LIMITED SCOPE EXAMINATION OF PHARMACY BENEFIT MANAGERS

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EXECUTIVE SUMMARY

Health insurers utilize the services of Pharmacy Benefit Managers ("PBMs") to manage prescription drug benefits on their behalf. While PBMs were originally designed to reduce administrative costs in administering a prescription drug program, PBMs have grown and now have substantial profitmaking ability through price spreading and rebates.

Amid concerns about PBM practices, the state of Arkansas passed the 2018 *PBM Licensure Act* which authorizes the Arkansas Insurance Commissioner ("Commissioner") to license and regulate the activities of PBMs. Subsequently, the Arkansas Insurance Department ("AID") issued Rule 118: *Pharmacy Benefits Managers Regulation* which licenses and regulates the activities of PBMs. Additionally, the Arkansas State Legislature passed Act 994 of 2019 which explicitly prohibited spread pricing as of July 24, 2019. Additional guidance surrounding this was provided in AID Bulletin No. 7-2019.

In 2019 the Commissioner engaged Lewis & Ellis, Inc. ("L&E") and its subcontractors, Ideal Health Strategies ("IHS") and Regulatory Insurance Advisors, LLC, ("RIA"), (collectively the "auditors" or "examiners") to perform a limited scope market conduct examination to review spread pricing [1] and other reimbursement activities of PBMs providing prescription coverage for state funded health plans issued through either the Arkansas Works ("AR Works") program (Arkansas Works Act of 2016, Ark. Code Ann. §§ 23-61-1001 et seq) or the Provider-led Arkansas Shared Savings Entity (PASSE) system created by Act 775 of 2017. The PBMs subject to the examination were Optum Rx, CVS/Caremark, and Express Scripts, Inc. (ESI)

The differential pricing analysis showed that National Chain pharmacies were reimbursed more (defined as greater than 5% difference) than Regional Chain and Independent Pharmacies for the same drug product unit (i.e. tablet, capsule).

The spread pricing analysis showed that one of the three PBMs being audited, ESI, was employing significant spread pricing practices during the audit time frame. Specifically, ESI was charging the health benefit plan an estimated 15.26% more than was being paid to the pharmacies.

[1] "spread pricing" is defined in AID Rule 118 to mean "the model of prescription drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for prescription drugs although the contracted price may differ with the amount the pharmacy benefits manager pays the pharmacist"

The Direct and Indirect Remuneration (DIR) or "clawback" analysis showed that both CVS Caremark (9.71%) and ESI. (4.55%) assessed DIR or "clawback" fees to the pharmacies during the audit timeframe. OptumRx's clawback pricing could not be evaluated.

While the report focuses on several pharmaceutical pricing practices, it does not provide a complete picture of pharmacy costs and PBM compensation. There are a number of additional factors that impact PBM revenues and pharmacy reimbursements that were either outside of the scope of this report or unavailable due to the lack of PBM response. These additional factors include rebates, additional insurer fees, and pharmacy fees.

PURPOSE & SCOPE

BACKGROUND AND SCOPE

Health insurers utilize the services of Pharmacy Benefit Managers ("PBMs") to manage prescription drug benefits on their behalf. PBMs offer a variety of services, including but not limited to claim adjudications; customer service or call centers; clinical services such as prior authorizations; drug utilization reviews; and mail-order and specialty pharmacies.

PBMs provide many cost-cutting measures to health insurers, e.g. by establishing pharmacy networks. These networks give PBMs purchasing power, allowing them to negotiate discounted prescription coverage for insurers and their customers. PBMs can also negotiate manufacturer rebates directly with the pharmaceutical company to further reduce prescription drug costs. These services allow PBMs to generate revenue through several approaches, including administration and service fees charged to insurers for processing prescriptions, through operation of their own mail-order and specialty pharmacies, and on the margin between the amount charged to insurance plan sponsors and the amount paid out to pharmacies for a prescription.

