PEHP Needs Transparency from ESI to Maximize Savings

Chapter II
True Drug Costs Are Hidden by PBM and Manufacturers' Practices

Our review of Pharmacy Benefit Managers (PBMs) found that contracting and pricing practices prevent policymakers and health care plans from effectively overseeing prescription drug costs. Accordingly, we recommend that plans pursue full prescription cost data through their contracting practices, and policymakers should consider requiring more disclosure of this information to help plans obtain data that they can use to make informed decisions. Prescription pricing and reimbursement is a multi-layered and tiered process where actual cost to insurers is buried within pricing charts, rebates, administrative fees, and other pricing structures. The ability to audit this structure is filled with roadblocks resulting from the opaque relationship between PBMs and manufacturers which inhibits plans from making cost-effective decisions.

Once we were able to collect the necessary data, we ascertained that PBM payments to pharmacies were lower than the amount charged to the health care plan. As reported by auditors in other states, the amount public entities pay to the PBM and what PBMs pay pharmacies for the same covered drug is a different amount, which is called spread pricing. We estimate that the Public Employees Health Program's (PEHP) contract allowed its PBM to collect up to $6.1 million in 2018 as a result of spread pricing. However, we found that spread pricing is often understood as a transparency issue and does not represent a one-to-one savings opportunity. We did not find evidence that spread pricing necessarily increases the overall cost to the health care plan. Pharmacies' reimbursement rates are not based on what plans pay; rather, the rates are independently contracted with PBMs.

Pharmacies' reimbursement rates are not based off what plans pay but what they independently contract with PBMs.

We also found manufacturers dictate the price of drugs but PEHP's PBM can leverage steep discounts and rebates on prescription drugs. Finally, we looked at other states' audits and legislative actions. We found transparency and spread pricing are common concerns with PBMs. Legislation has been passed in other states to address spread pricing and transparency concerns; however, the methods currently addressing transparency may not be sufficient to achieve cost savings. Therefore, requiring more specific pricing information to be provided

by the manufacturer to support the Legislature in making informed decisions or achieve cost savings may be necessary. We recommend that the Legislature consider requiring manufacturers to share the wholesale acquisition cost for drugs on a quarterly basis with the Legislature, as well as consider requiring PBMs to provide health care plans with specific rebate and fees information on a claim-level basis.

Attempting to Uncover Prescription Costs Led to Many Obstacles

Specific prescription cost data and rebates are closely held by PBMs and not easily obtained through a standard audit request.

Specific prescription cost data and rebates are closely held by PBMs and not easily obtained through a standard audit request. The data is a crucial piece to understanding how plans are affected by prescription costs. Without this data, we cannot give a complete picture of what is driving increases in prescription costs paid by plans, and the plans' ability to make informed decisions is diminished. In order to obtain necessary data to analyze prescription costs, extensive legal review was required, and agencies were required to notify PBMs that we were requesting the data, which added time and a complexity to the audit.

PBM Contractual Agreements Delayed Access to Data

Data requests required negotiations with PBMs that took a great deal of time.

Despite our authority to conduct audits of public entities, some of the information necessary to conduct the audit resided with private entities or was controlled through legal or contractual terms. We found this arrangement at PEHP, Utah Medicaid, and the University of Utah Pharmacy. These entities were very cooperative, however obtaining the data required requests and negotiations with PBMs that took a great deal of time. Since no single entity has all the data necessary for a complete analysis of prescription costs, our analysis was limited until all requests were fulfilled. We will be releasing our findings and analysis on prescription pricing and Utah Medicaid pharmaceutical practices early next year.

PEHP Rebate Analysis Was Limited by Contract Restrictions. As will be described in Chapter III, PEHP does not receive data that describes which specific claims receive rebates; rebate information is provided only through a quarterly aggregate report. While PEHP's PBM, Express Scripts Inc. (ESI), was cooperative, meaning within contract specifications they complied with our requests, its process to

obtain data is very restrictive. ESI reports that the proprietary and confidential nature of prescription cost and rebate data necessitates an established audit protocol that limits the possibility of unauthorized disclosures. These restrictions generally occurred in three different ways.

ESI's audit protocol imposed restrictions on our analysis.

Obtaining Medicaid Rebate Data Required Collaboration Between Legislative and Executive Branch Legal Counsel. In addition to on-site audit of ESI, we also had to work extensively with Medicaid to get rebate information. This required considerable negotiations between the Office of Legislative Research and General Counsel (representing our office) and the Utah Attorney General's office (representing Medicaid). They determined how our office could obtain and secure the federally protected[2] Medicaid rebate information.

Pharmacy Data Is Closely Guarded. In addition to rebate data for PEHP and Medicaid, we requested pharmacy cost information from the University of Utah pharmacies. These pharmacies have

[2] U.S.C. § 1396r-8(b)(3)(D).
(D) Confidentiality of information Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph…is confidential and shall not be disclosed by…a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except—**… (iv)**to States to carry out this subchapter…

contracts with many PBMs, each of which limits the ability of the pharmacies to share information with the parties. In order to provide us with the data, the university was required to notify each PBM and give them a chance to respond to the request. Because of the considerable time involved, we were not able to get all the pharmacy data but obtained data from the ten PBMs with the highest total payments to the university pharmacies. While it took a substantial amount of time to obtain the data, it resulted in valuable analysis for this report and a subsequent report scheduled for release in 2020.

Data requests can take some time to complete in any audit, but the amount of work required to get the data for our analysis far exceeded our usual processes. Because PBMs are private entities, the best way for us to obtain data was through the state-funded health care plans and pharmacies that contract with them. Since these entities may not have the ability to negotiate who they can give PBM data to, we recommend that the Legislature consider requiring PBMs to provide plans with specific rebate and fees information on a claim-level basis. As will be discussed in Chapter III, this information would give plans increased transparency with prescription pricing and policymakers valid data to help determine the cost effectiveness of the PBMs.

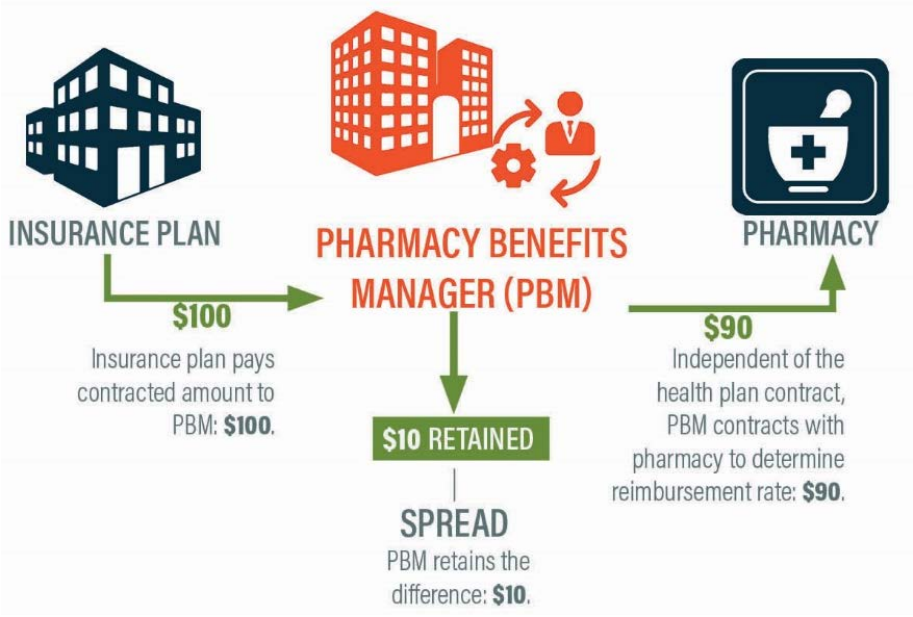
We recommend that the Legislature consider requiring PBMs to provide plans with specific rebate and fees information on a claim-level basis.

