Vermont State Auditor

Douglas R. Hoffer

Report to the Department of Human Resources

RECOMMENDATIONS FOR IMPROVING THE PERFORMANCE OF THE STATE OF VERMONT'S PRESCRIPTION DRUG BENEFIT PROGRAM

Prepared by TessellateRx LLC

The State Auditor's Office provided this report to the Department of Human Resources May 10, 2018.

DOUGLAS R. HOFFER
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

May 9, 2018

Beth Fastiggi
Commissioner
Department of Human Resources

Dear Commissioner Fastiggi,

Pharmacy benefit managers (PBM) have been the subject of multiple lawsuits around the country alleging a variety of inappropriate business tactics that have led to hundreds of millions of dollars in fines and settlements. In fact, in 2008, the Vermont Attorney General's Office along with other states entered into a settlement of claims of deceptive business practices against Express Scripts, Inc. for $9.3 million.

In the fall of 2017, the State Auditor's Office (SAO) initiated a review of the Department of Human Resources' (DHR) PBM contract with Express Scripts, Inc. (ESI) because of the following factors:

1) litigation has shown PBMs' business practices are controversial;

2) the ESI contract could cost up to $151 million from 1/1/2014 to 12/31/2018; and

3) DHR's external auditors concluded that ESI failed to discount brand drugs as contractually required, overcharging the State by $1 million in 2010/2011 and $743,000 in 2012/2013, and our subsequent follow-up with DHR in 2013 and 2015 found that the department had not resolved these findings.

DHR has taken steps to increase oversight of its ESI contract and to pursue recovery of the amounts identified by the external auditors. According to DHR, the department had informed ESI in 2015 that future ESI invoices would be offset by the amount owed to the State but ESI disagreed. DHR reported that additional follow-up was delayed because legal counsel advised the department to wait until contract negotiations with ESI were completed in 2016. This seems like a wasted opportunity to take advantage of potential leverage during negotiations. The department hired a consulting firm in 2015 to review and assess ESI's performance on a continuous basis and in December 2017, the Attorney General's Office sent ESI notification of

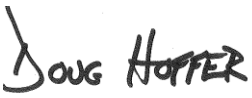
a breach of contract related to the overcharges in 2012/2013.

For all these reasons, SAO hired TessellateRx to review four components of the State's prescription drug benefit program and to provide suggestions for improving each component: 1) contract with ESI; 2) plan design documentation; 3) plan performance; and 4) PBM oversight mechanisms. The work performed by TessellateRx was not conducted under generally accepted auditing standards and had a smaller scope of work than an audit. Therefore, their conclusions are more limited.

We are hopeful that the attached report by TessellateRx will provide valuable insight and actions that DHR can use when negotiating the PBM contract during its ongoing request for proposal (RFP) process and in its administration of the pharmacy benefit plan for state employees. This report contains information that has been designated confidential by ESI and other information exempt from public inspection and copying.

Finally, we appreciate the assistance provided by DHR as the department was very helpful throughout the project.

Sincerely,



Douglas R. Hoffer
Vermont State Auditor

PBM Overview

Nationally, total prescription dispensing revenues of retail, mail, long-term care, and specialty pharmacies reached $412 billion in 2016. The amount of money people spend on prescription drugs has nearly doubled over the past three decades as pharmaceutical sales and profit margins have ballooned, according to a November 2017 report by the Government Accountability Office. Pressures to effectively manage prescription drug costs remain as high as ever, given the many factors (e.g., increasing demand, drug inflation rates, specialty drug development, and aggressive drug marketing) driving even higher drug spending.

PBMs are third party administrators of prescription drug programs who contract with employers (referred to as "plan sponsors") to provide prescription drug benefits to employees ("members") of the plan sponsor and to manage drug spending. In 2016, Express Scripts-Medco, CVS Caremark, and OptumRx accounted for approximately 70 percent of the prescriptions processed in the United States.

The structure of the services provided by PBM's and the pricing models utilized to charge plan sponsors for prescription drug claims and PBM services are complicated.

PBMs create the drug formulary (a list of preferred drugs that will be covered under a plan) and negotiate drug prices with pharmaceutical manufacturers. PBMs also contract with pharmacies, where they reimburse pharmacies at an agreed upon price for the members' prescriptions. Many PBMs promote utilizing mail order pharmacies to fulfill members' prescriptions. PBMs often own or are affiliated with these pharmacies and have expanded their profitability through in-house mail-order prescription drug delivery services. The trend by PBMs to encourage more activity with the companies' online pharmacies has a direct impact on instate businesses. In addition to processing claims between pharmacies and plan members, PBMs review the medications members fill at all pharmacies under the plan (referred to as drug utilization).

PBMs generate revenue by three main methods:

Price spread
A common practice among PBMs, "price spread" allows PBMs to pay their contracted network pharmacies at one rate and then charge the plan sponsors a higher rate, pocketing the difference.

Rebates and other program fees from manufacturers
PBMs place brand drugs on a formulary because pharmaceutical manufacturers often provide rebates for using these drugs. The PBM's selection of drugs for placement on the formulary may be influenced by the amount of manufacturer rebates received. Depending on the contract, some PBMs retain a portion of a plan sponsor's rebate dollars. PBMs may receive revenue from manufacturers for sales of claims data or for administering the rebate program

Plan services fees
PBM contracts vary as to how fees are structured for the administration of plan services. Some contracts stipulate a flat fee for all plan services, while others charge for different services individually.

PBMs evolved as a means to lower overall drug prices and simplify the prescription services process by automating administrative services, obtaining discounts on drugs, and managing drug utilization. However, PBMs have come under increasing scrutiny. PBM's have closely guarded access to their data and contractual arrangements with pharmaceutical manufacturers and pharmacies. It is difficult to assess the actual prices in PBM contracts because this information may not be disclosed. PBM contracts often have language that is ambiguous, vague, or undefined.

Vermont state law, 18 V.S.A. §9472, addresses requirements for PBMs operating in Vermont such as providing all financial and utilization information requested by a health insurer (e.g., plan sponsor) relating to the provision of benefits to beneficiaries through the health insurer's health plan. In addition, PBMs are required to disclose to the health insurer all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefit manager and any prescription drug manufacturer. (TessellateRx believes that ESI is not in compliance with this requirement, see page 18 of the report.) Per 18 V.S.A. §9472(c)(5), this information may be designated as confidential by the PBM. PBMs are also required to disclose the amount the PBM retained on all claims charged to the health insurer for prescriptions filled during the preceding calendar year in excess of the amount the PBM reimbursed pharmacies. This disclosure must be provided to the Department of Financial Regulation, the Green Mountain Care Board, and the health insurer. This information may be exempt from public disclosure under Vermont's public records law, 1 V.S.A. §317(c)(9).

RECOMMENDATIONS FOR IMPROVING THE PERFORMANCE OF THE STATE OF VERMONT'S PRESCRIPTION DRUG BENEFIT PROGRAM

FINAL: MAY 8, 2018

Prepared by TessellateRx LLC

State Auditor's Note:

Certain data designated by ESI as confidential per 18 V.S.A. §9472(c)(5) and data exempt from public disclosure per 1 V.S.A. §317 has been redacted in the report.

Attachment B has been removed as it is exempt from public disclosure per 1 V.S.A. §317(c)(9).

Attachment A is a CD with multiple documents, a list of which is included in the report pages 6 – 8.

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ATTACHMENTS

PRELIMINARY STATEMENT AND DISCLAIMER

Pursuant to its contract with the State Auditor's Office ("SAO"), TessellateRx has agreed to review various pieces of the State of Vermont's Prescription Drug Benefit Program and to provide recommendations for improving the overall performance of that program moving forward. Nothing herein in intended to provide, nor shall be construed as providing, legal advice to the State of Vermont and/or to the SAO. TessellateRx has not been asked to provide legal advice, and it has not agreed to provide legal advice, regarding any matter, including but not limited to contract compliance or assigning fault to any entity mentioned in this report.

The recommendations presented herein are just that – recommendations based on our experience in the pharmacy benefit arena and our view as to the best practices in the current market. Other consultants and service providers, including those currently under contract with the State, may disagree with our recommendations and present their own views regarding best practices. They, of course, are free to do so, and it is up to the State to take all view points into consideration and decide, in its discretion, the best course of action for the State's prescription drug benefit program and its members.

TessellateRx appreciates this opportunity to present its recommendations, and we thank the SAO for its diligence in gathering various documents for our review. We hope you find our recommendations helpful.

EXECUTIVE SUMMARY

Pursuant to its contract with the SAO, TessellateRx has agreed to review the following four components of the State's prescription drug benefit program and to provide recommendations on how the State might be able to improve each component moving forward: (1) the State's contract with Express Scripts, Inc. (ESI) ; (2) the State's Plan Design Documentation; (3) the State's Plan Performance; and (4) the State's Pharmacy Benefit Management (PBM) Oversight Mechanisms. Here is a quick recap of what we found and what we recommend in each area. We were not asked to review, and we did not review, the State's Employee Group Waiver Plan (EGWP).

Express Scripts Contract Review and Recommendations

The State is caught up in the routine of following the standard forms and procedures of the past, with the State allowing Express Scripts to control the drafting of the key contract terms for the past fourteen years. We understand that the Department of Human Resources (DHR) has issued a request for proposal (RFP) for benefit administration services that appears to take a similar approach. We recommend that, in the future, the State take a new approach to PBM contracting and implement a "contract-based" RFP process wherein the State requires bidders to accept the terms of a PBM contract prepared by on or behalf of the State, not the PBM. In doing so, the State should present a "pass-through" contract that: (1) prohibits pricing spreads for brand, generic and specialty drugs; and (2) requires the PBM to pass through to the State 100% of all drug manufacturer revenue streams and/or financial benefits tied to the State's utilization/purchases.

