Ohio Medicaid Pharmacy Benefit Manager Performance Review

June 21, 2018

Key Findings

- *There is an **8.8 percent spread** between the amount pharmacy benefit managers billed Medicaid managed care plans and the amount they paid pharmacies.*
- *Compared to CVS pharmacies, CVS Caremark reimburses independent pharmacies **3.6 percent more for brand drugs** and **3.4 percent more for generic drugs**.*
- *Compared to fee-for-service pricing, Medicaid managed care pharmacy benefit managers **save Ohio taxpayers at least $145 million annually**.*

Background

Pharmaceutical manufacturers go to extreme lengths to keep drug prices secret from the public. This secrecy is passed down through the value chain, creating mistrust among payers, insurers, benefit managers, pharmacists and patients. All are forced to speculate whether the price they pay for drugs is fair. Recently, this mistrust has been exacerbated by patients paying more out of pocket for drugs and payers insisting on aggressive cost control measures.

Ohio Medicaid decided in 2011 to move the pharmacy benefit out of fee-for-service and into managed care. That decision has saved Ohio taxpayers hundreds of millions of dollars (the analysis below indicates $145 million annually) from administrative efficiencies. To achieve these savings, Ohio Medicaid contracts with five Medicaid managed care plans and each plan in turn contracts with a pharmacy benefit manager (PBM). PBM activities typically include negotiating rebates for plans, ensuring access to a network of pharmacies, assistance in formulary design, and clinical care management. Currently United contracts with OptumRx and Buckeye, CareSource, Molina and Paramount contract with CVS Caremark.

Recent Concerns

The Ohio Pharmacists Association has alleged that PBMs working for Medicaid managed care plans take advantage of the lack of transparency in manufacturer drug prices to engage in anti-competitive behavior that harms pharmacies. This allegation is not unique to Medicaid – similar concerns have been raised about the role of PBMs in the commercial market.

The Ohio Pharmacists Association has been hearing from its members about erratic generic drug reimbursement from Medicaid managed care PBMs and drops in gross margins on medications dispensed to managed care enrollees. In some cases, the pharmacies report PBM reimbursement is below the pharmacy's cost to acquire the drugs. This could be the result of constructive market forces pushing pharmacies to be more efficient or, as the pharmacists claim, PBMs using the lack of transparency related to manufacturer prices to engage in anti-competitive behavior. Specifically, the Ohio Pharmacists Association has alleged that PBMs overbill Medicaid managed care, underpay pharmacies, and pocket the difference.

Recent Actions

Ohio Medicaid has been working with interested parties and legislators to address questions about PBM business practices since the fall of 2017. As part of those conversations:

1. Ohio Medicaid has been working with pharmacists to identify how they can bill for additional services, increase access to pharmacy-provided services like Medication Therapy Management, and improve member access to specialty pharmacy services.

2. In January 2018, Ohio Medicaid implemented a new maximum allowable cost (MAC) pricing model that sets a maximum amount managed care plans will pay for brand name drugs that have generic versions available. While the new model provides transparency into the price the state pays through the managed care plans to the PBMs, it does not provide transparency into the reimbursement provided to pharmacies by the PBM.

3. In April 2018, the Ohio Department of Insurance published a bulletin that clarifies what would constitute prohibited practices related to pharmacy benefits, including gag orders to prevent any entity from sharing information about less expensive ways to purchase prescription drugs, and cost-sharing requirements that exceed the amount an individual would pay for the same drug if it was purchased without coverage under a health benefit plan. These prohibitions apply to all health insurance companies and PBMs.

4. In April 2018, Ohio Medicaid added language to its managed care plan provider agreement that requires enhanced pharmacy data reporting and oversight beginning July 1, 2018. The provider agreement now requires:

    a. Managed care plans must disclose to Ohio Medicaid all financial terms and agreements for payment of any kind that apply between the plan and downstream entities, including PBMs;

    b. Effective July 1, 2018, each managed care plan must submit encounters that include the amounts paid by a sub-contracted vendor (e.g., PBM) to the provider at the claim level (e.g., pharmacy);

    c. A PBM must disclose to Ohio Medicaid any difference between the amount paid to a pharmacy and amount charged to the managed care plan; and

    d. The plans must publish on their websites the requirements and process for submitting an appeal related to MAC pricing for pharmacy providers.

