Report to
Commission on Government Forecasting
and Accountability

Potential for Savings on Pharmacy Benefit Management Costs

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Introduction

Our firm, Winkelman Management Consulting [WMC] has been engaged by the Illinois Commission on Government Forecasting and Accountability [The Commission] to examine the ways in which the various Illinois Agencies obtain pharmacy benefit management services for eligible recipients. In particular, the Commission asked us to examine the potential for the State to become its own Pharmacy Benefits Administrator [PBA]. This report details our analysis and suggestions.

Executive Summary

Three major Illinois State Agencies account for most of the State's expenditure for Pharmacy Benefits. These are, in order of spending:

- The Medicaid Program [Department of Healthcare and Family Services (DHFS)], which spends over $1.6 Billion per year;
- The Department of Central Management Services [CMS], which spends over $320 million;
- The State Prison System [Department of Corrections (DOC)], which spends about $17 million.

There is a huge potential for the State to achieve savings through better administration of these benefits, as described in this table:

State Program	**Medicaid***	**State Employee Rx Benefits***	**Prison System***
Annual Expenditure	$1.6 Billion	$320 Million	$17 million
Savings Potential	$142 Million	$10 Million	$6 million
Savings percent	7.8%	3.1%	36%
Methodology	Reduce reimbursement rates for Medicaid, to match those paid for State employee Rx benefits.	State becomes its own Pharmacy Benefits Administrator [PBA].	Obtain drugs for prisoners at 340B prices.

The annual savings would be nearly $160 million per year, or about 7.4% percent of total spending.

*** All of these calculations are based on data provided by these agencies, pursuant to a questionnaire prepared by WMC.**

Background

Drug benefit management is complex and difficult to understand. The materials below are intended to help clarify this confusing area.

Drug Costs

Prescription costs are increasing by more than 12% every year. At this rate, they will double every six years. These increases are caused by three primary factors. Pure inflation is the easiest to understand. Drug manufacturers routinely raise their prices. But this accounts for a rather small portion of the total. The two primary drivers are the introduction of new drugs and increased utilization.

While the drug manufacturing industry is incredibly profitable, and many of their marketing and promotional practices are questionable, they deserve accolades for the wonderful new drugs that have been introduced over the last several years. But these new drugs are very costly. In the past few years the average cost of a prescription has risen to over $60, and many prescriptions now cost several hundred dollars.

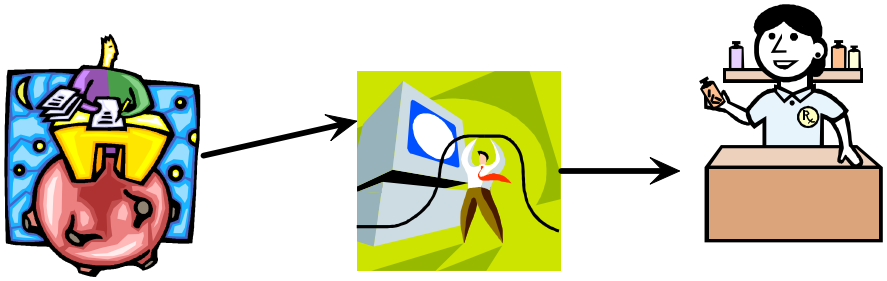
Utilization is also on the rise. Today, the average American will get about twelve prescriptions every year. A few years ago, we used only eight Rxs yearly. This increase in utilization is occurring for a number of reasons:

- Our population is aging, and older people simply need more medicines.
- Therapies are now available that did not exist a generation ago. Consider such drugs as Prozac and the other drugs in its class: The Selective Serotonin Reuptake Inhibitors (SSRIs); or Fosamax for osteoporosis.
- Direct to Consumer advertising of prescription drugs (DTC) has had a profound – and not necessarily good – effect on drug utilization. Drug firms are spending millions to promote their drugs directly to end users. Prescribers generally succumb to pressures from patients, who want the drugs they learn about on television.

The Growth of the PBM Industry

Most health plan sponsors – employers, HMOs, state governments and others – provide a prescription benefit as part of overall health insurance coverage. Because of the increasing size and complexity of pharmacy benefits, most plan sponsors contract with companies known as Pharmacy Benefit Managers (PBMs) to administer the process for them.

PBMs are third-party administrators of prescription drug benefits. They handle such administrative tasks as collecting funds from health plan sponsors and using those funds to pay providers; processing claims; answering questions posed by pharmacists, doctors and health plan participants; and negotiating with drug companies. They operate mail-order pharmacies which they force an increasing number of plan participants to use. PBMs have become a dominant, rapidly growing force in the pharmacy industry.



Health Plan Sponsors **PBM** **Pharmacies**

Three PBMs control about half of America's prescription drug transactions: Medco, Express Scripts and Caremark. They have become a lightning rod for controversy, and have been subject to scrutiny on a number of issues, including:

- **Sidestepping their fiduciary responsibility**

PBMs actively resist the acceptance of their role as fiduciaries in managing prescription benefits. Yet private health plan sponsors do have this duty and many industry experts, including this writer, believe that, since PBMs manage funds for their health plan sponsors, have discretion in how these funds are spent, and meet other similar standards, they are fiduciaries by default, no matter what they claim. This matter is the subject of a number of lawsuits.