At the very least, the State should ensure that key contract terms are addressed and corrected to protect the interests of the State moving forward. We provide specific recommendations for the following four key contract provisions: (1) plan design implementation; (2) pricing; (3) rebates; and (4) audits.

Plan Documentation Review and Recommendations

The State's plan design documentation appears to be outdated and in need of DHR review to ensure that the details of the State's prescription drug benefit are accurately recorded in a comprehensive plan document. If not done so already, the State should undertake an immediate review of the Express Scripts Benefit Design document (EBD) and the related Set-Up Forms to ensure that they accurately reflect the current terms of the State's plan. Any errors or disconnects need to be corrected and reported to Express Scripts for prompt implementation. It is essential that the State prepare and retain a signed copy of an

accurate EBD and then secure Express Scripts' agreement to implement all plan design elements as recorded in that signed EBD.

As for improving specific plan design elements, we provide recommendations for: (1) the State's drug formulary (currently the standard Express Scripts Formulary); (2) prescriber ID numbers; (3) prior authorizations; and (4) refill-too-soon edits.

Plan Performance Review and Recommendations

Due to delays in obtaining claims data for audit and concerns regarding the confidentiality of that data, we did not analyze any claims data as part of our review. Instead, we agreed to provide a list of plan performance evaluations that the State can request Remedy Analytics to perform and report on to the State. We recommend that Remedy evaluate: (1) contract pricing guarantees for 2017; (2) specialty drug pricing; (3) deductibles, copayment and annual maximums; (4) copayment claw backs; (5) the State's mandatory generic rule; (6) "dummy" Drug Enforcement Agency (DEA) numbers; (7) refill-too-soon edits; and (8) compound drugs.

Recommendations for Additional Analysis of PBM Oversight Mechanisms

The State's current PBM oversight mechanisms consist of periodic claims adjudication audits and rebate audits plus on-going oversight analytics and reporting by the State's PBM consultant Remedy Analytics. While such mechanisms are consistent with industry standards, we recommend that the State improve its audit follow up procedures and make better use of the capabilities of Remedy Analytics. The key is to ask questions, request action items and recommendations, and then follow though to make sure all disconnects between the State's prescription drug benefit plan and the PBM's implementation of that plan are addressed and corrected to the satisfaction of the State.

MATERIALS RECEIVED AND REVIEWED

Over the course of August to October 2017, the SAO provided for our review many documents relating to different aspects of the State's prescription drug benefit program. Presented below is a list of those documents:

PBM Contract Documents:

1. 2016 PBM Contract: Vermont Department of Human Resources – Express Scripts, Inc. Amended and Restated Contract for Personal Services (Contract # 26281) – Effective 2/1/2016 to 12/31/18

2. 2014 PBM Contract: Vermont Department of Human Resources – Express Scripts, Inc. Contract for Personal Services (Contract # 26281) – Effective 1/1/2014 to 12/31/2015, Amended 12/31/15 to extend contract one month to 1/31/2016

3. 2009 PBM Contract: Vermont Department of Human Resources – Express Scripts, Inc. Contract for Personal Services (Contract # 14430) – Effective 1/1/2009 to 12/31/2011, Amended 7/1/2011 to "enhance" pricing terms from 7/1/2011 to 12/31/12; Amended 1/1/2013 to extend contract one year to 12/31/2013

RFP Documents:

1. Draft RFP – Medical, Behavioral Health, Prescription Drug, Dental Benefits Administrative Services and Stop Loss Reinsurance (1/1/2014 Contract Effective Date)

2. Final RFP – Medical, Behavioral Health, Prescription Drug, Dental Benefits Administrative Services and Stop Loss Reinsurance (1/1/2014 Contract Effective Date)

Active Employee Plan Design Documents:

1. DHR Summary of Benefits – SelectCare POS Plan (revised 10/2016)

2. DHR Summary of Benefits – TotalChoice Plan (revised 10/2016)

3. State of Vermont Group Health Benefit Document (revised May 2014)

4. Express Scripts Benefit Design Document (EBD) – Effective 1/1/2014, unsigned

5. Express Scripts Set-Up Documents:
    - Corrections Needed: OOP Set Up (signed 4/17/14, effective 1/1/13)
    - Contraceptives (Signed 9/26/14, effective 1/1/14)
    - OOP Changes (signed 9/25/14, effective 1/1/15)
    - COB Claims (Signed 12/4/14, effective 1/1/15)
    - Respiratory Supplies and Devices (signed 12/4/14, effective 1/15/15)
    - Vaccine coverage for Flu, Shingles, Pneumonia (signed 2/5/15, effective 3/1/15)

6. DHR Excel Reports – Copayments/Accumulator Grids

Express Scripts Reports

1. Rebate Allocation Reports
    - State Plan: 8/15/17 Cover Letter and Supporting Tables
    - EGWP Plan: 8/22/17 Cover Letter and Supporting Tables

2. Pharmacy Spread and Rebate Disclosures Reports Pursuant to VT Act 144, 18 VSA § 9472
    - 2014 Disclosures
    - 2015 Disclosures
    - 2016 Disclosures

PBM Audit Reports

1. TriCast Audit Report: ESI Claims Adjudication 1/1/15 – 12/31/16; Rebates Q12015 (Draft 9/14/17)

2. TriCast Audit Report: ESI Claims Adjudications 1/1/12 – 12/31/13; Rebates Q42012, Q12013 (12/10/14)

3. CGI Audit Report: ESI Claims Adjudication 7/1/09 – 6/30/11 (Report not Dated)

4. CGI Audit Report: ESI Rebates Paid to DHR 1/1/10 – 12/31/10 (Report not Dated)

Remedy Analytics Documents

1. Remedy – DHR Contract (8/10/15)

2. Remedy – DHR Contract Amendment (5/1/16)

3. Remedy Mark-Up of DHR-Express Scripts 2016 Contract (No Date)

4. Remedy Report: Evaluation of ESI Contract Renewal (12/14/15)

5. Remedy Report: Claims Incurred 1/1/16 – 9/29/16 (12/15/16)

6. Remedy Report: Claims Incurred 1/1/16 – 12/31/16 (April 2017)

For ease of reference and recordkeeping, we attach a password protected CD that contains the above referenced documents in appropriately named folders. We will transmit an email with the password for the CD.

EXPRESS SCRIPTS, INC. CONTRACT REVIEW AND RECOMMENDATIONS

A. THE BIG PICTURE

Since at least 2004, the State of Vermont has contracted with Express Scripts, Inc. for the provision of pharmacy benefit management services. While we were not provided with a copy of the 2004 contract, we suspect that it follows the same format as the 2009, 2014 and 2016 contracts identified above and included on the attached CD, namely: (1) the parties executed the State's standard-form "Contract for Personal Services"; and, in doing so (2) agreed to the "Specifications of Work to be Performed" (Contract Attachment A) and "Payment Provisions" (Contract Attachment B), which appear to be standard contract terms prepared by Express Scripts. In short, for the past 14 years (2004-2018), Express Scripts has served as the State's pharmacy benefit manager ("PBM") under key contract terms that were prepared by Express Scripts with the presumed overall goal of protecting Express Scripts' interests, not the State's interests.

Our review of the RFP that led to the 2014 PBM Contract with Express Scripts confirms that the State has worked with Express Scripts' standard contract terms, as the State listed certain contract provisions that had to be included in the winning bidder's contract. *See, e.g.,* RFP at 68. Stated otherwise, the State has not presented its own PBM contract and requested bidders to accept that contract and/or identify the terms that the bidders were unwilling to accept. To be clear, it is not unusual for a self-funded entity, like the State, to run RFPs that end up with that entity executing a contract drafted in large part by the winning bidder. But after fourteen years of following the same procedures, it might be time to undertake a new approach to PBM contracting.

RECOMMENTATION: During the pendency of this project, the State held an RFP for its comprehensive medical plan, including pharmacy benefits. The RFP closed on March 16, 2018, and finalist meetings are set for the week of April 30, 2018. We recently received a copy of the RFP, and our quick review shows with that the State has chosen to adhere to its prior practice of working off a contract that will be prepared by the winning bidder.

Given this commitment to "staying the course," we recommend that the State scrutinize the winning bidder's contract to avoid the "traps" and problems we flag in the following section. Ideally, the State should select a bid that demonstrates a commitment to the "pass-through" model of PBM services and a willingness to accept contract modifications that prohibit pricing spreads and require the pass through of 100% of financial benefits the PBM receives from drug manufacturers based on the State's utilization/purchases. Such contract terms will promote transparency in pricing and deliver true cost savings over the term of the contract. While the State will pay an administrative fee to a pass-through PBM, that fee

will be known and will eliminate the multiple "fees" the State will pay to a "spread-pricing" PBM when one properly accounts for retail and specialty spread pricing and retained manufacturer rebates as fees paid to such a PBM.

CAUTION: On March 8, 2018, Cigna announced its agreement to acquire Express Scripts for $62 billion. We have not reviewed the details of the acquisition for purposes of this review and provide no comments regarding its possible impact (good or bad) on Express Scripts' services under its existing contract with the DHR going forward. With that said, we recommend that the DHR ask that its current PBM consultant, Remedy Analytics, study the acquisition and keep the DHR up to date on its possible impacts going forward.

B. DRILLING DOWN

Effective 2/1/2016, the State amended and restated, in its entirety, its 2014 contract with Express Scripts. While the State conducted an RFP for the 2014 contract, it did not do so for the 2016 contract. DHR had requested and received a waiver of time to extend the 2014 contract beyond its original four-year term (2014-2017) for the one-year period ending 12/31/18. As such, the 2016 Contract follows the same form of the 2014 Express Scripts contract with certain amendments/modifications.