5. In April 2018, Ohio Medicaid exercised its authority under ORC 5162.10 to conduct investigative reviews by contracting with HealthPlan Data Solutions (HDS) to conduct an independent third-party analysis of Medicaid health plan PBM performance. Specifically, Ohio Medicaid asked HDS to identify the spread between the price billed to managed care plans and the price paid to pharmacies. The HDS findings are summarized below.

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In May 2018, Ohio Medicaid contracted with HDS to conduct an independent third-party analysis of (1) the spread between the price billed to managed care plans by their PBMs and the amount paid to pharmacies, (2) allegations of anti-competitive pricing against independent pharmacies, and (3) the cost to the state of the pharmacy benefit in managed care compared to fee-for-service. HDS reported its findings in a June 15, 2018 report, summarized below.

1. ***The spread between what was billed to managed care plans and paid to pharmacies is 8.8 percent.*** Anecdotal examples of spread pricing created a perception that the margin of spread retained by PBMs was much greater, but those estimates were based on a small subset of prescribed drugs selected by pharmacies. The HDS analysis is based on one full year of actual pharmacy claims, and calculates the total spread based on the total amount billed to the plans and the total amount paid to the pharmacies.

2. ***Independent pharmacies were reimbursed 3.6 percent more for brand drugs and 3.4 percent more for generic drugs compared to CVS pharmacies.*** HDS could not identify any preferential pricing paid to CVS-owned pharmacies by CVS Caremark that would create an anti-competitive advantage over independent pharmacies.

3. ***Medicaid managed care PBM pricing saves Ohio taxpayers at least $145 million annually compared to fee-for-service pricing.*** HDS compared the current prescription claim prices billed to the plans by the PBMs to the prices that would have been paid under the Medicaid fee-for-service methodology. ***In addition, the Medicaid managed care pharmacy benefit generates $100 million in fees and revenue that further offset program costs, <u>resulting in total taxpayer savings of $245 million annually</u>***.

As far as the state team is aware, the HDS report provides greater transparency into Medicaid managed care PBM pricing than any other state has achieved.

Next Steps

Based on the HDS analysis of actual pharmacy claims, there is no evidence of anti-competitive behavior by PBMs that would justify regulatory intervention by the State of Ohio. However, there is always room to improve. For example, now that the total paid per prescription is known for pharmacies ($59.19) and PBMs ($5.70), Ohio's taxpayers, legislators, managed care plans and others are in a better position to assess whether or not the products and services provided for that price is fair and inquire further about what portion is retained as profit.

On June 21, 2018, Ohio Medicaid sent a letter to the Medicaid managed care plan CEOs outlining how the department will use the HDS analysis to drive further innovation in pharmacy benefit administration. Specifically, Ohio Medicaid will:

1. Require each Medicaid managed care plan to review the HDS report and ongoing data collection and not later than September 30, 2018 notify the Medicaid Director of any changes the plan intends to make related to pharmacy administration;

2. Use the HDS report and ongoing data collection to inform the state's process of Medicaid managed care rate setting, which will occur in November 2018 for calendar year 2019 rates;

3. Monitor PBM pricing on a quarterly basis and share the information that Medicaid managed care plans need to pressure their PBMs to demonstrate value or risk being replaced; and

4. If at any point the quarterly review raises an alarm, immediately notify the Joint Medicaid Oversight Committee and initiate a process to consider additional reforms.

The purpose of these actions is to ensure the continued transparency of pricing information as a safeguard against the possibility of future anti-competitive behavior and to provide the information that is necessary for market competition to drive further innovation in pharmacy benefit administration. The goal for the state is to stay focused on making sure Ohioans have access to the pharmacy benefits they need while also holding down costs for taxpayers, and not to be drawn into provider disputes that are best resolved through competition in the market.

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