While PBMs were originally designed to reduce administrative costs in administering a prescription drug benefit program, PBMs have grown and now have substantial profitmaking ability through price spreading and rebates, which are payments negotiated directly with pharmaceutical manufacturers. It can be difficult for health insurers to oversee compliance with prescription benefit programs outsourced to PBMs in part because they are not subject to industry-wide regulation. Exact terms of the financial arrangements for pharmacy services are obscured in part by the sheer number of entities involved in every transaction including insurers, PBMs, pharmacies, wholesalers, manufacturer, and by the contract provisions that keep most of the transactional details confidential. These issues result in a lack of transparency in the expenditure of Arkansas's dollars spent on public pharmaceutical programs.

Therefore, amid growing concerns about PBM practices, the state of Arkansas passed Act One (1) and Act Three (3) of the Second Extraordinary Session of 2018 by the Ninety-First (91st) Arkansas General Assembly, "*An Act To Create The Arkansas Pharmacy Benefits Manager Licensure Act*," (hereafter, the "PBM Licensure Act") which authorizes the Arkansas Insurance Commissioner ("Commissioner") to license and regulate the activities of pharmacy benefits managers ("PBMs").

The PBM Licensure Act was amended by Act 994 of 2019. On August 18, 2018, AID issued a rule licensing and regulating the activities of PBMs in AID Rule 118: "Pharmacy Benefits Managers Regulation".

Pursuant to the PBM Licensure Act and AID Rule 118, in 2019 the Commissioner engaged Lewis & Ellis, Ideal Health Strategies, and Regulatory Insurance Advisors to perform a limited scope market conduct examination to review spread pricing and other reimbursement activities of PBMs providing prescription coverage for state funded health plans issued through either the Arkansas Works ("AR Works") program (Arkansas Works Act of 2016, Ark. Code Ann. §§ 23-61-1001 et seq) or the Provider-led Arkansas Shared Savings Entity (PASSE) system created by Act 775 of 2017.

This examination is authorized to be conducted under the following Arkansas Code and Arkansas Insurance Department (AID) rules:

- Ark. Code Ann. § 23-61-201 for health insurance issuers.
- Ark. Code Ann. § 23-76-122 for health maintenance organizations.
- AID Rule 117, Section 7 (A)(7) for PASSE organizations, and
- Ark. Code Ann. § 23-92-508 and AID Rule 118, Section 8 for PBMs.

The Health Plans and their contracted PBMs included in this examination are defined in Table 1 below.

Table 1. Arkansas Health Plans and PBMs Examined

Arkansas Health Plan	Program	PBM
Arkansas Total Care	PASSE	CVS Caremark
Celtic Insurance Company d/b/a/ Arkansas Health & Wellness	Arkansas Works	CVS Caremark
Empower Healthcare Solutions	PASSE	CVS Caremark
QCA Health Plan	Arkansas Works	OptumRx
QualChoice Life and Health Insurance Company	Arkansas Works	OptumRx
Summit Community Care	PASSE	Express Scripts (ESI)
USAble Mutual Ins Co d/b/a/ Arkansas Blue Cross Blue Shield	Arkansas Works	CVS Caremark

LIMITS ON DISTRIBUTION AND UTILIZATION

This report has been prepared for the use of the AID regarding the financial examination of health insurers and PBMs specifically participating in either the Arkansas Works or PASSE programs. A review of ERISA plans, Commercial Markets and comparable markets was not performed. The data and information presented is not appropriate for any other purpose.

Any user of this report must possess a certain level of expertise in health insurance, pharmacy services, actuarial science, and/or financial examinations, so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that the authors do not make any

representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against the authors, under any theory of law, related in any way to this material.

CONFIDENTIALITY OF REVIEW & RELIANCES

Examination records of AID are considered confidential and privileged under §§ 23-61-207, 23-61-107, 23-61-103(d), provisions which are applicable to both health insurers under examinations, and PBMs, pursuant to Rule 118, Section 8, and Ark. Code Ann. § 23-92-508.

The auditors were required to share and access data, records, work papers and other information, from this limited scope examination. The auditors agreed to accept the same restrictions limiting the disclosure of any of the above referenced data, records, and information as are applicable to AID.

The term "confidential data" includes all working papers, recorded information, documents, and copies produced by, obtained by, or disclosed to the Commissioner or any other person during this examination.