- **Price Spread**

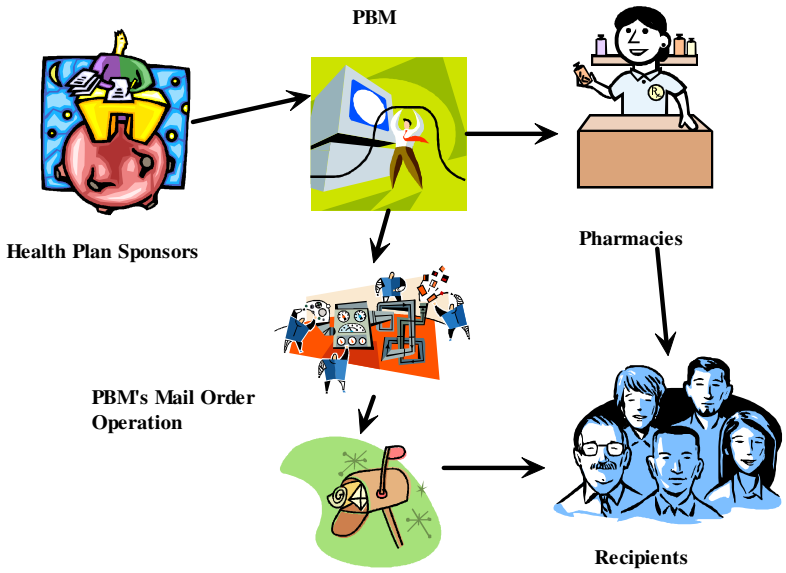
PBMs employ a number of questionable practices to maximize their profits. One of the most egregious is their tactic of reimbursing pharmacy providers at one rate, then charging the health plan sponsor a higher rate. This difference is not fully disclosed and is often far more than the PBM's administration fee. It is important for the reader to understand that such practices would be precluded were the PBM to be obliged to act as a fiduciary.

- **Rebate retention**

PBMs create formularies, which are intended to favor one drug over another. The principle motivation is to persuade the drug manufacturer to pay rebates for the right to have its drug so favored. PBMs then negotiate the share of these rebates with their clients. But PBMs have become adept at finding cute, hidden tricks to keep an inordinate share of these rebates. These techniques include disguising the rebates as administrative fees and the like. Moreover, PBMs have been sanctioned for putting drugs on the health plan's formulary for the primary purpose of enriching themselves, while actually adding cost to the drug benefit.

PBMs represent themselves as prudent managers of drug benefits, but prescription drug benefit costs continue to rise. At the same time, the major PBMs enjoy robust profits. Their business model yields incredibly high margins, all too often at the expense of their customers, their recipients and their pharmacy providers.

- **Mail order pharmacy**



PBMs learned that by operating mail order pharmacies [MOPs], they could become both managers and providers. This lets them skew benefit design and pricing in ways that maximize profits. *Nowhere else in health care is the benefits manager also allowed to be a provider.*

All large PBMs own and run MOPs, which have become vital profit centers that account for about 20 percent of all retail prescription sales in the United States. PBMs have convinced their customers that MOPs can achieve significant savings through automation.

The growth of the PBM mail-order business is remarkable since they can fill only prescriptions for what are called "maintenance" drugs taken for chronic conditions. Because there is typically a two-week turnaround between order submission and receipt of shipment, prescriptions for antibiotics and other acute care drugs can be filled only by community pharmacies.

By being both manager and provider, PBMs find ways to promote themselves and maximize profits. Typically, they design the payment system so that plan sponsors often experience higher unit drug costs by mail than from the community pharmacies. As an example, our firm recently studied the mail order rates for Medco, the nations largest PBM.

We found that, while Medco's mail order rates for brand name drugs were extremely low, below cost in some cases, their generic costs were much higher

than the same drugs would have cost at the neighborhood drug store. As the study proves, when these costs are arrayed against a 'market basket' of actual drug usage, the aggregate mail order rate is actually higher than if all of those drugs were obtained at the local drug store. It is also worthwhile to note that PBMs compel retail providers to accept much lower reimbursement rates for generics than the PBMs pay themselves when these drugs are dispensed at their captive mail order pharmacies.

Frankly, this is not too surprising. It must be understood that, under federal marketing guidelines, mail order pharmacies are in the same class of trade as the local drug stores and therefore have no purchasing advantage. In fact the largest drug chains such as Walgreen and CVS actually purchase more drugs than the mail order pharmacies.

MOPs are regulated by almost all states, but interstate commerce laws leave the state powerless to stop mail order pharmacies located elsewhere from shipping drugs into the state. To be sure, virtually all states have promulgated regulations to provide them with some oversight of the out-of-state mail order operators.

- **Medicaid Rx Benefits**

There are also a few PBM-like organizations that specialize in managing Medicaid Rx benefits. But many states, including Illinois, have concluded that they can manage these benefits internally.

- **PBM Practices**

The PBMs have been severely criticized for the opacity of their business practices. This criticism has fostered two important initiatives. First, many states, including Illinois, are considering legislation to force these PBMs to operate on a more transparent basis, and to allow community pharmacies to compete for the maintenance drug prescriptions.