Spread Pricing Is One Way PBMs Earn Profit and Is Often Misunderstood

Spread pricing has been cited as a transparency issue with pharmacy services and administrative costs. Our analysis of one pharmacy for calendar year 2018 showed that ESI received a spread of 24 percent on generics and 0.49 percent on brand drugs, which translates to about $6 million in spread revenue if extrapolated to all PEHP prescriptions. Spread pricing is the result of two separate processes, both of which are controlled by the PBM. The PBM contracts with health care plans to provide covered drugs at specific rates; independent of this transaction, PBMs contract with pharmacies to reimburse them at certain rates for drugs they dispense to consumers. As a result of these separate processes, a price difference between the contracted health care plan's drug rate and the pharmacy's contracted reimbursement rate leads to spread pricing, which is retained by the PBM. Figure 2.1 details the process of spread pricing.

In 2018, ESI received a spread of 24 percent on generics and 0.49 percent on brand drugs from one pharmacy. If extrapolated to all PEHP prescriptions, this would translate to about $6 million in spread revenue for ESI.

Figure 2.1 Spread Pricing Is a Major Revenue Source for PBMs. The price difference between what the plan pays and what is reimbursed to pharmacies is the spread amount the PBMs retain as revenue.



Icons by Freepik and Gregory Cresnar via Flaticon.com

As the figure shows, PBMs can retain revenue from the difference paid by the plan and the reimbursement to the pharmacy. Though pharmacies contract with PBMs to be reimbursed, we spoke to two pharmacists who claim that the reimbursement rates are not negotiated but are determined by the PBM. One pharmacist said that they must accept whatever reimbursement the PBM offers.

ESI May Have Received Up to $6 Million in Spread Pricing, but Transparent Contract Was Still More Expensive for PEHP

We reviewed one pharmacy's data that accounts for 2 percent of all PEHP claims and found that the spread (the difference between ESI's contracted rate with PEHP and the rate reimbursed to pharmacies) was 24 percent for generics and 0.49 percent for brands in 2018. If these spread amounts hold across all pharmacies, ESI would have received $6.1 million in 2018. While the spread percentage likely varies across pharmacies, the $6.1 million serves as a real-world example of the levels of spread that are occurring.

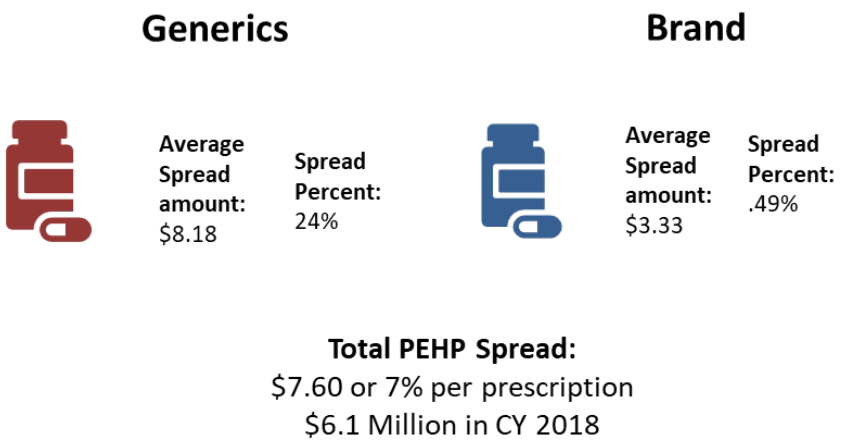
PEHP's last competitive bid process showed it would have cost them an additional $9.5 million over three years to select the least expensive transparent contract.

PEHP's last competitive bid process showed it would have cost them an additional $9.5 million over three years to select the least

expensive transparent contract, which was with a different vendor. This concern is discussed more in Chapter III.

Figure 2.2 shows the percentage of spread pricing for PEHP.

Figure 2.2. PEHP Spread Pricing was 7 Percent in Calendar Year 2018. The difference between what PEHP paid and what the pharmacy was reimbursed for generic drugs was $8.18, while for brand name drugs it was $3.33.



This calculation of spread is based on one pharmacy, and overall spread for PEHP may vary based on the type of pharmacy, location, and other factors.

This calculation of spread is based on the one pharmacy from which we could obtain PBM reimbursement data, so the overall spread for PEHP may vary based on the type of pharmacy (chain or independently owned), location (urban or rural), and other factors. Figure 2.3 shows the five-year percentage and average spread amounts.

Figure 2.3. Spread Pricing Average Has Increased for Generics Over the Past Five Years. The average spread amount for generics has increased from $1.69 to $8.18.

	Generic		Brand		Overall	
	Percent	Avg. Amount	Percent	Avg. Amount	Percent	Avg. Amount
2014	7.56%	$1.69	-2.04%	$(8.11)	0.56%	$0.40
2015	9.49	2.55	-0.90	(4.39)	1.98	1.67
2016	11.16	3.40	0.14	0.78	3.26	3.07
2017	22.40	8.32	2.43	14.59	8.86	9.04
2018	24.44%	$8.18	0.49%	$3.33	6.92%	$7.60

Auditor Generated from University of Utah Pharmacy Data

PEHP's spread percentage was in line with average spread identified in other states' audits.

Based on other states' audits and discussions with a plan representative, we would expect that average spread would be between 7 to 12 percent, which falls in line with what we have found in recent years. It is clear this is one major method PBMs employ to generate revenue under traditional contracts.

PEHP's traditional contract allows ESI to collect spread pricing. Contracts that do not collect spread pricing are considered transparent contracts. Transparent contracts generally charge an administrative fee for each claim and may have different price guarantees. In the case of PEHP, a transparent contract would have been more expensive than the traditional contract.

Spread Pricing May Not Be the Cause of Low Pharmacy Reimbursements

On a transparent contract, the plan pays the same price for the prescription as what the pharmacy is reimbursed. A transparent contract charges the plan an administrative fee for each claim, whereas a traditional plan does not charge an administrative fee.

Audits and legislation in other states have pushed for greater transparency regarding spread pricing, believing spread pricing has led to low pharmacy reimbursements or excess costs for the plan. One way to eliminate spread pricing is to require the plan to have a transparent contract, unlike the traditional contract used by PEHP. With a transparent contract, the plan pays the same price for the prescription as what the pharmacy is reimbursed. A transparent contract charges the plan an administrative fee for each claim, whereas a traditional plan does not charge an administrative fee. However, it must be noted that pharmacies contract a rate that is independent of what the plans pay.

According to our analysis, spread pricing did not necessarily result in the lowest reimbursement rates for pharmacies. Our analysis of the

pharmacy data did not show lower pharmacy reimbursement rates based on the type of contract used (transparent or traditional). Based on our limited sample, moving from a traditional to a transparent contract may ensure that the charge to the health care plan is the same as the reimbursement to the pharmacy, but does not guarantee either savings for the plan or higher reimbursement for the pharmacy.