We present below our observations and recommendations regarding specific contract terms that might not be in the best interests of the State and its overriding goal of controlling prescription drug costs. In doing so, we focus on the four core components of a PBM contract: (1) plan design; (2) pricing; (3) rebates; and (4) audits.

1. Plan Design

As the State's PBM, Express Scripts implements the terms of the State's prescription drug benefit plan (the "VT Plan"). That is perhaps Express Scripts' most important service, as contract pricing only comes into play once it is determined that the script at issue is covered under the terms of the VT Plan. State otherwise, price is irrelevant if the script is not covered. Thus, it is essential that the PBM contract terms address plan design implementation and make it clear that Express Scripts is responsible for: (1) implementing the VT Plan correctly; and (2) maintaining in readily accessible format all plan design records. Moreover, the contract should clearly state that Express Scripts' failure to implement the documented plan design correctly results in an overcharge that Express Scripts owes to the State. The 2016 contract comes up short on all three points.

First, Express Scripts' obligation to implement the documented plan design correctly is not clearly stated in the 2016 Contract. Section I.A. (page 3) identifies the Express Scripts Benefit Design ("EBD") as the key record that documents the VT Plan as communicated by the State to Express Scripts, but it does not state that Express Scripts assumes the obligation to implement the terms of the EBD correctly. Indeed, that Section, as written, imposes obligations on the State and not Express Scripts. Similarly, Section II "Duties of Contractor

[Express Scripts]" includes several provisions that touch on Express Scripts' obligation to implement the EBD correctly, but that language could be improved. The key term is found in Section II. B. 1. "Claims Processing" (page 4), where Express Scripts states that it will provide claims processing services, including "(i) verifying eligibility, (ii) performing drug utilization review (DUR), ***(iii) calculating benefits in accordance with the EBD,*** and (iv) adjudicating the claims." (emphasis added). The next sentence, however, provides that the State retains the "final responsibility" to make all benefit decisions.

Second, the 2016 Contract does not address the responsibility for maintaining a readily accessible record of the EBD and all changes to that EBD over the contract term. As noted above, while we were provided with a copy of an EBD, that copy is dated 2014 and it is not signed. Moreover, while we were provided with several signed copies of "Express Scripts Set-Up Documents," those documents were signed in 2014 and early 2015 – suggesting that this is not a complete record of all plan design changes from 2014-2017. Recordkeeping is key, as the 2016 Contract states that the EBD must be signed and that any changes to that EBD must be recorded in a signed document.

Third, the 2016 Contract does not expressly address Express Scripts' liability for overcharges in the event it fails to implement correctly a plan design term that the State communicated to Express Scripts and recorded in a fully-executed EBD and amendments.

RECOMMENDATIONS: The 2016 Contract expires at the end of this year, and it is our understanding that the State is conducting an RFP for a new PBM service provider effective January 1, 2019. Given that time-line, we recommend that the RFP process and new PBM contract expressly address and clarify that: (1) the PBM assumes the obligation to implement the VT Plan correctly; (2) the PBM assumes the obligation to maintain, in a readily accessible format, the document(s) that record the terms of the VT Plan as communicated by the State to the PBM; and (3) the PBM agrees to reimburse to the State in the event the PBM fails to implement a plan design term that (a) the State communicated to the PBM; and (b) is recorded in the plan design record as maintained by the PBM.

2. Pricing

The 2016 Contract contains pricing terms that may not be in the State's best interest, exposing the State to excessive costs for brand, generic and specialty drugs. We discuss the key terms below.

a. Spread Pricing v. Pass-Through Pricing

In general terms, a "spread pricing" PBM contract is one where the PBM agrees to bill the plan sponsor the prices as stated in the contract, irrespective of the price that the PBM pays to the dispensing pharmacy. Thus, under a spread contract, the PBM retains for itself the difference aka "spread" between the price it pays the dispensing pharmacy and the price it bills to the sponsor, which most often is higher than the price paid to the pharmacy. Very rarely

does a PBM create and retain the risk of a negative spread, i.e., it pays the pharmacy more than it bills the sponsor.

In contrast, under a "pass-through" contract, the PBM agrees to negotiate with the pharmacies on behalf of the plan sponsor and to pass through to the sponsor all price discounts that the pharmacies agree to. Thus, under a "pass through" contract, there is no "spread" – the discounted price the PBM pays to the pharmacy is the exact same price the PBM bills the plan sponsor. Conservatively, and without analyzing the utilization data, the savings generated through a "pass-through" contract should, in our estimation, have an return on investment (ROI) on the administrative fee of 2.5 to 1 (i.e., for every $1 paid in administrative fees approximately $2.50 in savings will be generated).

The 2016 Contract is a "spread contract," though as we discuss below there is an issue as to whether Express Scripts is allowed to create and retain a spread on certain generic drugs. Contract Attachment D, Section 15 requires Express Scripts to report, on annual basis, the "spread" between what it charged the State and what it reimbursed to the dispensing pharmacies. In accordance with that requirement, ESI has disclosed that for the three-year period 2014-2016 it has retained a spread of over $[redacted] for claims dispensed at retail pharmacies and charged to the State.[1]

RECOMMENDATIONS: In its recent RFP, DHR has included a request for pass-through pricing. While a step in the right direction, in the future the State should consider conducting a contract-based RFP under which the bidding PBMs agree to accept the terms of a "pass-through" contract as prepared by, or on behalf of, the State. The large PBMs, including Express Scripts, might decline to serve under a "pass-through" contract. There are, however, several reputable PBMs that will agree to a "pass-through" arrangement. We can provide you with a list of such PBMs upon request.

b. Brand Drug v. Generic Drug Pricing

The 2016 Contract sets forth different prices and pricing guarantees depending on whether a claim is dispensed as a brand drug or a generic drug. And as one would expect, the State pays a much lower price if the claim is dispensed as a generic drug.

Under the 2016 Contract, Express Scripts determines whether a drug will be priced as a brand drug versus a generic drug. Specifically, as set forth Exhibit 1, Definitions, Express Scripts determines the brand or generic status of a dispensed drug via the use of its proprietary "Brand/Generic Algorithm" or "BGA." In turn, the contract definitions of "brand drug" and "generic drug" refer back to the BGA. While the contract allows the State to audit Express

[1] The stated dollar amount is arrived at by adding up the numbers set forth in Express Scripts 2014, 2015 and 2016 "PBM Spread Disclosure Report Pursuant to Vermont Act 144, 18 VSA § 9472," as provided to us by the SAO. Those reports are designated "Confidential-Not to Be Publicly Disclosed." Accordingly, we refrain from providing specific numbers in our report. We have included copies of the Express Reports on the enclosed password protected CD, and we caution that those reports should be kept confidential and not disclosed to the public.

Scripts "application of the BGA to confirm that [Express Scripts] is making brand and generic determinations with such algorithm," there is no clearly stated right to audit whether the algorithm itself is making brand-generic determinations that are in the State's best interests.

RECOMMENTATIONS: Express Scripts' Brand-Generic Algorithm is not universally accepted in the industry as a valid and impartial source of determining the brand or generic status of a drug. As stated in the 2016 Contract, it is proprietary to Express Scripts, which means Express Scripts retains the sole discretion to determine whether a drug will be priced as a brand or generic drug with little to no recourse to the State. There are alternatives in the marketplace, including Medi-Span MONY codes. We recommend that the State require the use of an alternative in any new PBM contract.

c. Brand Drug Pricing – Average Wholesale Price (AWP)

As is typical in the industry, the 2016 Contract sets the price that the State pays for a brand drug as a discount off the AWP of the drug. In turn, the Contract defines AWP to mean "the average wholesale price of a prescription drug as identified in the Medi-Span Master Drug Database (MDDB) (or other source nationally recognized in the prescription drug industry selected by [Express Scripts])." Exhibit 1 (Contract page 12). Thus, once again Express Scripts controls a key pricing term.

RECOMMENDATION: We recommend that the State adopt in any future PBM contract a contract definition of AWP that limits the PBM to the use of the MDDB, with no discretion to select some other source without advance notice to and agreement from the State.

d. Generic Drug Pricing – Maximum Allowable Cost (MAC) v. Maximum Reimbursement Amount (MRA)

Under the 2016 Contract, and subject to an annual reconciliation of aggregate guarantees, Express Scripts bills the State a price for each claim that is dispensed to a plan member. For generic drugs dispensed at a retail pharmacy, Express Scripts is required to bill the State the lesser of the Ingredient Cost Charge,[2] MRA, or Usual & Customary (U&C) plus the applicable dispensing fee (net of the member copayment). For generic drugs dispensed at a mail order pharmacy, Express Scripts is required to bill the State the lesser of the Ingredient Cost Charge, MRA plus the applicable dispensing fee (net of the member copayment). *See* Contract, Attachment B, Exhibit 1 (Fees and Charges). The Contract, however, does not define the term MRA.

As we previously reported in our conference call on September 21, 2017, there is a disconnect in the 2016 Contract regarding the use of the term MRA and MAC. The contract defines the term MAC, states that Express Scripts will apply MAC List prices for retail and mail

[2] The term "Ingredient Cost Charge" is not defined in the 2016 Contract. We assume that it refers to the calculated ingredient cost of AWP minus the contracted % discount. The State should ask Express Scripts to confirm.

order claims and obligates Express Scripts to produce to the State the "MAC list and MAC prices." Here are the key contract terms, as set forth at pages 14 and 34 of the 2016 Contract:

- "Maximum Allowable Cost" or "MAC" – "means the maximum allowable cost per unit of drug ***that a pharmacy will be reimbursed***, as determined by ESI." Contract, page 14 (emphasis added). Per this Contract definition, MAC is the price paid to the pharmacy.