Secondly, a number of consortia have come together in an attempt to aggregate their buying power to lower rates. WMC managed two such consortia for public sector health plan sponsors that achieved considerable savings through their combined efforts.

The first was in New England, where a group of states combined to recruit a PBM to manage Medicaid drug benefits. The second, a coalition of several states, was organized by the West Virginia Public Employees Insurance Agency [PEIA] to negotiate for prescription benefits for state employees. This effort produced a very competitive arrangement with a large PBM, resulting in millions of dollars of savings.

Pharmacy Benefit Administration Basics

While PBMs encourage the notion that managing these benefits is complex, there are actually less than a dozen basic elements:

- Plan design and implementation;
- Network development and maintenance;
- Claims processing and payment to providers;
- Reporting and analysis;
- Recipient and Provider support;
- Formulary and rebate management;
- Drug Utilization Review [DUR];
- Clinical Management;
- ID Cards and enrollment processing;
- Auditing;
- Prior Authorization [PA] management.

Moreover, as described herein, virtually all of these can be outsourced and, in fact, many smaller and successful PBMs do exactly that.

The Potential Savings

Medicaid

Illinois Medicaid pays more per claim than do commercial PBMs. Here is a comparison of the reimbursement rates per claim, for Illinois Medicaid as compared with rates from the PBM that manages the Rx benefit for State Employees. The calculation includes the annualized saving that would be achieved if the State Medicaid program lowered its reimbursement rates to those paid by the PBM.

COST ELEMENT	PBM	DHFS	SAVINGS PER CLAIM	ANNUAL SAVINGS
Discount off Average Wholesale Price [AWP] for Brand Drugs	15%	12%	$3.40	$ 45 million
Brand Drug Dispensing fee	$1.50	$3.40	$1.90	$ 25 million
Generic Drug Dispensing fee	$1.50	$4.60	$3.10	$72 million
Total Annual Savings				**$142 million**

Please note that the math in the table above is based on the State's *excellent 64% generic utilization* for the Medicaid program. Also note that both the PBM and Medicaid use a similar metric for pricing generic drugs, which is called Maximum Allowable Cost [MAC], so there is little or no savings potential for the State through use of the PBM's generic reimbursement rate to providers.

So, if the State simply reduced the rates it pays pharmacies for Medicaid claims, the savings would exceed $140 million per year, or about 7% of total costs. A detailed analysis follows.

Program Name	DHFS		
ASSUMPTIONS			
Covered Lives	2,400,000		
Annual cost	$ 1,800,000,000		
CLAIM VOLUME			
MONTHLY CLAIMS	3,033,333		
MONTHLY COST	$ 150,000,000		
AVERAGE COST	$ 49.45		
(LESS REBATES PER CLAIM)	$ (11.87)	24%	
NET PER CLAIM COST	$ 37.58		
COST ELEMENTS			
	MEDICAID	**PBM**	
Discount from AWP for Brand Claims	12%	15%	
Brand Dispensing Fee	$ 3.40	$ 1.50	
Generic Cost Basis, as PCT AWP	46%	46%	
Pricing rule for non-MAC generics, as pct AWP	25%	25%	
Generic Dispensing fee	$ 4.60	$ 1.50	
UTILIZATION			
PERCENTAGE OF CLAIMS FILLED WITH GENERICS	64%		
PERCENTAGE OF CLAIMS FILLED WITH FORMULARY DRUGS	95%		
ESTIMATE OF CURRENT MONTHLY COSTS AND BREAKDOWN			
	BRAND	**GENERIC**	**TOTAL**
AVERAGE AWP	$ 113.50	$ 30.00	
AVERAGE COST TO MEDICAID	$ 99.88	$ 16.20	
DISPENSING FEES	$ 3.40	$ 4.60	
{LESS COPAYMENT)	$ (1.00)	$ (1.00)	
	$ 102.28	$ 19.80	
CLAIMS	1,092,000	1,941,333	
MONTHLY COST	$ 111,689,760	$ 38,438,400	$ 150,128,160
ESTIMATED OF COSTS IF PRICED AT PBM RATES			
AVERAGE AWP	$ 113.50	$ 30.00	
AVERAGE COST AT PBM RATE	$ 96.48	$ 16.20	
DISPENSING FEES	$ 1.50	$ 1.50	
{LESS COPAYMENT)	$ (1.00)	$ (1.00)	
	$ 96.98	$ 16.70	
CLAIMS	1,092,000	1,941,333	
MONTHLY COST	$ 105,896,700	$ 32,420,267	$ 138,316,967
SAVINGS			**$ 11,811,193**
ANNUAL SAVINGS			**$ 141,734,320**

But WMC readily admits that this logic is too facile and is incomplete. Medicaid, historically, has always had a higher reimbursement methodology, for a number of reasons:

- Many, but not all Medicaid pharmacy providers operate in marginal locations, and might not be able to remain in business were they forced to accept the lower rates.
- Medicaid recipients often decline to pay the required copayment. When that happens, the pharmacy must nevertheless dispense the medicine, and absorb the resultant loss.
- PBMs pay their bills on time – and the State doesn't. When a claim is adjudicated by the PBM, there is a virtual guarantee that the claim will be paid in full within two or three weeks. By comparison, state Medicaid programs often are unable to pay claims on a timely basis. Unfortunately, Illinois has a long history of slow payments to Medicaid providers, which creates a huge financial problem for them. Accordingly, WMC believes that the State could not match or approach the PBM rates until the cash flow problem is solved.