The auditors certified that they would use the confidential data received pursuant to this Agreement for the sole purpose of the examination and not for any other purpose, and in no event shall the auditors disseminate or communicate the confidential data in any form to any other person or entity, other than to AID.

The auditors certified that they would not use or disclose any confidential data with any of its personnel or departments that are not directly engaged in the examination.

The auditors certified that any claims data or rebate information received in the course of the examination shall only be disclosed to persons within its organization who: (1) are required to protect and otherwise not disclose or use the confidential data except as provided in the examination; and (2) need to know the confidential data.

Confidential data was held in the strictest confidence at all times and will not be divulged to any party other than the auditors, including but not limited to, other employees, officers, directors or agents of the auditors, and will not be used for any purpose other than the examination.

The auditors' work was based upon data and information obtained through the AID, the insurers, the PBMs, and Pharmacies. The auditors did not perform a complete audit of the data provided. The auditors relied upon the above parties to attest to the accuracy of the information provided. The auditors did review the data for overall appropriateness. If there were any material inaccuracies in the data provided, the conclusions reached in this report may be invalid.

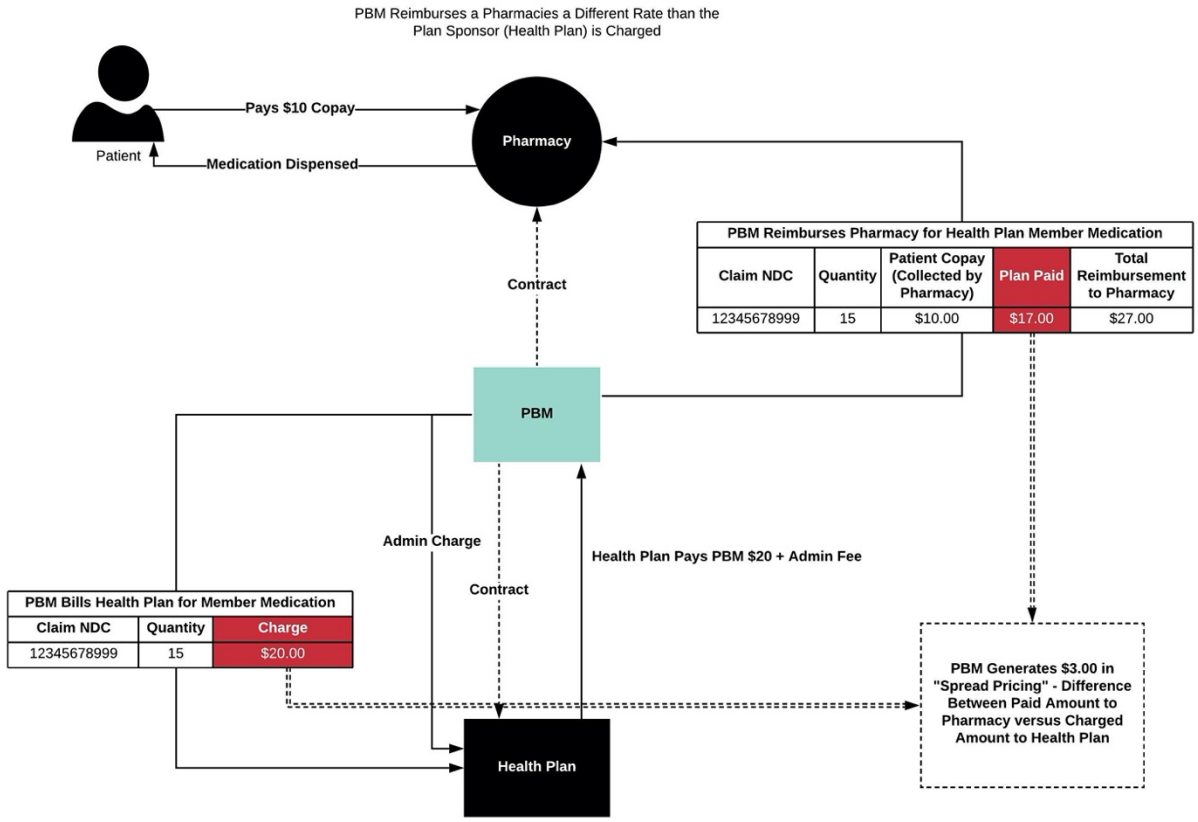
As examiners appointed by you pursuant to Ark. Code Ann. § 23-61-201 et seq, L&E and its subcontractors Ideal Health Strategies (IHS) and Regulatory Insurance Advisors, LLC (RIA) shall have immunity from liability for any statements made or conduct performed in good faith while carrying out the provisions of the examination statutes stated above.