- "A copy of the ***MAC list and MAC prices*** will be provided at no cost to the State and/or the State's authorized designee upon request and not to exceed quarterly. In order to receive the ***MAC list and MAC prices***, the State must have signed a contract, all invoices must be in good standing and confidentiality must be maintained." Per this contract term, ESI agreed to produce the MAC List, not an MRA List.

- "The ***MAC list applied to Mail Service claims*** will have identical products as the ***MAC list applied to Participating Pharmacies claims***. The ***Mail Service MAC list prices*** will be equal to or better than the ***Participating Pharmacies MAC price list***." Contract, page 34 (emphasis added). Per this contract term, ESI agreed to apply the MAC List prices to the Participating Pharmacy claims and represented that the MAC List prices for Mail order claims will be equal to or better than the Participating Pharmacies MAC prices. It did not agree to apply an MRA List to retail claims or represent that MRA prices for mail order claims would be equal or better than retail MRA prices.

Simply stated, there is a significant disconnect between the 2016 Contract multiple's references to MAC and its use of the undefined term "MRA" in setting the per claim pricing for generics. That disconnect, in turn, raises the question of whether the Contract allows Express Scripts to create and retain a spread on generic drugs.[3]

RECOMMENDATION: We recommend that the State ask Express Scripts to explain in writing why the 2016 Contract states that Express Scripts will apply MAC list pricing to retail and mail order claims but then uses the undefined term "MRA" when setting the price that the State will pay for generics dispensed at retail and mail. Absent adequate explanation, the State should consider referring the matter to the State Attorney General's office for investigation. As noted above, Express Scripts has reported that it retained over $[redacted] in spread pricing for claims

[3] During this project, Express Scripts declined to produce to the DHR the MAC list Express Scripts used to pay the pharmacies, maintaining that the client MAC List is the MRA list. That position, however, appears to be at odds with the Contract – which states that MAC refers to the price paid to pharmacies and requires Express Scripts to produce its MAC price list to the State upon demand. Indeed, while the 2014 Contract included a definition for the term MRA, that definition was deleted from the 2016 Contract, leaving MAC as the only defined pricing term for generics.

dispensed at retail from 2014 to 2016. While those reports do not state how much of that spread related to claims priced at MAC/MRA, the dollars at stake could be substantial.

e. Specialty Drug Pricing

According to the April 2017 Remedy Analytics PharmaLogic Report, the State and its members paid $14,142,823 for specialty drugs in 2016, which represented 31.8% of the total drug spend of $44,414,865 for that year. Report at page 4. The 2016 Contract contains several specialty drug terms that could be improved to better protect the State and it's plan members' exposure to excessive specialty drug costs.

First, the contract defines the term "specialty product" to mean "those injectable and non-injectable drugs on the "Specialty Product List," which in turn is defined to mean "the standard list of Specialty Products and their reimbursement rates applicable to the State under the applicable (exclusive or open) option maintained and updated by [Express Scripts] from time to time." Contract, Attachment A, Exhibit 1 (Definitions). In other words, Express Scripts, in its discretion, gets to: (1) determine which drugs are to be treated as specialty drugs; and (2) set the prices for those high-cost drugs.

The Specialty Product List included in the 2016 Contract is now outdated, and we have not been provided the current Product List. With that said, the prices presented in the 2016 Contract appear uncompetitive, and while Express Scripts agreed to an annual guarantee of AWP-[redacted]%, that guarantee apparently does not apply as the State did not elect the "exclusive" option. *See* 2014 EBD at page 20 (selecting "open" option).

Second, because the State elected the "open" option for specialty pharmacies, the State has not benefited from the more aggressive (aka better) pricing stated in the Specialty Product List for the "Exclusive" option. And while the "open" option allows the members to obtain specialty products at retail pharmacies that are under contract with Express Scripts, it is not clear if members are taking advantage of that option or primarily obtaining such products from Express Scripts' specialty pharmacy Accredo. Claims analysis is needed to determine if the State would be better off electing the "Exclusive" option to take advantage of the more aggressive pricing available under that option.

RECOMMENDATIONS: The 2016 Contract essentially delegates to Express Scripts complete control over the pricing for specialty drugs. And while plan members are free to obtain specialty drugs from retail pharmacies under contract with the State (i.e., Participating Pharmacies), not all such pharmacies have been approved by Express Scripts to dispense specialty drugs and, as written, the contract does not prohibit Express Scripts from creating and retaining a spread on specialty drugs dispensed at approved pharmacies. Simply stated, the State's exposure to excessive specialty costs is very high.

To limit the State's exposure, we recommend that the State consider a "carve-out" option for specialty products in any future PBM contract. Under such a carve-out, the

contracting PBM would agree that the State would be free to contract separately with an independent specialty pharmacy, with that separate "specialty" contract setting aggressive pricing terms for a comprehensive list of specialty drugs, with the State retaining the right to amend that list as new specialty drugs come to market.

In the alternative, the State could allow the contracting PBM to participate in the State's specialty drug program, but only under key terms that best protect the State's interests, including: (1) the State, in consultation with the PBM, will establish the specialty product list, reserving the right to amend that list as new specialty drugs come to market; (2) the PBM agrees to pass-through pricing at participating pharmacies, i.e., the PBM bills the State exactly what it paid the dispensing pharmacy; and (3) for claims dispensed at the PBM's specialty pharmacy, the price will be set at: (a) the PBM's acquisition cost plus a reasonable dispensing fee and/or administrative fee, or (b) at acquisition cost plus a reasonable mark-up with no dispensing or administrative fees.

f. Pricing – The Numbers

Overall, the prices set forth in the 2016 Contract for retail, mail order and specialty drugs appear to be below the current market. Indeed, our review of the 2009 and 2014 contracts indicates that pricing has remained somewhat flat over the past eight years. We attach at Attachment B a table that tracks pricing under the 2009, 2014 and 2016 Contracts.

While the 2016 Contract allows the State to perform a market check pursuant to Section X of Attachment B to the State's EGWP contract with Express Scripts, that Section has been redacted in the copy of the EGWP contracted provided to us. Thus, we are unable to decipher the scope of the State's right to a market check.

As for pricing guarantees, the recent TriCast audit found that Express Scripts failed to meet the pricing guarantees in 2015 and 2016 for both the commercial and EGWP plans. While Express Scripts paid the State $683,219.52 for the 2016 shortfall, TriCast concluded that Express Scripts was entitled to off-set the 2015 shortfall of $1.1 million with an overperformance on rebate guarantees such that no money was due to the State. *See* 9/14/17 TriCast Report at 12. We have not received any reports regarding the prices delivered for 2017 and whether those prices met the contract guarantees.

RECOMMENDATIONS: The State should ask its current PBM consultant, Remedy Analytics, to provide advice on pricing currently available in the market and suggest strategies for getting Express Scripts to improve its pricing in the final year of the contract. At the very least, the State should investigate whether the 2017 annual reconciliations have been performed and how any discrepancies between the guaranteed price and actual price delivered have been handled.

Pursuant to its contract with the DHR, Remedy Analytics is required to perform "annual reconciliations of contractual financial guarantees" beginning in calendar year 2016. *See*

Remedy Contract at pages 6-7. So perhaps this work has been performed or is about to be completed.[4] The State should follow up with Remedy and investigate any and all discrepancies in prices delivered versus prices guaranteed for 2017.

3. Rebates

In a normal commercial setting, a manufacturer will pay a rebate directly to the consumer who purchases the manufacturer's product. Unfortunately, the prescription drug world is far from a normal commercial setting. PBMs, like Express Scripts, have inserted themselves between the drug manufacturers and the folks who pay for prescription drugs, i.e., self-funded plan sponsors like the State. In doing so, PBMs often enter into contracts with the manufacturers that create multiple revenue streams for the PBMs. The key is for plan sponsors to understand those revenue streams and to negotiate and execute contracts with PBMs that best protect the sponsor's interest in securing the full value of all drug manufacture revenue streams that are tied to the sponsor's purchases. Here, the 2016 Contract falls short in accomplishing that task.

First, the 2016 Contract states that Express Scripts contracts with drug manufacturers on its own behalf and that Express Scripts, not the State, "retains all right, title and interest" in rebates and administrative fees paid by drug manufacturers. Contract at page 28. Thus, despite the fact that the State, not Express Scripts, funds the purchases that generate the rebates, the State has agreed that rebates and related administrative fees are the property of Express Scripts, not the State.

Second, under the 2016 Contract, for brand name drugs and specialty drugs dispensed to plan members and paid for by the State, Express Scripts is required to pay the State the greater of: (1) "[redacted]% of the Rebates and Manufacturer Administrative Fees received by ESI or its affiliates"; or (2) the guaranteed dollar amounts set forth in separate tables, provided the State meets certain plan design requirements (with the guaranteed amounts for specialty drugs exceeding those for brand name drugs). *See* 2016 Contract at Attachment B. In turn, the 2016 Contract defines the term "Rebates" to mean any amount payable to Express Scripts "pursuant to the terms of a ***formulary rebate contract*** negotiated independently by ESI and directly attributable to the utilization of certain Covered Drugs to Members." 2016 Contract at page 15. And the term "Manufacturer Administrative Fee" is defined to mean fees paid to Express Scripts "directly in connection with ESI's ***administering, invoicing, allocating and collecting*** Rebates under the Rebate program." Contract at page 14 (emphasis added).