It is also important to recognize the impact of the Federal Medicare Modernization Act [MMA], which took effect in January. There are now fewer Medicaid prescriptions, since Rx coverage for recipients for the dually eligible was transferred to the new Part D plans.

National statistics show that while these dually eligibles account for less than ten percent of the covered lives, they account for about forty percent of the claims. Many of these older people are on a number of maintenance medicines. It is not unusual for them to get as many as sixty separate prescriptions annually.

Importantly, when the dually eligibles were transferred to Medicare Part D, pharmacy providers accepted lower fees for those claims than are presently paid by Medicaid, since the Part D Plans are administered by PBMs at rates comparable to the CMS metrics. The State should consider how best to adjust to this new reality, mindful of the claw-back provision in MMA.

Also, the State should consider the impact of the reduction in claim volume under the Medicaid program. WMC estimates that DHFS will process twelve (12) million fewer claims annually now that prescription claims processing for the dually eligible has been assigned to the Part D Plans. WMC suggests that the State consider using this capacity to take over the processing of claims for State employees, which WMC estimates to be less than eight (8) million claims annually.

State Employees

The State recently concluded a procurement effort which led to the selection of Medco Health Solutions [Medco] to manage the prescription benefit for State employees and their covered dependents. The fee for that service is $2.81 per enrollee per month. In addition, Medco will receive supplemental revenue for specific services, as defined in the Agreement between the State and Medco:

Type of payment	Monthly revenue to Medco
Administrative fee of $2.81 per enrollee per month	$1,194,000
'Rational Med' fee of $0.28 per enrollee per month	$119,000
Drug Utilization Review for High Utilization of $.02 per claim	$2,500
Schedule C Health Education of $0.15 per enrollee per month	$4,000
Total Medco *Fee* Revenue per month	$1,387,000
Medco Net Revenue per enrollee per month	$3.27

It is instructive to overlay this revenue per enrollee with actual claim data to examine the PBM's revenue per claim, based on WMC's estimates:

Covered State Employee Lives	425,000
Monthly Retail Claims	589,000
Retail Claims per Enrollee per Month	1.38
Annual Program cost to State	$320 Million
Medco Revenue per retail claim*	$2.35
WMC Projected cost per claim through internal benefit administration	$1.00
Savings per claim	$1.35
Annual Savings	$9,700,000
Savings as percentage of program cost	3.1%

*** Almost all agreements between health plan sponsors such as The State of Illinois and PBMs provide for no administrative fee to the PBM for mail order claims, since the PBM operates its own mail order operation as a separate profit center. (See below.)**

WMC believes that an equivalent prescription benefit program could be arranged for much less per claim – perhaps under $1.00. By doing so, the State could save $1.35 per claim, or about $10 million per year.

As is explained below in more detail, these savings can be achieved if the State became its own Pharmacy Benefits Administrator [PBA]. Moreover, this could occur with little or no capital investment, by outsourcing some – or even all –

functions. By way of illustration, WMC contacted a large Illinois based Pharmacy Systems firm that provides claims processing and related services to a number of PBMs. We asked them for an estimate of the costs for outsourcing claims processing, reporting, audits, payments to providers and other related services. They believe this could be done in the range of $0.50 per claim.

The reader may well ask why this is so. The answer is simple.

- First of all, an internally managed PBA would have no marketing expenses, nor would it need to make a profit for shareholders.
- Moreover, as described above, PBMs have crafted a number of tactics to inflate their profits through such stratagems as price spread, rebate retention and the like.
- Obviously, the State would avoid all of these 'extras' and could therefore administer the benefit at lower costs.

In the course of our analysis we reviewed both the RFP for the PBM services for State employees and the subsequent agreement with the PBM. WMC believes that the State made a sub-optimal arrangement for these services; we offer the following comments:

1. Role of PBM as fiduciary

WMC believes that large health plan sponsors such as the State of Illinois should require that their PBM accept fiduciary responsibility for management of this benefit. While it is widely believed that PBMs are fiduciaries based on the role they play, the PBMs have largely been successful in avoiding that responsibility.

By requiring the PBM to act as a fiduciary, the health plan sponsor can assure that the PBMs interests are fully aligned with its own. Such a relationship will preclude the PBM from putting any other entity's goals ahead of the client's. This would prevent the PBM from engaging in a number of practices that increase costs to sponsors, such as price spread and formulary commitments to favor a single drug manufacturer.

WMC is aware that at least one state, Louisiana, recently concluded a PBM recruitment effort that required its PBM to accept fiduciary responsibility. It would be instructive to review that effort.

2. Despite agreeing to a fee per enrollee per month, Medco is still allowed to operate its own 'captive' mail order pharmacy as a separate profit center. Medco's mail service to State enrollees will be extremely profitable to them. Two examples:
    - Medco is not required to bill the State for mail order claims using the cost for the actual package size from which the drug was

dispensed. Rather, Medco is permitted to use the product number for the small size. [Typically the cost per dose is lower for the larger size; Medco is allowed to keep the difference.]