ESI Rebates Are Not Keeping Pace with Manufacturers' Price Increases

We received the list prices of drugs from various manufacturers when we visited ESI and found that average drug prices increased 8 percent from 2016 to 2017.

We received the list prices of drugs from various manufacturers when we visited ESI and found that average drug prices increased 8 percent from 2016 to 2017. These drug prices were consistent across all drug plans covered by ESI. During this same period, we found that overall, rebates had increased but were not keeping pace with drug prices. As far as we observed, manufacturers control drug pricing. However, we found that ESI was able to negotiate various rebates and PEHP was not receiving the highest rebates available. Other plans that covered larger populations and used ESI's formulary were getting much higher rebates. It appeared that ESI was able to offer rebates to client health care plans that differ based on formulary placement, utilization, and other factors. Manufacturers may determine the ultimate cost of prescription drugs, but as ESI demonstrated, PBMs can aggressively negotiate steeper rebates on behalf of client health care plans. In PEHP's case, the use of a custom formulary has resulted in lower overall costs even though it has resulted in lower rebate collection.

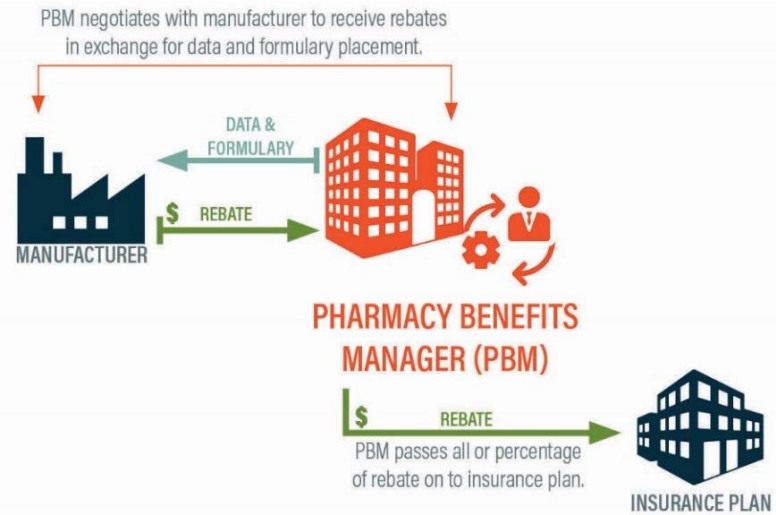
We were unable to determine any direct influence the PBM has on the list price, however, we did see considerably higher rebates other plans were receiving when compared to PEHP. PEHP does control its own formulary (covered drug list), as opposed to using a national formulary. Taking part in a national formulary may result in higher rebates. However, there are some drawbacks to a national formulary:

- the PBM may prioritize higher rebates over lower priced drugs with equivalent clinical outcomes
- assessments are based on results from a more national committee, as opposed to a more local committee
- the national formulary is not reflective of plan-specific utilization.

PBMs Negotiate Rebates with Manufacturers Using Claims Data from Insurers. Rebates are a percentage discount from the drug cost. Manufacturers determine the cost of the drug, but depending on the number of lives covered, PBMs have the ability to negotiate for higher rebates Figure 2.4 traces the path of rebates from the manufacturer to the insurance plan.

Rebates are a percentage discount from the drug cost. Manufacturers determine the cost of the drug, but depending on the number of lives covered, PBMs have the ability to negotiate for higher rebates.

Figure 2.4. Manufacturers Give Rebates to PBMs in Exchange for Plans' Utilization Data and Formulary Placement. PBMs send utilization data to manufacturers and often determine which drugs of the manufacturers are covered on insurance plans.[3]



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Utilization data collected by PBMs is used by manufacturers for purposes that include making business decisions and developing new drugs; however, the way this data is used is not made known to the insurance plans. This data, together with PBMs' control over which

Utilization data collected by PBMs is used by manufacturers for purposes that include making business decisions and to develop new drugs.

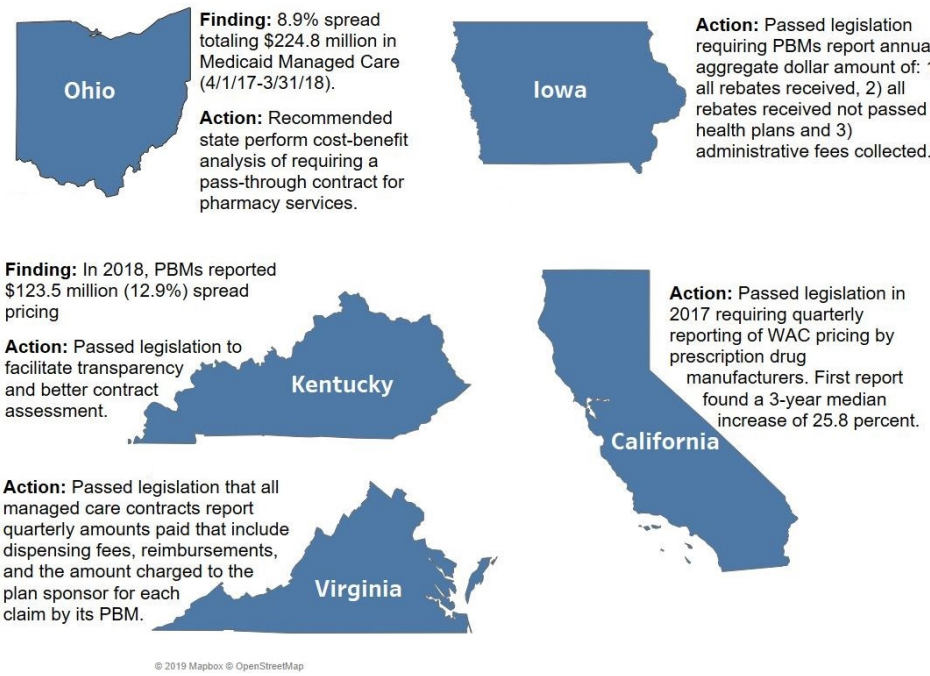
[3] ESI reports data use by PBMs and manufacturers is in accordance with applicable law, including Health Insurance Portability and Accountability Act.

drugs are covered by insurance plans, gives the PBMs the ability to negotiate with manufacturers.

Other States Are Using Audits and Legislation to Deal with Opaque PBM Process

Gaining a greater wealth of information from PBMs has also been an aim for other states. States have addressed concerns about rebate amounts, spread pricing, wholesale acquisition costs, transparency, and administrative fees so plans can make more informed decisions. Figure 2.5 summarizes what other states are doing to address these issues.

Figure 2.5. Various States Are Looking into the Operating Practices of PBMs. Reports and legislation have identified spread pricing and reporting rebate amounts as some of the issues.



California requires manufacturers to report quarterly wholesale acquisition cost (WAC) increases of more than 16 percent. WAC is the list price for drugs that is set by manufacturers. In addition, the manufacturers are required to give a description of the specific financial and nonfinancial factors used to make the decision to increase WAC. If a manufacturer is noncompliant, they are liable for a civil penalty of $1,000 per day after the reporting period.

In 2018, Utah passed similar legislation to that passed by Virginia, which includes:

Utah passed legislation requiring PBMs to report aggregate rebates and administrative fees.