So where does all this contract language leave the State? Our answer – not in a very good position. The State has agreed that Express Scripts owns all rebates and administrative

[4] It is not clear why TriCast audited the 2016 pricing guarantees when the Remedy contract states that Remedy would perform that work. *See* Remedy Contract at 3, 6-7. To clarify matters, the State should ask Remedy to provide a detailed description of the nature and scope of its work and then request TriCast to explain how its work was different.

fees paid by drug manufacturers to Express Scripts based on the State's purchases, and Express Scripts has agreed to pay to the State no more than: (a) the guaranteed minimum per claim payments stated in the contract tables; or (b) if greater, [redacted]% of the "formulary rebates" and the administrative fees that the manufacturers pay to Express Scripts for invoicing and collecting such formulary rebates. Stated otherwise, Express Scripts owns all drug manufacturer rebates and administrative fees and has agreed to share with the State just one slice of that pie.

While Express Scripts "represents and warrants that it will not enter into any agreement with a pharmaceutical manufacturer for other pharmaceutical revenue ***with the intent to reduce Rebates***" (Contract, page 15 (emphasis added)), such language provides little protection to the State. Express Scripts is free to secure for itself multiple revenue streams that can increase over time as long as the State's single revenue stream (i.e., formulary rebates) remains flat and does not decrease. Indeed, the reference to Express Scripts' "intent" could mean that Express Scripts can negotiate terms that in practice result in a decrease in formulary rebates as long as Express Scripts did not "intend" such a result.

Section 15 of Attachmet D to the 2016 Contract (see page 85) requires Express Scripts to disclose to the State "all financial terms and arrangements for remuneration of any kind that apply between [Express Scripts] and any prescription drug manufacturer that relate to benefits provided to Members under or services to the State's Plan, including formulary management and drug-switching programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees." We have not received any reports wherein Express Scripts discloses this detailed information. While we have received copies of Express Scripts' reports pursuant to Vermont Act 144, 18 VSA § 9472 for the years 2014-2016, those reports simply report a dollar amount that represents the "aggregate remuneration invoiced by Express Scripts to pharmaceutical manufacturers for the preceding calendar year that relate to benefits provided to beneficiaries under or services to the State of VT Government Plan." The reports do not disclose "all financial terms and arrangements for remuneration of any kind" between Express Scripts and drug manufacturers that relate to the State Plan.[5]

As for rebate payments that the State has received from Express Scripts, we have received one report covering the period 1/1/2017 to 3/31/17. While that report shows a payment of $902,986.94 due to the State, it does not indicate whether that payment is based on the guaranteed minimum per claim amounts set forth in the contract tables or [redacted]% of the formulary rebates and related fees received by Express Scripts. Moreover, the report does not

[5] The Contract "disclosure" language matches the language found in the Vermont statute. Thus, the State apparently has accepted Express Scripts' interpretation of the level of disclosure required under the contract and statute. The State might want to reconsider its position and insist that Express Scripts provide more detail regarding its dealings with drug manufacturers.

provide a separate accounting for brand name drugs and specialty drugs as required under the 2016 Contract and its separate provisions/tables for brand and specialty drugs.

As for rebate audits, the audit reports we received show that the State conducted three rebate audits that covered less than two years of Express Scripts' "rebate" payments to the State. While all three reports found no errors, it is not clear whether the audits covered both the guaranteed minimum payments and the "[redacted]% of Rebates and Administrative Fees."

RECOMMENDATIONS: We recommend that the State perform a comprehensive review of its current rebate program. The review should: (1) address the contract shortcomings noted above; (2) investigate whether Express Scripts is required to provide more detailed reporting under the 2016 Contract (Attachment D, Section 15); and (3) include a comprehensive rebate audit that tests whether Express Scripts has in fact paid to the State the greater of (a) the guaranteed rebates, or (b) [redacted]% of formulary rebates and administrative fees.

As noted above, TriCast has audited rebates for the periods Q42012-Q12013 (12/10/2014 Report) and Q12015 (Draft 9/14/2017 Report). Both audits involved TriCast reviewing a set of rebate contracts on-site at Express Scripts' offices. We recommend that the State ask TriCast to explain in more detail the scope of its audits and its conclusions. Given the on-site reviews, TriCast might be able to provide the State with valuable insights on how the State can protect its interests moving forward.

4. Audits

The 2016 Contract includes a one-paragraph audit provision that requires Express Scripts to "maintain all records pertaining to performance under this agreement" and to make those records available to the State during the contract term and for three years after the close of the contract. Contract, Attachment D, Section 15. Importantly, the audit terms do not provide Express Scripts with the right to approve the State's auditor or to place restrictions on the scope of the audit. PBMs, including Express Scripts, often seek to impose such restrictions and it is good to see that they are not found in the 2016 Contract.

RECOMMENDATIONS: While a step in the right direction, the audit provision could be improved to address the specifics of claims adjudication audits and rebate audits. We recommend that the State include in future PBM contracts language that details the exact data and records that the PBM must maintain and produce upon demand for claims adjudication audits, including readily accessible claims data in a set format (e.g., fixed-length text file) with all fields necessary for audit, complete with a data dictionary and file layout. The State should also include the requirement, mentioned above, that the PBM maintain and produce for all audit a complete record of the State's plan designs as communicated by the State to the PBM and signed off by both parties. Similar detail should be provided for rebate audits.

By email dated April 20, 2017, we proposed language that the SAO could use for purposes of requesting claims data and MAC Lists for audit. We attach that language to this

report at Attachment C and suggest that the State include such detailed language in future PBM contracts. To ensure a streamlined audit process with little to no delays in securing data suitable for audit, we suggest that the State require the PBM to produce on a quarterly or annual basis a data file that satisfies the State's requirements for claims adjudication audits. By doing so, the State will have the data in its possession and avoid having to rely on the PBM to extract and produce such data in advance of any audit.

PLAN DOCUMENTATION REVIEW AND RECOMMENDATIONS

A. THE BIG PICTURE

The State's plan documentation consists of: (1) the documents that set the terms of the State's prescription drug benefits; and (2) the documents by which the State communicates those terms to the service provider that implements those terms, i.e., Express Scripts. As discussed below, our review has uncovered several issues that should be addressed as soon as possible.

1. The State's Plan Documents

The State's plan documents consist of a comprehensive "Group Health Benefit Plan Document" that covers all medical benefits, including prescription drug benefits, and two summaries of benefits: (1) The SelectCare POS Plan Summary of Benefits; and (2) the TotalChoice Summary of Plan Benefits. The Group Health Benefit Plan Document is dated May 2014 and the two summaries are dated October 2016.

The State provides the same prescription drug benefit to employees enrolled in the SelectCare Plan and the TotalChoice Plan. The only difference, based on the summaries of benefits, is that the SelectCare Plan does not cover out-of-network prescriptions whereas the ChoiceCare Plan covers such prescriptions. Members who are enrolled in SelectCare must get their prescriptions at a retail pharmacy under contract with Express Scripts or at Express Scripts' mail order facility. If they go out-of-network, SelectCare members must cover the entire cost of the prescription. TotalChoice Plan members, on the other hand, may obtain their prescriptions at any pharmacy, subject to the same deductible and copayment requirements that apply to SelectCare members.

The details of the State's prescription drug benefit are set forth in the Group Health Benefit Plan Document, Section IX.P. (pages 33-35). In presenting those details, this comprehensive plan document states that "[e]xcept for prescriptions filled outside the U.S., no out-of-network pharmacy benefit is available. If a Member obtains a prescription from a non-network retail or mail order pharmacy in the U.S., she/he is responsible for 100% of the charges." 2014 Plan Document (PD) at page 34. Thus, there is an apparent disconnect between the TotalChoice summary of benefits and the comprehensive 2014 Plan Document.

As for the other plan terms presented in the 2014 Plan Document, the level of detail is lacking. For example, in describing prior authorizations, the Plan Document simply states "[f]or a limited number of drugs, prior authorization is required." PD at page 34. It does not list the drugs requiring a PA or explain how a member can obtain a copy of the current PA List. Similarly, in describing drugs that are excluded from coverage, the 2014 Plan Document simply states that "[i]tems not covered include a limited number of prescription drugs, over the

counter vitamins, minerals, food supplements and other items that do not require a prescription by law." PD at page 34.

In listing the medical conditions, services, supplies and expenses that are excluded from coverage under the State Health Benefit Plan, Section XIII of the comprehensive Plan Document states that "[d]rug exclusions are detailed in the Pharmacy Schedule of Benefits." PD at page 68. Our copy of the 2014 Plan Document did not include that Schedule of Benefits, so perhaps additional details of the prescription drug benefit are presented in that missing document.

RECOMMENDATIONS: We recommend that the State undertake a comprehensive review of its plan documents to ensure that those documents accurately record the details of the State's prescription drug benefit. Any differences between the benefit for SelectCare plan members and TotalChoice plan members must be clearly stated and recorded in the comprehensive Plan Document and disclosed in the benefit summaries.

In that regard, the State should consider carving out prescription drug benefits from the comprehensive medical benefit plan document and preparing a separate plan document dedicated to detailing the State's prescription drug benefit. In doing so, the State should improve the level of detail currently provided by addressing and accurately stating a comprehensive set of plan designs, including deductibles, copayments, out-of-pocket maximums, drugs subject to prior authorizations, excluded drugs, mandatory generic rules and the calculation of related ancillary charges, refill-too-soon rules (aka amply supply limits), quantity limits, specialty drug coverage rules and biosimilar coverage rules. If there are multiple differences between the SelectCare drug benefit and the TotalChoice drug benefit, the State should consider preparing a separate document for each plan.

The key is for the State to ensure that the details of its prescription drug benefit are clearly and accurately recorded in a comprehensive plan document. In turn, that plan document can serve as the basis for: (1) identifying and correcting errors in the unsigned EBD; (2) updating the EBD and securing Express Scripts' agreement to implement that EBD throughout the remainder of the 2016 Contract; and (3) advising RFP bidders of the precise terms of the State's plan and securing the winning bidder's agreement to implement those terms as recorded in the State's comprehensive plan document.