- Medco is allowed to bill the State for generics by mail at a discount off AWP of 57%. WMC estimates that Medco's cost is actually in the range of 85% off AWP. Again, Medco keeps the difference.

3. Despite agreeing to a fee per enrollee per month, Medco is still able to pay provider pharmacies at rates lower than it bills the State. When that happens, Medco pockets the difference. This 'price-spread' is described above.
4. The agreement specifies that Medco will audit its own mail order operations. This is quite extraordinary, in that Medco, in effect, is allowed to police itself. The contract should establish rules and requirements for outside audits.

WMC suggests that, even if the State does not move forward to become its own PBA, it would be worthwhile to review the current arrangement with the present vendor.

State penitentiary inmates

The State has an opportunity to obtain medicines for its penitentiary inmates at substantially lower prices by taking advantage of PHS or 340B pricing. The State of Texas has been doing this for several years, and other states are adopting this option.

The methodology is straightforward. It requires that the inmates become patients of a 340B covered entity. This can be achieved in several ways, but the simplest is to 'partner' with a hospital that has a disproportionate share (DSH) adjustment percentage, as determined under section 1886(d)(5)(F) of the Social Security Act, greater than 11.75 percent. There are a number of hospitals in Illinois that meet this standard.

WMC estimates that the State could save about $6 million annually through this approach:

Covered Lives	13,000
Annual Retail Claims	1.6 million
Annual cost to State for medicines for inmates	$16.7 Million
Average drug cost per Rx, based on purchasing at Wholesale Acquisition Cost [WAC] less 1.5%. This is equal to AWP – 22%	$10.42
Currently drugs are purchased at Average Wholesale Price [AWP] minus 22%. 340B costs are about AWP-50%. The difference per Rx is	$3.75
Annual Savings	$6 million
Savings Percentage	36%

To fully understand this cost savings opportunity, the reader must be familiar with 340B drug pricing, which is explained on the following page.

Description of 340B Drug Program

In 1992, Congress enacted Section 340B of the Public Health Service Act (PHSA). The Pharmacy Affairs Branch (PAB) in conjunction with the US Department of Health and Human Services (HHS) through the Health Resources and Services Administrations (HRSA) and Bureau of Primary Health Care (BPHC) administers the 340B discount program. This legislation was enacted to provide indigent populations greater access to medication by offering steep discounts for pharmaceuticals to the "covered entities" that serve these populations. If a grantee or hospital meets the qualifications specified for a covered entity, discounted drugs can then be purchased through a prime vendor who serves as the liaison with the wholesalers and/or manufacturers and is responsible for distribution to the 340B participating entities.

Participation Requirements

Under Section 340B, a covered entity includes facilities that participate in designated federal grant programs that serve people with specified illnesses and those belonging to designated populations. These entities include federally qualified health centers (FQHCs) as defined in section 1905(1) (2) (B) of the Social Security Act (SSA). FQHCs, city and county health departments, and other small facilities that do not have in-house pharmacy capability are allowed to utilize contract pharmacies. Section 340B identifies those entities that are eligible for 340B pricing and specific requirements for participation in the program. Covered entities include:

- FQHCs;
- health centers for residents of public housing;
- family planning service centers;
- early intervention services for HIV;
- other certified HIV health care service programs;
- state-operated AIDS drug assistance programs (ADAP);
- black lung clinics;
- hemophilia diagnostic treatment centers (HTC);
- certified state or local entities for the treatment of sexually transmitted diseases (STD) or tuberculosis;
- native Hawaiian health centers;
- urban Indian organizations;
- certain subsection hospitals that are: owned or operated by a unit of state or local government, are a public or private non-profit corporation that are formally granted governmental powers by a unit of state or local government, or is a private non-profit hospital that has a contract with a state or local

government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the Social Security Act [SSA] or eligible for assistance under the state plan under this title; has a **disproportionate share (DSH) adjustment percentage, as determined under section 1886(d)(5)(F) of the SSA, greater than 11.75 percent for the most recent cost reporting period that ended before the calendar quarter involved; and does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.**

The PAB has published final notice of guidelines on the definition of a patient to allow a clearer understanding of which individuals may receive prescribed medications purchased by 340B programs. "In summary, an individual is a 'patient' of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if:

- the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; and
- the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; and
- The individual receives a health care service or range of services from the covered entity, which is consistent with the service, or range of services for which grant funding or federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals (DSH) are exempt from this requirement.

The 340B legislation also mandates the following five additional requirements:

- A covered entity may not request payment under title XIX of the SSA for medical assistance with respect to a drug that is subject to an agreement under this section if the drug is subject to the payment of a rebate to the state under section 1927(a)(5)(C);
- The Secretary is responsible for ensuring compliance with this first additional requirement;
- A covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity;
- A covered entity shall permit the Secretary and the manufacturer of a covered outpatient drug that is subject to a 340B purchasing agreement with the entity to audit at the Secretary's expense the records of the entity that directly pertain to the entity's compliance with the requirements stated above;
- In the case of a covered entity within a distinct part of a hospital, the hospital shall not be considered a covered entity under this paragraph unless the hospital is otherwise a covered entity as defined above.

Section 340B also ensures that drug manufacturers who sell covered drugs to eligible entities that serve Medicaid populations must sign a pharmaceutical pricing agreement with the Secretary of HHS. In this agreement, the manufacturer agrees to charge a price for covered outpatient drugs that will not exceed the statutory ceiling price. The ceiling price is the Average Manufacturers' Price (AMP) reduced by a drug-specific discount.