- Reporting the total aggregate of all rebates and administrative fees that are attributable to enrollees of a contracting insurer
- Reporting the percentage of aggregate rebates that the PBMs retained under the agreement with the insurer

These requirements greatly increase the data that is available from PBMs. However, limitations in data access remain, including the inability of plans to determine whether the PBM is getting all eligible rebates for eligible drugs and the lack of claim-specific information that could provide true pricing transparency. Access to specific claims data would allow us to determine when a manufacturer pays a rebate. The PBM's relationships between manufacturers and pharmacies are not currently open to analysis by the plans. These relationships can only be understood by having access to contracts PBMs have with manufacturers, currently available only through on-site audits, as well as contracts PBMs have with pharmacies.

Recommendation

1. We recommend that the Legislature consider requiring manufacturers to share the wholesale acquisition cost for drugs on a quarterly basis with the Legislature.

Chapter III
PEHP Needs Transparency from ESI to Maximize Savings

We were asked to review PEHP's relationship with its pharmacy benefit manager (PBM), which is Express Scripts Inc. (ESI), to assess whether concerns identified in other states apply to PEHP as well. As discussed in Chapter II, others states have found issues with lack of transparency, spread pricing, and rebate payments. We reviewed PEHP's contracting practices to determine if it is maximizing possible savings and taking advantage of the best contracting options available. Specifically, we reviewed PEHP's most recent RFP process to determine if a transparent contract approach would be more beneficial than the traditional contracting approach. This review included analysis of spending on prescription drugs over the last five years. Finally, we assessed the sufficiency of PEHP's oversight of ESI's contract performance.

We reviewed PEHP's relationship with its PBM, ESI.

We found that PEHP selected the PBM contract with the best pricing after undergoing a competitive bid process. Our analysis of spending showed that, despite selecting the most favorable contract terms and taking additional steps to control costs, costs are still increasing. Pharmacy costs per member after rebates increased 8 percent from calendar year 2014 to calendar year 2018 despite PEHP's efforts to lower costs. For PEHP to be the most successful in controlling costs, it needs to bolster oversight of its PBM to ensure it receives the most competitive prices and rebates. Rebates reduce costs, but lack of transparency hinders PEHP's ability to leverage them effectively, thus legislative action may be necessary. We also recommend that the Legislature consider requiring PBMs to provide their clients access to claim-level rebate information, which is currently available only through on-site audits as described in Chapter II.

We found PEHP should bolster oversight of ESI.

PEHP Uses Competitive Bid Process to Select Most Favorable PBM Contract

We reviewed PEHP's process for selecting a PBM and pricing structure. We found they follow a competitive bid process and appropriately consider multiple factors that impact total cost. We validated that PEHP selected a traditional contract instead of a

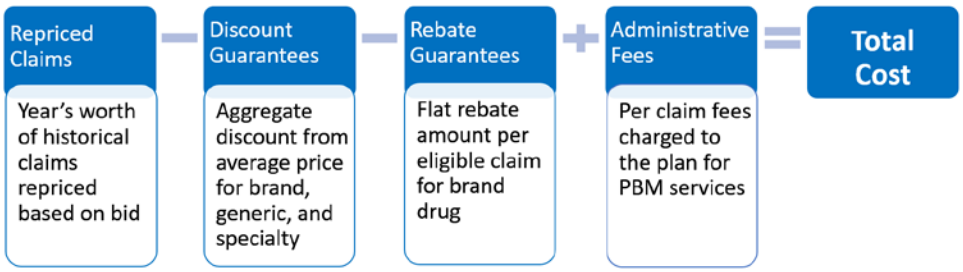
transparent contract because of lower total cost over the life of the contract. The results of the bid process showed that transparent contracts offered to PEHP are more expensive than traditional contracts due to smaller discounts, smaller rebates, and additional administrative fees.

Bid Process Used to Determine Future Cost of Contract

Every three years, PBMs may submit bids for both transparent and traditional contracts during PEHP's competitive bid process.

In the last year of its three-year contract, PEHP issues a request for proposal (RFP). PBMs submit a bid for either a transparent contract or a traditional contract, or both. Figure 3.1 outlines the components evaluated during the selection process.

Figure 3.1 Criteria for Evaluation of PBM Bids. PEHP estimates total cost based on four components.



Because PEHP uses repriced claims to trend rates over three years, bidders with low cost claims have an advantage. PEHP also compares bids to the pricing of the contract currently in place. This analysis identified differences between transparent and traditional models.

Transparent Contracts Were More Expensive Than Traditional Contracts in PEHP's Bid Process

In 2017, PEHP identified the lowest total cost to be a traditional contract with ESI.

As discussed in Chapter II, with transparent contracts, the amount the PBM charges the plan for a prescription is the same amount the PBM reimburses the pharmacy for that prescription. Under a traditional model, the PBM charges the health plan an amount higher than they reimburse the pharmacy for the prescription. The difference between the charge to the plan and the pharmacy's reimbursement is called the spread. PEHP's analysis of bids identified the lowest cost to be a traditional contract with ESI, their existing vendor. Figure 3.2 shows how other finalists compared to the selected bid.

Figure 3.2 Cost Difference Over Three Years Compared to Selected Bid. Transparent bids were more expensive than traditional for the two finalists who submitted both.

Cost Difference Over Three Years		
	Transparent	**Traditional**
Vendor A	$9.5 million	-$1.3 million
Vendor B	No bid	$40.3 million
Vendor C	>$40.3 million*	No bid
Vendor D	$51.1 million	$0 (Selected bid)

Source: PEHP RFP Documentation
**Vendor C's specialty and Medicare costs over three years were not priced because the rates were not competitive, thus the final cost would be higher than the $40.3 million shown here.*

The two least expensive bids overall were traditional models. Our comparison of traditional bids to transparent bids consistently found that transparent models cost more because of reduced discounts and the extra expense of a per-claim administrative fee, as well as reduced rebates in some cases. Traditional contracts usually do not charge a per-claim fee except for those that require additional processing, such as claims that are submitted in hard copy form. PEHP found transparent models to be more expensive than traditional models in 2011 and 2014 RFPs as well.

Unlike transparent contracts, traditional contracts usually do not charge a per-claim administrative fee.

Figure 3.2 also shows that Vendor A's traditional bid was $1.3 million lower than ESI's. However, Vendor A's bid did not include transitional costs for switching to a new PBM, which PEHP's analysis determined could be as high as $1.9 million. As a result, staying with ESI was estimated to be lower cost.

Vendor A was lower than ESI by $1.3 million, but PEHP estimated transitional costs for switching to a new bid to be as high as $1.9 million.

Actual Rebates Can Exceed Guarantees Evaluated in the Bid Process. PEHP noted that comparing rebate guarantees does not give a good indication of rebate amounts the plan can expect to receive once the contract begins. Rebate guarantees represent the lowest amount the plan will receive, but in PEHP's experience, actual rebates exceed these guarantees by millions of dollars. Thus, bids do not offer a realistic estimate of the actual costs the plan will incur. As discussed later in this chapter, insufficient information about rebates hinders PEHP from evaluating whether another PBM has better rebates available.

In PEHP's experience, actual rebates exceed guarantees in contract proposals by millions of dollars.