2. Plan Design Communications with Express Scripts

As noted above, the 2016 Contract requires the State to record the details of the State's prescription drug benefit in the Express Scripts Benefit Document (EBD) and to certify, via an authorized signature, that the EBD is accurate and complete. If a plan design term is not presented in a signed EBD or a signed amendment to the EBD, the State may have no recourse against Express Scripts for failing to implement that plan design when adjudicating the State's claim. Thus, it is essential that the State accurately record the details of its prescription drug benefit in the EBD, sign and send that document to Express Scripts and then maintain a readily accessible copy of the signed EBD in the State's files.

As we reported during our 9/21/2017 conference call, the EBD that has been provided to us is dated 1/1/2014 and is not signed by the State or Express Scripts. Moreover, while the Express Script Set-Up Forms (i.e., the standard form for amending the EBD) are signed, they are dated 2014 and early 2015 and thus do not appear to be a complete collection of all plan design changes. While there may be emails and other unsigned documents that purport to communicate plan design changes to Express Scripts, the 2016 Contract requires all changes to be communicated via a signed document.

RECOMMENDATIONS: If it has not done so already, the State should undertake an immediate review of the unsigned 2014 EBD and the signed Set-Up forms to ensure that they accurately reflect the current terms of the State prescription drug benefit. If there are any disconnects, the State should make the necessary corrections and report them to Express Scripts for immediate implementation. In that regard, we note the unsigned EBD states that "non-participating pharmacies are not covered" (EBD at page 5, Member Payment) whereas the TotalChoice summary of benefits states that such pharmacies are covered. That apparent disconnect should be investigated and corrected as needed.

As part of its plan design review, we recommend that the State ask Express Scripts to confirm in writing that the unsigned 2014 EBD (as amended) has served as the controlling plan design document under the 2014 and 2016 Contracts despite the fact that it lacks the required signature. If Express Scripts refuses to do so, the State should consider sending Express Scripts a signed copy of the EBD (after confirming its accuracy) and instruct Express Scripts to implement all plan designs as set forth in that EBD throughout the remainder of the 2016 Contract. By doing so, the State will at very least protect its interests for the remainder of the Contract.[6]

B. DRILLING DOWN

Our review of the State's plan documents and the unsigned EBD has uncovered several plan design terms that may not be in State's best interest. We identify those terms below and recommend changes that could better serve the State's interests in controlling prescription drug utilization and the related costs.

[6] We note that the recent TriCast Audit Report (Draft 9/14/2017) states the TriCast audited Express Scripts' implementation of the State's plan designs (e.g., drug exclusions, prior authorizations, age rule, quantity limits) "based on documentation provided by ESI." TriCast Report at 17. TriCast, however, does not identify the specific documentation that it received from Express Scripts. The State should investigate to determine whether TriCast audited plan designs as recorded in the unsigned 2014 EBD or some other document(s). The key is to confirm that TriCast audited an accurate statement of the State's plan and not a document that misstates the terms of that plan.

1. The Express Scripts Formulary

The State has adopted the Express Scripts Formulary, which is a list of the preferred brand name drugs and generic drugs covered under the State's plan, subject to the applicable copayments. *See* 2016 Contract at page 13 (defining "Formulary"). If a drug does not appear on the Express Scripts Formulary, plan members will incur the higher 40% copayment for "non-preferred" drugs. While the State has reserved the right to reject Express Scripts' changes to the Formulary through Set-Up forms, none of the forms provided to us reject any formulary modifications, and the formulary provided is marked "2017 Express Scripts Basic Formulary."

To secure a spot on the Express Scripts Formulary and thereby increase market share as a preferred drug, drug manufacturers are willing to pay rebates and other financial benefits to Express Scripts. In turn, those financial benefits have the potential to emerge as a driving factor for placement on the formulary, with cost, effectiveness, safety and side effects perhaps playing a secondary role. Thus, while the State's copayment structure incentivizes the dispensing of formulary drugs with its lower copayment for preferred drugs, less expensive brand name drugs often are available in the market within each therapeutic category, even after accounting for the payment of "formulary" rebates.

We recommend that the State consider undertaking a more aggressive role in monitoring the Express Scripts Formulary, including the use of Remedy to assess alternative drugs when a change is proposed by Express Scripts.

2. Prescriber Identification Numbers

Prescriptions for controlled substances must include the prescriber's DEA number, and the presence of an invalid DEA number in the claims record is an indication of fraud, waste and abuse. Accordingly, the unsigned 2014 EBD requires Express Scripts to reject any claim for controlled substances (Classes I-V) that does not carry a valid prescriber DEA number. *See* 2014 EBD at page 15. That DEA edit, however, provides that all claims "must pass the DEA check digit edit."

The reference to the "DEA check digit edit" raises a concern as there are numerous "dummy" DEA numbers that pass the DEA check digit, even though those "dummy" numbers are not valid DEA numbers. PBMs might choose to allow the use of "dummy" DEA numbers to avoid disruption at the pharmacy counter when the script is illegible or missing the required DEA number.

We recommend that the State consider adopting a more restrictive DEA number edit that expressly prohibits the use of "dummy" DEA numbers. It is our understanding that PBMs, including Express Scripts, have the ability to block claims with known "dummy" DEA numbers. The State should address this issue with Express Scripts and ask that the more restrictive edit be put in place as soon as possible. At the same time, and as discussed below, we recommend

that the State ask Remedy Analytics to run a list of known dummy DEA numbers against historical claims data to shed some light on the scope of this potential problem.[7]

3. Prior Authorization (PA)

In general terms, prior authorization refers to a process under which a plan member must demonstrate that a particular drug or drug therapy is medically necessary and/or meets certain criteria prior to obtaining that drug. Typically, a prior authorization is required for high-cost drugs or drugs that may be subject to fraud, waste or abuse and thus serves an important role in promoting the health and welfare of members and avoiding excessive costs. The 2016 Contract describes the prior authorization process (Contract at pages 7-8), and the unsigned 2014 EBD identifies those drugs that are subject to a PA requirement and includes a "prior authorization override worksheet" dated 12/8/05.

We recommend that the State consider undertaking a comprehensive review of its prior authorization program to ensure that it is up to date and serving the interests of the State and its plan members. As new drugs come to market, especially high-cost specialty products and biosimilars, the State should ensure that appropriate prior authorization requirements are put in place and managed correctly. As part of its review, the State should clarify the rules regarding the expiration of a PA to ensure that PAs are not treated as "golden tickets" that permit members to receive an endless supply of the drug in question.

4. Refill-Too-Soon (RTS)/Ample Supply Edits

A refill-too-soon edit (aka ample supply edit) prohibits a member from obtaining a refill until the member has used a set percentage of a prior script for the same medication. The edit is designed to ensure that members adhere to the correct drug therapy and do not engage in the hoarding of drugs or "doc shopping." The unsigned 2014 EBD sets a 25% RTS edit for retail scripts and a 40% RTS edit for mail order scripts. EBD at page 15. Thus, a plan member who receives a 30-day script at a retail pharmacy cannot obtain a refill of that same medication until he/she has utilized 75% of that script, leaving a 25% supply at the time of refill. Under the 40% RTS edit for mail order, a member cannot obtain a refill of the same medication until he/she utilizes 60% of the existing medication, leaving a 40% supply at the time of refill. Moreover, as stated in the EBD, Express Scripts applies a 7-day grace period for mail order scripts, which allows the member to obtain scripts seven days prior to utilizing 60% of the existing medication.

The 2014 TriCast Audit Report (covering the period 1/1/11-12/31/13) identifies problems with Express Scripts application of the RTS edits. That report, however, apparently accepted Express Scripts' explanation that "[p]lan benefit design shows that the client has been setup with a soft reject that allows the medication to be filled with a warning per refill too soon

[7] The CGI Audit covering 7/1/09-6/30/11 noted the presence of "fictitious" DEA numbers in the State's claims data, questioned Express Scripts' response and recommended that the State monitor the situation. CGI Report at 13-14. It is unclear whether the State did so.

guidelines. The pharmacist is allowed to make a professional judgment based on the needs of the patient." 2014 Report at 17. A review of the unsigned 2014 EBD shows that the RTS edits at page 15 are marked with an "F" and that per that same page, "F" means "fatal error – rejected."

We recommend that the State ask Express Scripts to confirm in writing that it is applying the 25% and 40% RTS edits as hard or "fatal" edits and not as "soft" edits that do not reject claims that violate the edit. If Express Scripts indicates that a soft edit is in place, we suggest that the State instruct Express Scripts to apply a hard/fatal edit going forward and secure Express Scripts' agreement to do so in writing. We also recommend that the State instruct Express Scripts to refrain from applying its standard 7-day grace period for mail scripts as the 40% RTS edits for such scripts provides members with ample time to obtain a refill through the mail (40% of 90 days = 36 days to obtain refill). At the same time, and as discussed below, we recommend that the State ask Remedy to apply the RTS edits to historical claims to shed some light on the scope of this potential problem.

PLAN PERFORMANCE REVIEW AND RECOMMENDATIONS

A. SCOPE OF REVIEW

Pursuant to the SAO-TessellateRx contract, we agreed to evaluate the State's past utilization by analyzing claims data that would be provided to us by the SAO. Due to delays in securing claims data and concerns regarding the confidentiality of that data, we suggested, and the SAO accepted a modified approach to completing this task.

The State's current PBM consultant, Remedy Analytics, has access to historical claims data and the tools necessary to run queries against that data to test prior plan performance. Recognizing the capabilities of Remedy, we have agreed to recommend a set of plan performance evaluations that the State can request Remedy Analytics to perform and report on to the State. We present those recommendations below.