The 340B discount is calculated using the Medicaid rebate formula and is deducted from the manufacturer's selling price rather than paid as a rebate. The covered entities are also authorized to negotiate sub-ceiling prices.

Additional 340B Related Cost Savings Opportunities

For the outpatient drugs that are available through the covered entity, the discounted pricing methodology is dependent on the type of entity (e.g., DSH or HTC) and the scope of each entity's grant funding. Therefore, the formulary for each covered entity is dependent on the population that is being served and/or the clinical focus of the program. **Section 340B also mandates that in billing Medicaid for drugs, "a Section 340B entity can bill no more than its actual acquisition cost (AAC), plus a reasonable dispensing fee established by the state Medicaid agency."**

WMC is aware of at least two states – Minnesota and Louisiana – that have taken advantage of this provision, to lower State Medicaid drug costs. In both cases, the States encourage 340B Covered Entities [CEs] such as Federally Qualified Health Centers [FQHCs] to fill prescriptions with 340B drugs for Medicaid fee-for-service patients, by paying them a dispensing fee premium. This is a win-win scenario. The State is able to obtain these drugs at 340B prices and avoids both the costs and delays associated with the OBRA 90 Medicaid rebate program, and the Covered Entity gets a higher dispensing fee, which aids them in fulfilling their mission as Safety Net Providers.

State Patient Assistance Programs [SPAPs]

The MMA will have a profound impact on the various State Patient Assistance Programs [SPAPs] such as "The Circuit Breaker" and "Illinois Rx Senior Care". They will be attenuated and some may be discontinued. Accordingly WMC has excluded them from this analysis. Should they remain, WMC simply suggests that reimbursement levels should be equal to those for Rx benefits for State employees and they should be administered under one agency.

The Potential for internal Pharmacy Benefit Administration

Value-added features

The State already manages the Medicaid drug benefit internally, and its volume is much larger than any of the other programs. To be sure, as detailed below, the DHFS may not have the full infrastructure and capability needed to take on the other State programs initially, but these services could readily be managed through outsourcing arrangements until – and if – the State decides to perform them internally.

The State has already begun an initiative to put all pharmacy benefits procurements under a single agency. WMC applauds this move and suggests that it be accelerated as quickly as possible. Doing so will yield a number of benefits to the State, including:

- More efficient network contracting

The current process is quite wasteful, in that a single Illinois pharmacy has multiple agreements with the State, at different rates, with different rules, and so forth. It would be much more efficient to have one contracting effort, with one database.

- Uniform pricing

As we have described, pharmacies get different reimbursement levels for the State programs. At a minimum, there should be one MAC list, managed by the appropriate State Agency. This would assure fair and equitable reimbursements.

- Formulary and rebates

The State already has a Pharmacy & Therapeutics Committee [P & T]. Its mission should be broadened so as to have only one formulary for the State, which would be used for all State sponsored programs. Presently prescribers are confused as to which drugs are covered or preferred under the various State programs. If there were but a single list, prescriber compliance would be enhanced.

To be sure, the Medicaid program has a very specific rule set, and is eligible for much lower prices than for other programs, but a dual negotiation process is possible and worthwhile.

- Prescriber and Provider compliance and monitoring

Presently there is little or no cross-over in this regard, since there are separate databases. But common sense dictates that a sub-optimal Medicaid prescriber has the same traits for State employee patients. A common database would assure better compliance and facilitate better educational efforts. It would also be much easier to detect fraud and abuse – for prescribers, pharmacies and recipients!

Methodology for Becoming a PBA

WMC strongly recommends that the State become its own Pharmacy Benefits Administrator. As part of this initiative, it should decide which functions to bring in-house and which to outsource.

As discussed above, there are less than a dozen components to pharmacy benefit management. Some are easier to perform than others. This table lists them, and ranks the difficulty on a one to four scale, with one being the easiest to achieve:

Required Service	Ease of Outsourcing
Plan design and implementation	2
Network development and maintenance	2
Claims processing and payment to providers	1
Reporting and analysis	2
Recipient and Provider support	2
Formulary and rebate management	4
Drug Utilization Review [DUR]	2
Clinical Management	2
ID Cards and enrollment processing	1
Auditing	3
Prior Authorization [PA] management	2

Conclusion

The State of Illinois has the potential to achieve significant savings on its drug expenditures through more aggressive and assertive management. Necessary steps include examining the current cost arrangements and assuming greater control over benefits administration. WMC hopes that this analysis will be helpful in achieving those goals.

WMC appreciates the opportunity to be of service.