The bids submitted by PBMs did not give PEHP evidence to show how spread pricing would negatively affect the plan.

Spread Pricing Cannot Be Quantified as Part of the Bid Process. Additionally, when PBMs submitted two bids, repriced claims were the same for the traditional bid and the transparent bid, meaning the amount the PBM charges the plan for the prescription cost is the same under both proposed contracts. As a result, PEHP had no evidence to show how spread pricing would negatively impact costs to the plan. However, as discussed in Chapter II, spread pricing is not necessarily a large risk for plans.

PBMs guarantee a certain percentage discount from the average wholesale price.

PEHP Should Negotiate for Stricter Requirements for Discount Guarantees. The finalists who submitted two bids, vendors A and D, offered larger discount guarantees in their traditional bid than in their transparent bid. PBMs guarantee a certain percentage discount from the average wholesale price for each type of drug: brand, generic, and specialty. This guarantee is calculated at the aggregate level for a year's worth of claims.

In the current contract, ESI pays PEHP the difference if they do not achieve the discount guarantee. However, if ESI fails to meet the guaranteed discount for one category, the company can use overages from another category to offset the amount owed to PEHP. Figure 3.3 shows how this favors ESI.

Figure 3.3 Discount Guarantees for 2017 and 2018. ESI did not meet the guarantee for generic drugs but used better performance on brand drugs to reduce the amount owed to PEHP by millions of dollars over two years.

	2017	2018
Retail Brand	$ 1.30 million	$ 3.72 million
Retail Generic	$-1.35 million	$-4.16 million
Amount Owed to PEHP	**$-50,000**	**$-440,000**

Source: ESI Settlement Reports

As shown in the table, the discount guarantees can be improved by removing ESI's ability to offset a category's shortfall with a different category's overage. We recommend PEHP negotiate with its PBM during the next contracting cycle to hold the PBM accountable to the guarantee for each category.

Pharmacy Costs Are Increasing Despite PEHP's Proactive Efforts

Pharmacy costs per member after rebates increased 8 percent from calendar year 2014 to calendar year 2018 despite PEHP's efforts to lower costs. PEHP's control over its formulary is central to cost-reduction efforts because it incentivizes members to use generics over brands. When expensive drugs are used, prior authorization from PEHP staff is required before the prescription can be filled. PEHP also requires specialty drugs to be filled through ESI's specialty mail-order pharmacy. Our review showed that PEHP has been proactive in addressing utilization to control costs.

However, prices of prescription drugs continue to rise. Specialty drugs in particular are driving up total costs for PEHP. Increases in drug prices are outpacing increases in rebate payments, causing an overall upward trend in PEHP's spending on prescription drugs. As discussed in Chapter II, drug prices are arbitrarily set by manufacturers with involvement from PBMs. As a result, rising drug prices are not a singular indicator for a plan's performance, but they do highlight the financial implications of the relationship between manufacturers, PBMs, and health plans and the constant state of increasing costs in the healthcare system. We recommend that PEHP aggressively negotiate with its PBM to obtain more information about the pricing and rebates of its drugs. Further, as recommended in Chapter II, the Legislature can play a role in requiring more transparency.

PEHP Aggressively Promotes Cost-Effective Strategies

As part of its strategy to control costs, PEHP has maintained control of many functions that PBMs offer. Figure 3.4 outlines the tools PEHP uses to reduce costs while ensuring effective drugs are available to members.

PEHP's strategy to control costs includes internal control of many pharmacy benefit functions.

Figure 3.4 Cost-Management Strategies. PEHP promotes the use of low-cost, effective drugs over expensive brand drugs.

PEHP has a custom formulary instead of ESI's National Preferred Formulary.

As shown above, PEHP maintains a custom formulary for its members in contrast to many commercial plans that opt to follow ESI's National Preferred Formulary. PEHP focuses on low-cost drugs rather than prioritizing branded drugs with the highest rebates. As soon as generics are available, PEHP replaces the brand drug with the generic to keep costs down.

Use of ESI's specialty pharmacy results in better discount guarantees on specialty drugs.

Prior authorization applies for many expensive specialty medications. As part of this process, PEHP puts quantity limits on some drugs. Specialty medications must usually be filled through ESI's specialty pharmacy, Accredo. For this exclusivity, PEHP receives better discount guarantees on specialty drugs. Despite PEHP's efforts to provide additional oversight when expensive medications are used, costs continue to rise.

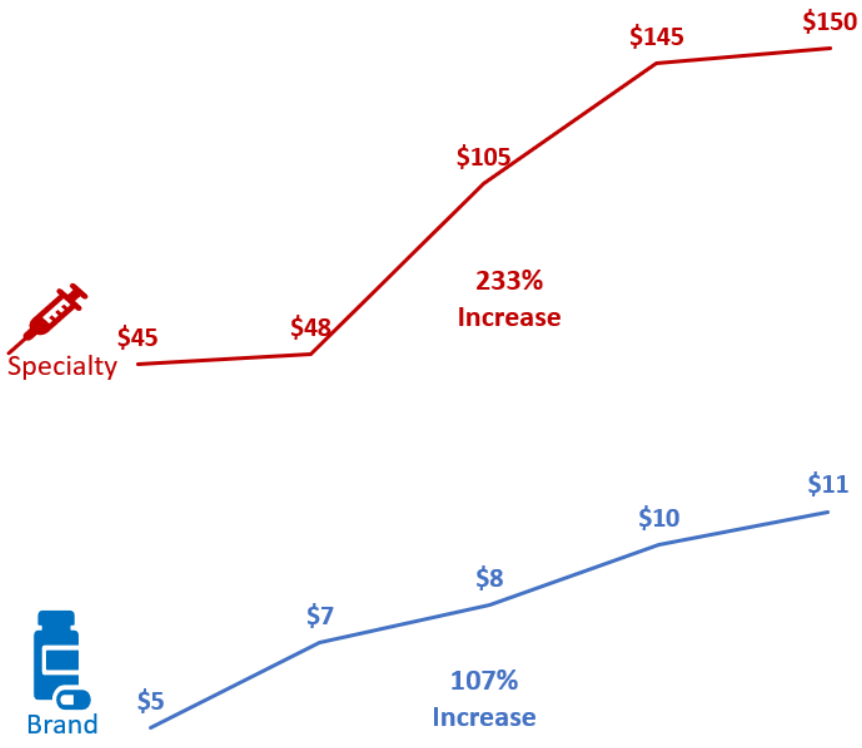
Prices of Brand and Specialty Drugs Continue to Increase, Driving Up PEHP's Prescription Spending

As a result of PEHP's strategy of preferring generic and low-cost drugs over expensive brands, the number of brand prescriptions decreased from calendar year 2014 through calendar year 2018, and brand prescriptions as a percentage of total prescriptions decreased

from 13 percent to 11 percent. However, brand drugs (including specialty brands) have increased from 66 percent of total cost in 2014 to 74 percent in 2018. The average price per unit for brand and specialty drugs combined was $7.80 in 2014 and $17.98 in 2018, an increase of 131 percent. This trend resulted from increases on brand and specialty drugs, not usage. Figure 3.5 shows how the average price per unit before rebates has risen.

The average price per unit for brand and specialty drugs increased by 131 percent from 2014 to 2018.