B. RECOMMENDATIONS

1. Pricing Guarantees

As noted above, the 2016 Contract requires Express Scripts to pay the State the difference between the contract price guarantees and the actual average prices delivered for brand name and generic drugs. In turn, under its contract with the State, Remedy has agreed to test Express Scripts' compliance with that requirement. As noted above, the recent TriCast audit covered the 2015 and 2016 guarantees. We have not received any reports indicating that this work has been performed for 2017. The State should investigate and ask Remedy to perform the work if not done to date.

In doing so, the State should ask Remedy to test Express Scripts' compliance by re-pricing the claims using the Medi-Span MONY codes (as opposed to accepting Express Scripts' BGA). Such a review could provide some valuable insights as to how Express Scripts' "proprietary" BGA might not be in the State's best interests.

2. Specialty Drug Pricing

Because the State did not elect the "exclusive" option for specialty drugs, the State is not entitled to the annual discount guarantee for such drugs. Instead, the State pays the per claim rates set forth in the table found at pages 38-53 of the 2016 Contract, with no right to a minimum guarantee. We have not been provided an updated rate table, if one exists.

We recommend that the State ask Remedy to test whether Express Scripts correctly identified specialty drug claims (only those drugs on the list are to be priced at the specialty rates) and priced those claims in accordance with the specialty table in effect on the date the claim was dispensed. While Remedy's April 2017 PharmaLogic Report presents certain

information regarding the State's specialty drug expenditures, it does not report whether the claims were priced correctly. While there might be a separate report providing that information, we have not received a copy of any such report.

3. Deductibles, Copayments and Annual Maximums

The State's prescription drug benefit includes: (1) a $25 individual deductible and a $75 per family deductible; (2) a member copayment structure of 10% for generics, 20% for preferred brand drugs, 40% for non-preferred brand drugs; and (3) an annual maximum copayment of $775/individual (inclusive of the $25 deductible). Further, the VT Plan provides that copayments for non-preferred brands do not apply to the annual maximum whereas copayments for specialty drugs do apply to that maximum. While we have received Excel tables indicating that the State is tracking the plan maximum accumulations, we have not received any reports that test whether the percentage copayments are being applied correctly.

The recent TriCast audit covered copayments for 2015-2016, but apparently did not test whether Express Scripts is calculating the percentage copayments correctly. *See* TriCast 9/14/2017 Report at 15-16. TriCast, however, found that Express Scripts was not applying the out-of-pocket maximums correctly and noted that Express Scripts had committed to working with the State "on the next steps including impact."

We recommend that the State ask Remedy to review the TriCast report and run additional tests as needed to determine whether the plan parameters for copayments are being implemented correctly. Such analysis should address the copayment concern we raised above, i.e., whether Express Scripts is allowing out-of-network claims for TotalChoice members at the stated deductible, copayments and annual maximums (*see* "State's Plan Documents" at page 21, above). Remedy and State should also confirm that Express Scripts has fixed the issue with the out-of-pocket maximums and has refunded any money due to the State and/or its plan members.

4. Copayment Claw Backs

In general terms, a copayment claw back occurs when: (1) a plan member pays a copayment that exceeds the discounted price paid to the pharmacy or the pharmacy's cash price (aka "usual and customary price"); and (2) the PBM recoups or "claw backs" the difference between the member copayment and the discounted price or cash price. Recently, a federal judge in Connecticut allowed Cigna members to pursue ERISA and RICO claims against Cigna for its alleged claw back practices.

The 2016 Contract appears to prohibit claw backs. *See* Contract at page 35 ("A member's Copayment charged for a Covered Drug will be the lesser of the applicable Copayment, Ingredient Cost Charge, or U&C"). We recommend that the State ask Remedy to test whether Express Scripts has satisfied this contract provision.

5. Mandatory Generic Rule

The State's plan includes the following mandatory generic rule: "If a Member or a provider requests the prescription be filled with a brand drug when a generic drug is available and medical information sufficient to justify dispensing of a brand drug is not presented at to the pharmacy benefit manager, the entire difference in cost between the brand name drug and the generic drug as well as any applicable deductibles and copays must be paid by the Member. Any amounts payable by the Plan will be based on the cost of the generic drug." Group Health Benefit Plan Document (May 2014) at page 33. The unsigned 2014 EBD includes the same rule. EBD at page 6, Ancillary Charge Policy.

As written, this rule is a "Dispensed as Written (DAW) 2" rule under which a member who obtains a brand name drug when a generic equivalent is available must pay the ancillary charge even if the prescriber requested the brand name drug with no substitution. A "DAW 1" rule would clearly state that the member is excused if the prescriber specifies no substitution, and such language is not found in the State's plan documentation. We recommend that the State confirm that the rule is a DAW 2 rule and then request Remedy to test whether that rule has been applied correctly (i.e., applied to all DAW 1 and DAW 2 claims) and that the correct ancillary charge has been applied to all claims that violate the rule.

6. Dummy DEA Numbers

As noted above: (1) the unsigned 2014 EBD states that claims for controlled substances will be allowed if the submitted prescriber DEA number passes the check digit test; and (2) there are many invalid DEA numbers that pass the check digit test. Thus, the State may be paying for controlled substances that lack a valid DEA number, raising the possibility of fraud, waste and abuse.

According Remedy's April 2017 PharmaLogic Report: (1) the State (and its members) paid $495,918 for 7,469 opioid prescriptions that were dispensed over the six-month period 7/1/16 to 12/30/16; and (2) "opioid patients have a ***six-month Rx plan cost 70% higher*** than the average patient." Report at page 12 (emphasis original). We recommend that the State ask Remedy to run a list of known dummy DEA numbers against those 7,469 claims and report how many claims included such a dummy DEA number and to repeat that exercise for controlled substance claims dispensed and paid for by the State in 2017. While the presence of a dummy DEA number does not necessarily mean that the underlying script is fraudulent, the results could warrant further investigation and support a plan design that prohibits the use of "dummy" DEA numbers.

7. Refill-Too-Soon/Ample Supply Edits

As noted above (1) the unsigned 2014 EBD sets a 25% RTS edit for retail claims and a 40% RTS edit for mail order claims; and (2) the 2014 TriCast audit (covering claims dispensed 1/1/11-12/31/13) indicates that Express Scripts has a "soft" edit in place that allows claims that

do not satisfy these RTS edits. As a result, the State is exposed to over utilization and the related costs.

We recommend that the State ask Remedy to apply the retail and mail order RTS edits to the readily accessible claims data to determine the extent of the State's exposure. In doing so, the State should instruct Remedy to treat as refills (and not new prescriptions) all successive claims that share the same medication at the same strength, including such claims that have a change in dose. Further, for mail order claims, the State should instruct Remedy to apply the 40% RTS edit without adding the 7-day grace period referenced in the EBD, assuming that such a grace-period is not a part of the State's benefit plan.

8. Compound Drugs

Under the 2016 Contract, compound drug claims are excluded from the average annual ingredient cost discount guarantees and are "paid by the State at the lesser of [redacted] or combined [redacted] plus [redacted] for [the] Participating Pharmacy." 2016 Contract at page 35. Further, the unsigned 2014 EBD restricts the dispensing of compound drugs to retail pharmacies and appears to set a per claim maximum of $100. EBD at page 15.

The 12/15/16 Remedy Report notes that, for the nine-month period 1/1/16-9/29/16, there were 325 compound drugs claims with a gross cost of $28,789 and a gross cost per claim of $89. *See* 12/15/16 Report at 66. We recommend that the State ask Remedy to review those 325 claims to ensure that Express Scripts priced them correctly and then test whether the frequency and overall cost of compound claims for all of 2016 and 2017 are within acceptable ranges.

RECOMMENDATIONS FOR ADDITIONAL ANALYSIS OF PBM PERFORMANCE OR OTHER PBM OVERSIGHT MECHANISMS

A. THE BIG PICTURE

In our view, there are four key components to building a prescription drug benefit program that performs as intended:

1. Adopt a comprehensive prescription drug benefit plan and then accurately communicate that plan, and all modifications, to the contracted PBM;
2. Draft a PBM contract that protects the State's interests and then secure, through a contract-based RFP, the PBM's agreement to be bound by the State's PBM contract;
3. Monitor the PBM's performance in implementing the State's plan designs and applying the contracted prices; and
4. Document all concerns with the PBM's performance, communicate those concerns to the PBM, and then follow through with the PBM to make sure all concerns are addressed and resolved to the satisfaction of the State.

Simply monitoring a PBM's performance does little good if the underlying Benefit Plan and PBM Contract are not drafted with overall goal of the protecting the State's interest in delivering a comprehensive benefit at reasonable prices. Stated otherwise, we believe that PBM oversight begins at the plan design stage and remains dependent on strong PBM contract terms, clear lines of communication and proper recordkeeping throughout the contract term. We have addressed Components 1-3 in the preceding sections of this report. Below we present several recommendations for improving Component 4.

B. RECOMMENDATIONS

Based on the documentation provided, the State's current monitoring program consists of: (1) conducting periodic audits of PBM claims adjudications and payment of rebates; and (2) retaining Remedy Analytics to provide on-going monitoring and analysis of the State's utilization and Express Scripts' adherence to pricing guarantees. While such PBM oversight is consistent with industry practices, we recommend that the State implement aggressive follow through procedures for its PBM audits and take better advantage of Remedy's analytical tools and reporting capabilities.

1. Claims Adjudication Audits

Over the course of its fourteen plus year relationship with Express Scripts, the State has conducted three claims adjudication audits that covered just five years of claims. *See* CGI Audit covering the period 7/1/09 – 6/30/11; TriCast Audit covering 1/1/12 – 12/31/13; and TriCast

Audit covering 1/1/15 – 12/31/16. As detailed in the audit reports, each audit uncovered problems/issues with Express Scripts' claims adjudications, resulting in possible significant overcharges to the State. The documentation provided to us, however, suggests that the State has not pursued all potential recoveries or followed through with Express Scripts to make sure all documented errors have been corrected to the satisfaction of the State.