Attachments:

- Medicaid Recap and Savings Potential
- State Employees Recap and Savings Potential
- State Employees Utilization Detail
- State Penitentiary Inmates Recap and Savings Potential
- Savings Potential Summary

Report to
Commission on Government Forecasting
and Accountability

Potential for Savings on Pharmacy Benefit Management Costs
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Attachments

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Medicaid Recap and Savings Potential

Program Name	DHFS		
ASSUMPTIONS			
Covered Lives	2,400,000		
Annual cost	$ 1,800,000,000		
CLAIM VOLUME			
MONTHLY CLAIMS	3,033,333		
MONTHLY COST	$ 150,000,000		
AVERAGE COST	$ 49.45		
(LESS REBATES PER CLAIM)	$ (11.87)	24%	
NET PER CLAIM COST	$ 37.58		
COST ELEMENTS			
	MEDICAID	**PBM**	
Discount from AWP for Brand Claims	12%	15%	
Brand Dispensing Fee	$ 3.40	$ 1.50	
Generic Cost Basis, as PCT AWP	46%	46%	
Pricing rule for non-MAC generics, as pct AWP	25%	25%	
Generic Dispensing fee	$ 4.60	$ 1.50	
UTILIZATION			
PERCENTAGE OF CLAIMS FILLED WITH GENERICS	64%		
PERCENTAGE OF CLAIMS FILLED WITH FORMULARY DRUGS	95%		
ESTIMATE OF CURRENT MONTHLY COSTS AND BREAKDOWN			
	BRAND	**GENERIC**	**TOTAL**
AVERAGE AWP	$ 113.50	$ 30.00	
AVERAGE COST TO MEDICAID	$ 99.88	$ 16.20	
DISPENSING FEES	$ 3.40	$ 4.60	
{LESS COPAYMENT)	$ (1.00)	$ (1.00)	
	$ 102.28	$ 19.80	
CLAIMS	1,092,000	1,941,333	
MONTHLY COST	$ 111,689,760	$ 38,438,400	$ 150,128,160
ESTIMATED OF COSTS IF PRICED AT PBM RATES			
AVERAGE AWP	$ 113.50	$ 30.00	
AVERAGE COST AT PBM RATE	$ 96.48	$ 16.20	
DISPENSING FEES	$ 1.50	$ 1.50	
{LESS COPAYMENT)	$ (1.00)	$ (1.00)	
	$ 96.98	$ 16.70	
CLAIMS	1,092,000	1,941,333	
MONTHLY COST	$ 105,896,700	$ 32,420,267	$ 138,316,967
SAVINGS			**$ 11,811,193**
ANNUAL SAVINGS			**$ 141,734,320**

State Employees Recap and Savings Potential

ASSUMPTIONS					
Covered Lives	424,308				
CLAIM VOLUME					
	MAIL	**MAIL PCT**	**RETAIL**	**RETAIL PCT**	**TOTAL**
MONTHLY CLAIMS	35,557	5.7%	589,261	94.3%	624,819
MONTHLY COST	4,382,359	14.3%	26,279,767	85.7%	$ 30,662,125
AVERAGE COST	$ 123.25		$ 44.60		$ 49.07
(LESS REBATES PER CLAIM)	$ (13.10)		$ (5.20)		$ (5.65)
NET PER CLAIM COST	$ 110.15		$ 39.40		$ 43.42
MONTHLY COSTS, NET OF REBATES	$ 3,916,556		$ 23,215,609		**$ 27,132,165**
REBATES AS PCT					11.5%
COST ELEMENTS					
	MAIL		**RETAIL**		
REBATES PER BRAND RX					
Discount from AWP for Brand Claims	25%		15%		
Brand Dispensing Fee	0		$ 1.50		
Generic Cost Basis, as PCT AWP	57%		59%	[Retail Generic Pricing	
Pricing rule for non-MAC generics, as pct AWP	57%		15%		
Generic Dispensing fee	$ -		$ 1.50		
Formulary Rebate Percentage retained by the PBA	0%		0%		
PBA CHARGES					
Administrative fee per enrollee per month of $2.81	$ 1,192,305				$ 1,192,305
Rational Med [$0.28 PMPM]	$ 118,806				$ 118,806
DUR High Utilization Management [$0.02 per claim]	$ 12,496				$ 12,496
Schedule C Health Eeducation [$0.15 PMPM]	$ 63,646				$ 63,646
Total					$ 1,387,254
Net Revenue per enrollee per month					$ 3.27
Monthly PBA Revenue					**$ 1,387,254**
PBA fees per retail claim					**$ 2.35**
[Note that the PBA has other sources of profit from this book of business, including spread on Specialty Claims & profit from its' captive mail order operation.]					
UTILIZATION					
PERCENTAGE OF CLAIMS FILLED WITH GENERICS	52%				
PERCENTAGE OF CLAIMS FILLED WITH FORMULARY DRUGS	50%				
ESTIMATE OF BREAKDOWN BETWEEN BRAND & GENERIC					
	BRAND	GENERIC	TOTAL		
AVERAGE COST TO STATE**	$ 83.20	$ 20.79			
CLAIMS	312,409	312,409			
MONTHLY COST	$ 25,992,453	$ 6,494,989	$ 32,487,442		
** FROM CAREMARK REPORT; REPORTING PERIODS ARE NOT MATCHED, HENCE THE DIFFERENCE					

State Employees Utilization Detail

		EMPLOYEES	RET	DEP	TOTAL
Quality Health Care Program	QCHP	37,623	55,758	53,409	146,790
Local Government Health Plar	LGHP	2,691	166	2,047	4,904
Teacher's Retirement Insuranc	TRIP		29,313	6,177	35,490
College Insurance Program	CIP				
College Choice Health Plan	CCHP		2,464	565	3,029
TOTAL		40,314	87,701	62,198	190,213