Figure 3.5 Average Price Per Unit for Brand and Specialty Drugs Before Rebates. Specialty drugs represented less than 1 percent of all prescriptions but accounted for 40 percent of brand costs from 2014 through 2018.



Source: PEHP Claims Data

The high price per unit of specialty drugs is a major driver of costs despite low utilization. Prices shown here do not include rebates. However, as shown in the next section, despite rebates, brand costs are still increasing considerably.

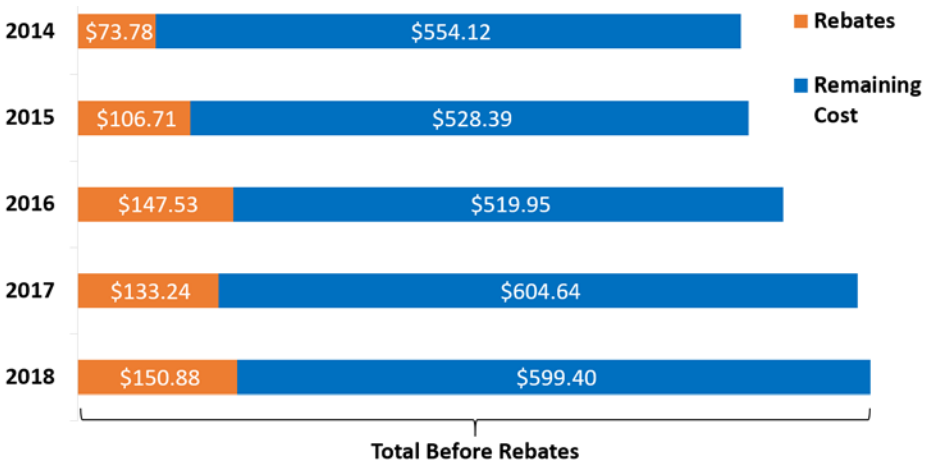
The high price per unit of specialty drugs is a major driver of costs.

Rebates Are Not Reducing Prescription Costs

Our on-site audit of nine manufacturer contracts and rebate amounts found that PEHP's average rebate amount per prescription

increased by 26 percent from 2016 to 2017. Despite this increase in rebates, net costs still increased by 8 percent during that time. Figure 3.6 shows how rebates impact PEHP's spending on brand prescriptions by taking the aggregate amount spent on pharmacy and dividing by the number of plan members.

Figure 3.6 Average Rebate Per Member Compared to Total Cost. The average annual rebate per member has increased by $77 since 2014, but average cost per member after rebates still rose by $45 during that time. This equates to $3.77 per member per month.



Source: PEHP

Although rebates increased by 105 percent from 2014-2018, the increase was not enough to prevent net costs from rising by 8 percent. The rising costs of brand drugs is outside of PEHP's ability to control, but PEHP can continue to aggressively negotiate with ESI to counteract rising costs by increasing discounts and rebates.

Legislative Intervention May Be Necessary to Require ESI to Provide Claim-Level Rebate Information

ESI credits rebate payments to PEHP four to five months after the end of the quarter. The credits indicate which risk pool (for example, State of Utah or Canyons School District) generated the rebate and show the total amount for the quarter, but do not include information on which drugs generated a rebate or how the rebates were calculated. PEHP uses rebate payments to lower members' premiums and does not retain any part of the rebate for operations.

PEHP uses rebate payments to lower members' premiums.

We found that ESI does not allow PEHP access to claim-level rebate information through regular reporting or auditing. While we verified that ESI passed through 100 percent of rebate payments from manufacturers in 2016 and 2017, PEHP cannot verify this data for itself due to ESI's protocols which require a third-party, on-site audit. We found that, in addition to better oversight, improved access to claim-level rebate information can help PEHP identify opportunities for negotiation. Although PEHP should try to negotiate access to its rebate data, we believe legislative action may be necessary before PBMs will share this information with their clients.

We verified that ESI passed through 100 percent of rebate payments to PEHP as the contract requires.

ESI Does Not Allow PEHP Access to Claim-Level Rebate Data

Our review found that PEHP receives insufficient data on rebates from ESI, preventing PEHP from understanding rebates on a claim level. PEHP is unable to directly access claim-level rebate data to assess whether all eligible rebates are being applied pursuant to the contract with ESI. As mentioned in Chapter II, at the expense of the Legislative Auditor's office, we visited ESI in St. Louis. Only at that time could it be verified that PEHP has received 100 percent of rebates paid by the manufacturer.

PEHP cannot access the information we analyzed during our audit of rebates at ESI.

PEHP has developed their formulary to focus on drugs with the overall lowest cost to the plan, not on obtaining the highest possible rebates. Because of its custom formulary, PEHP receives lower rebates for many drugs compared to the rebate available to plans that use ESI's national formulary. Some brand drugs that are used by PEHP receive no rebates, despite the fact that the manufacturer pays them to some health care plans. PEHP is able to submit scenarios to ESI to determine how total rebates for a class of drugs are affected by formulary decisions but cannot simply look up the rebate for a drug or see formulary requirements that ESI places on it to make it rebate-eligible.

We found that ESI passes 100 percent of rebate and administrative fee payments from manufacturers through to PEHP. Medicaid managed care contracts we reviewed did not always entitle the health plans to 100 percent of rebates and did not include administrative fees paid by the manufacturer to the PBM. While ESI provided general causes for the variance between amounts submitted to the manufacturers and actual payment received, we were not able to see which claims the manufacturer accepted or rejected. For example, one

PEHP receives lower rebates for many drugs compared to other commercial plans because its formulary focuses on lowest overall cost instead of maximum rebates.

manufacturer rejected claims filled at pharmacies they considered ineligible. While ESI was able to supply this explanation for a large variance with one manufacturer, we could not identify the individual claims affected by ineligible pharmacies.

PEHP Has Conducted Minimal Auditing of ESI

PEHP would benefit from a contract change allowing PEHP staff to perform an on-site audit instead of requiring a CPA to conduct a rebate audit.

PEHP reports they have never conducted an on-site rebate audit of ESI because of the generally good performance of its PBM. The current contract stipulates that PEHP may not see manufacturer contracts themselves but must instead hire a CPA from a top 100 accounting firm to perform a rebate audit, adding to the expense of an on-site audit. Without claim-level data, this limitation prevents PEHP from fully understanding how rebates are structured and lessens the value of an audit. Based on our experience in St. Louis, a contract change allowing PEHP staff to perform an on-site audit would be very beneficial.

Despite the current limitation on rebate audits, PEHP's contract allows them to conduct other types of audits without going to ESI or hiring an auditor. For example, PEHP audits discount guarantees annually. This type of audit involves analysis of average wholesale price discounts and dispensing fees to ensure that discount guarantees are met. PEHP could also conduct benefits plan audits to ensure members are not overcharged according to the specific plan they have through PEHP. Currently, PEHP has a member benefit verification process to ensure pharmacy and medical claims adjudicate properly, but an audit of adjudicated claims would enhance their oversight. In addition to regular monitoring activities, improvements can be made to the contract's rebate terms, as discussed in the next section.

Legislative Action to Require Rebate Transparency Would Bolster PEHP's Efforts to Negotiate Better Contract Terms

PEHP would benefit from having access to information showing which claims generated a rebate payment.