For example, the recent TriCast Audit report indicates that Express Scripts failed to meet its pricing guarantees for 2015 by over $1 million but was permitted to offset that amount by an overperformance in rebate guarantees.[8] The same report indicates that Express Scripts moved brands to generic guarantees and generics to brands guarantees during the reconciliation process, which in turn impacted the prices delivered – presumably via Express Scripts proprietary BGA.

We recommend that the State scrutinize all existing audit reports and consider pursuing all well-documented overcharges, if any, that fall within the applicable statute of limitations. At the very least, the State should ensure that all documented plan design implementation errors have been or will be corrected as soon as possible to avoid future overcharges. To the extent the State concludes that contract language prevents an audit recovery, the State should ensure that such language is corrected and does not work its way into any future PBM contract.

At the same time, we recommend that after entering into a new PBM contract (1/1/19) the State should perform an implementation "check" within 90 days to ensure that the new PBM has recorded and implemented correctly the State's plan designs and new pricing terms. Moving forward, the State should conduct 100% claims re-adjudication audits on an annual basis. The key is to be diligent in securing complete documentary proof of all audit findings and then following through with the PBM to ensure all errors are corrected and any payments due to the State are paid promptly.

2. Rebate Audits

Based on the documentation provided, the State has conducted three rebate audits covering less than two years of Express Scripts rebate payments to the State. *See* CGI Rebate Audit covering 1/1/10-12/31/10; TriCast rebate audit covering Q42012-Q12013; and TriCast rebate audit covering Q12015. All three audits found no errors, though each audit was limited in time and number of manufacturers. Moreover, as noted above, it is unclear whether these

[8] While not referenced in the TriCast Report, the 2014 Contract contains the following language at the end of a long list of "assumptions" in Exhibit 1 (Fees and Charges) to Attachment B: "Contractor will pay the difference of the State's net cost for any shortfall between the actual result and the guaranteed result. *Any excess achieved in any other guarantee offered pursuant to this Contract will be used to make up for, and offset, a shortfall in the other guarantees.*" (emphasis added). While this language appears to allow an offset, we recommend that the State consider referring the matter to the Attorney General's Office for further investigation. The same language was removed/deleted from the 2016 contract, and while similar language was in the 2009 Contract, it was not inserted at the end of a long list of "assumptions." Given the $1 million at stake, the State should consider taking a closer look.

audits tested both the per claim minimum guaranteed payments and the percent of "Rebates and Administrative Fees" stated in the 2009, 2014 and 2016 Contracts.

The most recent TriCast audit report is marked "Draft" and is dated 9/14/2017. Thus, that audit may remain open. We recommend that the State meet and confer with TriCast to better understand: (1) the scope of its rebate audit; and (2) whether Express Scripts is retaining any drug manufacturer revenue streams or other financial benefits that Express Scripts is not sharing with the State under the guise that those funds are not "Rebated and Administrative Fees" as used in the 2016 Contract. Such a discussion could shed some light on whether Express Scripts has retained any funds that are due to the State and/or assist the State in identifying contract issues that can be addressed in the current RFP process and fixed in the new contract, effective 1/1/2019.

3. Remedy Analytics Contract

Pursuant to its contract with the DHR, Remedy has agreed to provide a host of PBM consulting services, including: (1) conducting on-going Market Checks as directed by the State; (2) performing annual reconciliations of PBM contract pricing guarantees; and (3) performing on-going monthly claims collection and analytics utilizing Remedy's proprietary PharmaLogic software. As detailed in the DHR-Remedy contract, these services are quite extensive and should provide the State with excellent insights into the performance of its prescription drug program.

The Remedy documentation provided to us, however, suggests that the State is not taking advantage of the capabilities of Remedy and its analytical tool PharmaLogic. We have received just two Remedy reports, both covering claims dispensed in 2016. While the reports present helpful information regarding the State's utilization, they do not include a list of recommendations or action items designed to improve plan performance. While Remedy may have included such items in additional reporting, we have not received those reports.

We recommend that the State hold a "PBM Summit" with Remedy where the State can explain to Remedy its concerns with its plan's performance and ask Remedy to address those concerns with focused analytics and a comprehensive set of detailed recommendations. Communication is key, and the State should strive to voice its concerns and ask questions to ascertain a full understanding of the data and areas in need of improvement. In the preceding section of this report, we present a list of plan performance/audit checks for the State to present to Remedy for consideration. That list could serve as a guide for a productive dialogue with Remedy.

Along those same lines, the recent TriCast audit report identifies problems with Express Scripts' performance over the two-year period 2015-2016. We recommend that the State present the TriCast report to Remedy and ask Remedy to explain the audit findings and suggest how the State can "fix" the disconnects that underlie those findings. If possible, the State should include TriCast in those discussions.

TessellateRx

Document. Verify. Preserve.

RECOMMENDATIONS FOR IMPROVING
THE PERFORMANCE OF THE STATE OF VERMONT'S
PRESCRIPTION DRUG BENEFIT PROGRAM

FINAL: MAY 8, 2018

Prepared by TessellateRx, LLC

ATTACHMENT B

STATE OF VERMONT – COMPARISION OF CONTRACT PRICING 2009-2018

Data removed as it is exempt from public disclosure per 1 V.S.A. §317(c)(9)

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RECOMMENDATIONS FOR IMPROVING
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FINAL: MAY 8, 2018

Prepared by TessellateRx, LLC

ATTACHMENT C

SAMPLE CLAIMS DATA AND MAC LIST REQUESTS

CLAIMS DATA

Please produce an electronic record of all paid claims covering the period _____ to _____ in the standard NCPDP Billing Layout 2.0 (or higher). For each paid claim, we require a complete record of all NCPDP data fields, including but not limited to the following fields:

- Transaction Number
- Prescription Number
- Date of Service (aka dispense date)
- Paid date
- Group ID Number
- Contract ID Number
- Member ID Number
- Member Date of Birth
- Member Relationship Code
- Person Code
- Pharmacy Name and NABP & NPI Number
- Location Code
- Prescriber DEA Number
- Prescriber NPI Number
- Mail/Retail Indicator
- Brand/Generic Indicator
- Formulary Indicator
- Maintenance Indicator
- Compound Indicator
- Specialty Drug Indicator
- National Drug Code ("NDC") – 11
- Drug Name and Strength
- Quantity Dispensed
- Days Supply
- AWP Unit Price or Claim AWP
- Ingredient Cost
- Dispensing Fee
- Incentive Fee
- Tax Amount
- PBM Administrative Fee
- MAC cost
- MAC Flag
- Member Copayment/Co-Insurance
- Deductible
- Amount Billed to Sponsor
- DAW Code
- Ancillary Charge
- GPI-14
- Basis or Base of Cost (e.g., AWP discount, MAC or U&C)
- Prior Authorization Indicator/Number
- U&C price submitted by dispensing pharmacy
- Paid/Rejected Status
- Reversal Status

Please produce the claims data in a fixed length text file format, and please include: (1) a complete record layout; and (2) a data dictionary that defines all terms and/or codes appearing in the claims data.

MAC LIST(S)

Please produce an electronic version of the historic MAC List you used to adjudicate the State's prescription drug claims during the period _____ to _____. If you used different MAC Lists, please produce an electronic version of each list, with the start and end date stated for each MAC price and MAC List.

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ATTACHMENT D

VERMONT-EXPRESS SCRIPTS

CHRONOLGY OF CONTRACTS AND AUDITS

2004-2008: Contract No.1, five-year contract (1/1/2004-12/31/2008)

- Contract not provided

2009-2013: Contract No.2, original four-year contract term (1/1/2009-12/31/2012)

- RFP performed by Milliman in 2008
- Amended five times; final amendment extended contract one year (1/1/2013-12/31/2013)

2009-2011: Audit No.1, CTI/CGI Audit of ESI Claims Adjudications and Rebate Payments

- Two separate reports – both undated
- Claims Audit Report – plan implementation/contract pricing 1/1/2009-6/30/2011
- Rebate Audit Report – rebate payments received 1/1/2010–12/31/2010; limited to four manufacturers

2012-2013: Audit No. 2, TriCast Audit of ESI Claims Adjudications and Rebate Payments

- One Report dated 12/10/2014
- Claims Audit – plan implementation/contract pricing 1/1/2012–12/31/2013
- Rebate Audit – covers payments received Q42012-Q12013; limited to five manufacturers

2014-2015: Contract No. 3, original two-year contract term (1/1/2014-12/31/2015)

- RFP performed by Milliman in 2013
- Amended 12/31/2015 to extend contract one month to 1/31/2016

8/10/15: State-Remedy Analytics Contract (8/10/2015-12/31/2018)

- Contract review and claim price analysis for Active Employees and Retirees
- Conduct monthly claims collection and analytics and on-going market checks
- Conduct annual reconciliation of PBM contracted financial guarantees
- Perform on-going pharmacy benefit analytics and professional clinical services

2016-2018: Contract No. 4, effective 2/1/2016-12/31/2018

- Amends and restates Contract No. 3 in its entirety; no RFP
- Covers Active Employees and Medicare Qualified Retiree Prescription Drug Plan Services

2017: Audit No. 3, TriCast Audit of ESI Claims Adjudications and Rebate Payments

- Draft report dated 9/14/2017
- Claims Audit – plan implementation/contract pricing 1/1/2015-12/31/2016
- Rebate Audit – covers payments received Q12015; limited to five manufacturers