Self-Insured Managed Care Programs

		EMPLOYEES	RET	DEP	TOTAL
Quality Care Health Plan	QCHP	12,548	2,304	19,538	34,390
Local Care Health Plan	LCHP	1,495	44	873	2,412
Teachers Choice Health Plan	TCHP		4,289	634	4,923
College Choice Health Plan	CCHP		179	45	224
TOTAL		14,043	6,816	21,090	41,949

Insured Managed Care Programs

		EMPLOYEES	RET	DEP	TOTAL
	State	65,341	16,104	91,774	173,219
	LGHP	4,139	173	3,199	7,511
	TRIP		9,309	1,501	10,810
	CIP		467	139	606
TOTAL		69,480	26,053	96,613	192,146
Grand Total		**123,837**	**120,570**	**179,901**	**424,308**

Rx Usage Information

		# Rx			Dollars			AVG			PCT Mail	
Indemnity		Mail	Retail	Total	Mail	Retail	Total	Mail	Retail	Total	Rx	$$
	QCHP	242,935	3,268,339	3,511,274	$ 29,366,557	$ 151,511,609	$ 180,878,166	$ 120.88	$ 46.36	$ 51.51	7%	16%
	LCHP	6,899	83,140	90,039	$ 857,027	$ 4,012,704	$ 4,869,731	$ 124.22	$ 48.26	$ 54.08	8%	18%
	TCHP	116,158	744,504	860,662	$ 13,773,885	$ 34,180,626	$ 47,954,511	$ 118.58	$ 45.91	$ 55.72	13%	29%
	CCHP	13,633	69,612	83,245	$ 1,572,764	$ 2,229,581	$ 3,802,345	$ 115.36	$ 32.03	$ 45.68	16%	41%
		379,625	4,165,595	4,545,220	$ 45,570,233	$ 191,934,520	$ 237,504,753	$ 120.04	$ 46.08	$ 52.25	8%	19%
Self Funded Managed Care												
	State	1,476	153,420	154,896	$ 133,426	$ 11,046,959	$ 11,180,385	$ 90.40	$ 72.00	$ 72.18	1%	1%
	Local	471	45,635	46,106	$ 159,655	$ 2,379,490	$ 2,539,145	$ 338.97	$ 52.14	$ 55.07	1%	6%
	TCHP	3,865	148,224	152,089	$ 418,223	$ 7,352,136	$ 7,770,359	$ 108.21	$ 49.60	$ 51.09	3%	5%
	CCHP	271	6,736	7,007	$ 33,730	$ 335,050	$ 368,780	$ 124.46	$ 49.74	$ 52.63	4%	9%
		6,083	354,015	360,098	$ 745,034	$ 21,113,635	$ 21,858,669	$ 122.48	$ 59.64	$ 60.70	2%	3%
Insured Managed Care	State	25,153	2,178,523	2,203,676	$ 4,385,443	$ 86,066,817	$ 90,452,260	$ 174.35	$ 39.51	$ 41.05	1%	5%
	Local	1,828	105,079	106,907	$ 468,229	$ 4,429,893	$ 4,898,122	$ 256.14	$ 42.16	$ 45.82	2%	10%
	TCHP	13,250	255,421	268,671	$ 1,350,092	$ 11,270,488	$ 12,620,580	$ 101.89	$ 44.13	$ 46.97	5%	11%
	CCHP	750	12,501	13,251	$ 69,271	$ 541,850	$ 611,121	$ 92.36	$ 43.34	$ 46.12	6%	11%
		40,981	2,551,524	2,592,505	$ 6,273,035	$ 102,309,048	$ 108,582,083	$ 153.07	$ 40.10	$ 41.88	2%	6%
Total Usage		426,689	7,071,134	**7,497,823**	$ 52,588,302	$ 315,357,203	**$ 367,945,505**	$ 123.25	$ 44.60	$ 49.07	6%	14%
PMPY		1.01	16.67	**17.67**			**$ 867.17**					

State Penitentiary Inmates Recap and Savings Potential

Number of Lives		13,000
Monthly Claims Volume		133,333
Monthly Cost to State	$	1,389,750
Cost Per Claim	**$**	**10.42**
Cost PMPM	**$**	**106.90**
Retail claims		
AWP	$	13.36
AWP Discount		22%
340B Price	$	6.68
Savings	$	3.74
Annual Savings	$	5,986,615.38
Savings percentage		35.9%

Savings Potential Summary

Type	Monthly Costs	Annual Costs	
State Employees	$ 27,000,000	$ 324,000,000	
Medicaid	$ 150,000,000	$ 1,800,000,000	
Penitentiary inmates	$ 1,389,750	$ 16,677,000	
Total	$ 177,000,000	$ 2,124,000,000	
Savings Potential:	**Monthly**	**Annual**	**Percentage of Program Cost**
Reduce State Employees PBM fees to DPA rates:	$ 846,146	$ 10,153,751	3.13%
Reduce DHFS Network Rates to CMS levels	$ 11,683,033	$ 140,196,400	7.79%
Provide drugs to prison inmates at 340B prices	$ 498,885	$ 5,986,615	35.90%
Potential Total Monthly Savings	$ 13,028,064	$ 156,336,766	7.36%