The Legislature can consider requiring PBMs to share claim-level rebate information with their clients. This action would help PEHP obtain increased rebate transparency. Thus far, PEHP has negotiated with limited success for PEHP to perform an on-site audits and access claim-level rebate data. Access could be done through secure online methods, rather than requiring on-site visits to the PBM. During our audit in St. Louis, we verified that ESI electronically provides transactional rebate data to manufacturers, thus they have the capability to provide the same information to PEHP. Access to

information showing which claims generated a payment from a manufacturer would give PEHP the ability to assess brand drug rebates on their formulary and hold ESI accountable without undue expense. In lieu of legislative action, PEHP could prioritize gaining this access in the next contract negotiation.

PEHP Can Negotiate Directly with Manufacturers, but ESI Still Controls the Flow of Information. PEHP negotiated for the ability to contract directly with manufacturers for rebates and has successfully done so with one manufacturer. Unlike rebate credits handled by ESI, rebate payments and reports from this manufacturer give PEHP detailed information for each claim. The reports include rebate percentages and amounts for each claim and indicate if it was ineligible under the rebate agreement.

Direct contracting with one manufacturer has resulted in detailed, claim-level rebate information.

PEHP's current contract gives ESI the right to match any offer made by a manufacturer to PEHP within 30 days. In most cases, ESI does match the manufacturer's offer, resulting in a higher rebate for PEHP. Because ESI continues to process the rebates when they match a manufacturer's offer, PEHP receives no claim-level information. Removing the ability of ESI to match manufacturers' offers is currently a priority for PEHP as it would give them more control over the rebate process. The current lack of information on which claims receive rebates and the amount of the rebate leaves PEHP at a disadvantage when negotiating with manufacturers. Without knowing the amount of the rebate ESI has already negotiated, PEHP does not know what rebate to request from the manufacturer. As discussed in Chapter II, pricing and rebate amounts are closely held by manufacturers and PBMs, allowing these entities to exert control over health plans and their members. However, if PEHP were able to access claim-level rebate information from ESI, the right to match would no longer have a negative impact and some control would be restored to the plan.

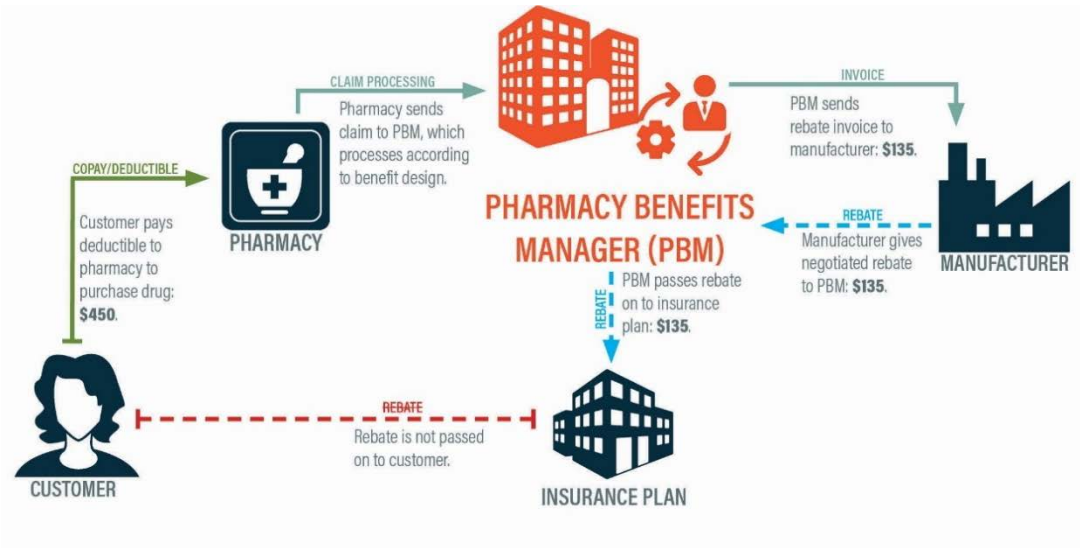
The current contract gives ESI 30 days to match any rebate offer made by a manufacturer to PEHP.

Point-of-Sale Rebates Would Reduce Member Costs, but ESI Has Been Unwilling to Meet PEHP's Request. PEHP reports it would prefer rebates be provided to members at the point of sale and allocated to individual members based on the portion of the bill paid by the member. Current point-of-sale rebates offered by ESI do not accommodate this request. Since ESI's program does not coordinate with PEHP's cost sharing, making rebates available at the point of sale would have a significant cost impact on the state. Figure 3.7 shows

PEHP would prefer to have rebates processed at the point of sale.

how the current system for rebates fails to directly benefit members using expensive drugs.

Figure 3.7 Current Rebate Process. Members on high deductible plans often pay full price for expensive drugs but only indirectly benefit from rebates.



Icons by Freepik and Gregory Cresnar via FlatIcon.com

PEHP has requested point-of-sale rebates allocated based on normal cost sharing with ESI in the past but has not been successful. Manufacturer contracts we reviewed in St. Louis included point-of-sale rebates on certain drugs for other health plans, but we did not see point-of-sale rebates allocated based on cost sharing. However, ESI reports it is currently discussing possible custom development options for point-of-sale rebates with PEHP.

Many of the eligibility criteria for rebates are set by manufacturers.

ESI Excludes All Claims from 340B[4] Pharmacies When Calculating Rebates, Although Not All Manufacturers Require Such Exclusions. PEHP should negotiate to reduce rebate restrictions in its next contract cycle. We found that many brand and specialty claims are not rebate eligible. While many of the eligibility criteria are set by the manufacturers, we identified other exclusions from generating a rebate that could also be negotiated in future contracts.

[4] According to the American Hospital Association, "Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients."

In addition, our on-site review of rebates found that claims from 340B pharmacies represent an opportunity for negotiation.

Currently, PEHP's contract with ESI excludes all claims from 340B pharmacies, but our review of rebated claims at ESI showed that some manufacturers determine eligibility by whether or not the claim was purchased at 340B pricing, allowing claims that did not receive the 340B discount to qualify for rebates when filled at 340B pharmacies. In 2018, of the 25,887 prescriptions filled at a large 340B pharmacy network in Utah, 5 percent were brand drugs that did not receive a 340B discount. Some of these would be eligible for rebates if PEHP successfully renegotiated its contract.

Additional claims could generate a rebate if the 340B restriction was adjusted.

Our audit found that PEHP's oversight of ESI has been limited because of contractual restraints common to PBM contracts. Although PEHP's small size leaves it at a disadvantage when negotiating contract terms with ESI, we identified areas we believe they should target in future contract cycles.

Recommendations

1. We recommend that Public Employees Health Program conduct rebate audits and benefit plan audits in addition to its current auditing activities.

2. We recommend that the Legislature consider requiring pharmacy benefit managers to provide their clients access to detailed, claim-level rebate information.

3. We recommend that for Public Employees Health Program to maximize its cost-efficiency, it should continue to aggressively negotiate with Express Scripts to improve contract terms, claim-level rebate transparency, and discount guarantees.

Agency Response

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December 3, 2019

Utah State Legislative Audit Committee

Dear Committee Members:

PEHP Health & Benefits (PEHP) appreciates the opportunity to submit our response to the Auditor General's Report No. 2019-13: **A Performance Audit of PEHP's Pharmacy Benefit Manager.**

We understand the importance of this Audit Report to the Committee as a matter of oversight and public policy, and very much appreciate the hard work and professionalism of the Auditor General in producing it. As the Report explains, the central role of Pharmacy Benefit Managers (PBM) in the healthcare ecosystem is not widely understood or appreciated. In general, the PBM industry operates on principles that discourage full transparency, leading to challenges that no one entity can adequately address. We appreciate the Auditor General's understanding of these issues and the recommendations it has accordingly made.

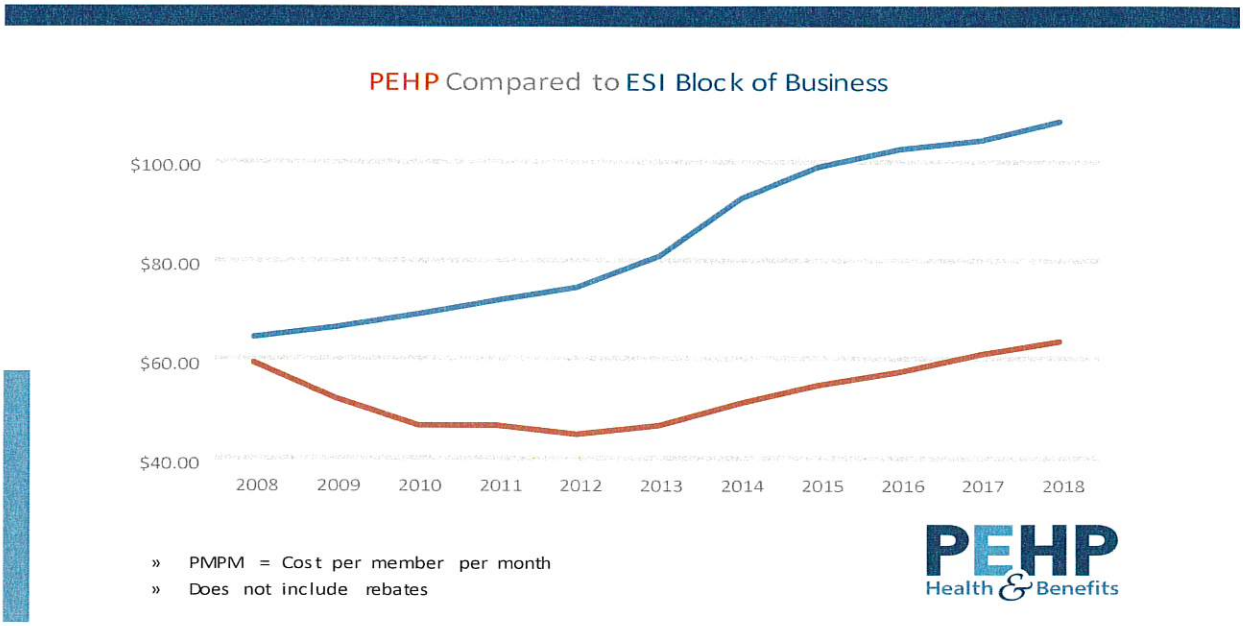
At PEHP, we take seriously our charge of providing the state and other public entities with health benefits "in the most efficient and economical manner." Utah Code Ann. §49-20-105(1).

Like other health plans, PEHP contracts with a PBM (Express Scripts (ESI)) to give our members convenient access to prescription drugs on a discounted basis. As such, we rely on ESI to secure the best possible terms with drug manufacturers for the drugs we cover and to make those drugs available to PEHP members through a broad network of contracted pharmacies. However, unlike many health plans, PEHP does not rely on ESI in deciding which drugs to cover and how to cover them. Instead, PEHP has adopted an inhouse pharmacy management program for independently determining the drugs to cover, the payment tier to apply, and the clinical policies to adopt for things like prior authorization and step therapy.

The overarching objective of PEHP's program is to optimize drug efficacy and costs. PEHP's pharmacists and physicians review medical literature, assess alternatives, and weigh relative costs in conjunction with a local panel of medical experts in deciding what to cover and how. PEHP's formulary of covered drugs encourages low-cost generic drugs when possible, while maximizing rebates for brand name drugs when that is the best choice. We never put rebates above total costs. An equally efficacious generic drug for $10 will always be a better option than a $200 brand name drug that still costs $100 after a $100 rebate.

We believe that the success of PEHP's inhouse pharmacy management program is demonstrated in the graph below, which shows how PEHP's drug spend on a per member per month basis (PMPM) improved immediately with the adoption of our program as compared with ESI's block of business. Today, PEHP's PMPM before rebates is in the low $60s, which is roughly equivalent to what PEHP paid on a PMPM basis in 2008 before implementing our program. This compares favorably to ESI's current average PMPM of almost $110. Adding rebates to the mix does not materially change this ratio.

Financial Impact of Inhouse Pharmacy Program



We further believe that certain findings within the Audit Report support the success of our inhouse pharmacy management program. For example:

- Traditional contracts have been the best option for PEHP to obtain the lowest possible costs for the state.

- PEHP is receiving 100% of eligible rebates under the contract terms we have negotiated, in contrast to some recent high-profile examples in other states.

- PEHP's cost reduction strategies have been effective in limiting pharmacy increases to a total of 8% over the five-year period of the audit (or 1.6% a year), notwithstanding significant cost pressures from expensive specialty drugs and the failure of rebates to keep pace with rising prices for brand name drugs. This, importantly, has not been accomplished through reductions in plan design. To the contrary, the pharmacy benefit has been enhanced by removing the pharmacy deductible for the Traditional Plan and adding coverage for preventative drugs before the deductible for the STAR HSA Plan.

We recognize that more can be done and appreciate the recommendations of the Auditor General in helping us to achieve that as follows:

1. ***For PEHP to conduct rebate audits and benefit plan audits in addition to current auditing activities.***

   PEHP response: PEHP accepts and supports the auditor's recommendation. PEHP currently has the contractual right to request an onsite rebate audit using an independent auditor to verify ESI's handling and distribution of rebates. While we've adopted internal processes to assess contractual compliance, we have yet to exercise our right to an onsite rebate audit. We agree with the Auditor General that this should be done regularly. As part of the next contract cycle, we will seek the ability

to perform onsite audits ourselves. We are also in agreement that we can improve on current auditing activities.

2. ***For PEHP to maximize its cost-efficiency, it should continue to aggressively negotiate with ESI to improve contract terms, claim-level rebate transparency, and discount guarantees***.

PEHP response: PEHP accepts and supports the auditor's recommendation. We believe that the Audit Report has identified areas in which we can and should seek to strengthen our contract terms. For example, PEHP should:

- Ensure that we receive either 340b pricing or the normal rebate for drugs purchased through a 340b pharmacy
- Continue to push for claim-level rebate transparency
- Ask PBMs to submit Transparent bids on cost-neutral terms with Traditional bids
- Seek the ability to contract directly with drug manufacturers without providing a first-right of refusal
- Emphasize our desire for point-of-sale rebates that reflect the proportionate cost sharing responsibilities of the member and the plan for a pharmacy claim
- Seek to perform onsite audits ourselves

We are grateful for the opportunity to serve the state, we invite input on how we can do this better, and we appreciate the work of the Committee and the Auditor General in connection with this Report. Please let us know if there is anything further we can do to be of assistance on this or any other matter.

Sincerely,

R. Chet Loftis
Managing Director
PEHP Health & Benefits