DEFINITIONS OF PBM PRICING PRACTICES EVALUATED

SPREAD PRICING

Spread pricing is the PBM practice of charging the health plan a certain amount for a prescription but reimbursing the pharmacy at a lower rate and retaining the difference ("spread") as profit. Figure 1 provides an illustration of PBM spread pricing.

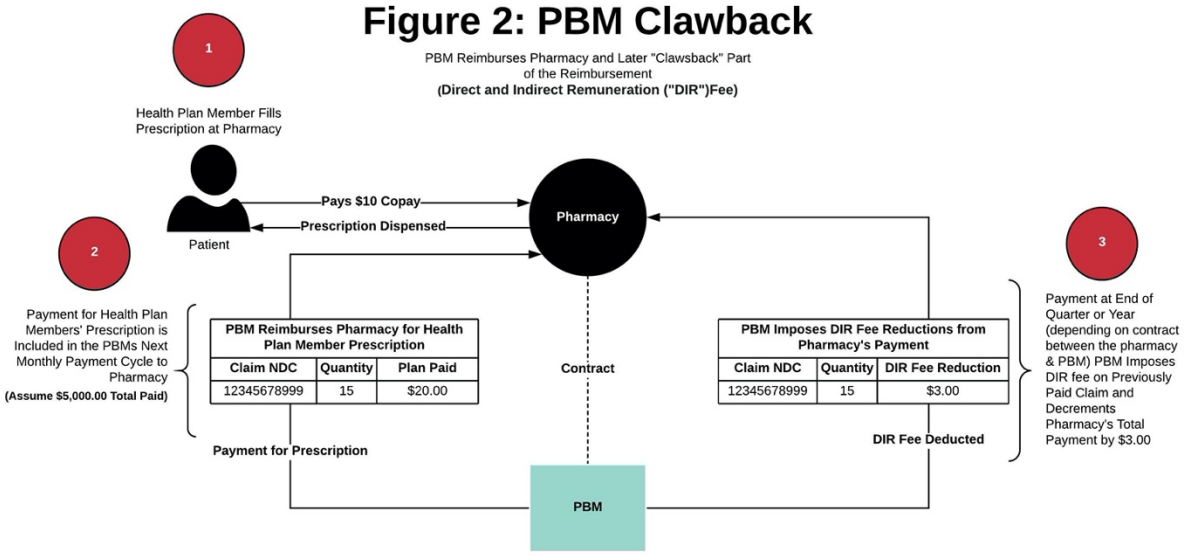
Figure 1: PBM Spread Pricing Example



DIRECT AND INDIRECT REMUNERATION (DIR) OR "CLAWBACK" FEES

Direct and Indirect Remuneration (DIR) or "clawback" are retroactive fees assessed by the PBMs on the dispensing pharmacy after the prescription is dispensed. DIR fees can be in numerous forms (e.g. service fees, network access fees, administrative fees, reconciliation fees, etc.) that are often unclear to pharmacies who are forced to accept the PBMs DIR fees in the pharmacy network agreement.

DIR fees are difficult for the pharmacy to quantify and reconcile due to the lack of transparency in the pharmacy's agreement with the PBM. Most pharmacies are unable to accurately reconcile DIR fees back to the original prescription claim to ensure DIR fees were imposed correctly per the contract because the PBMs do not provide claim-level reporting to pharmacies for the DIR fees [2]. DIR fees are often assessed months after the point of sale and add to the PBM profit at the cost of the pharmacies. Figure 2 provides an illustration of PBM DIR/Clawback fees.



DIFFERENTIAL REIMBURSEMENT

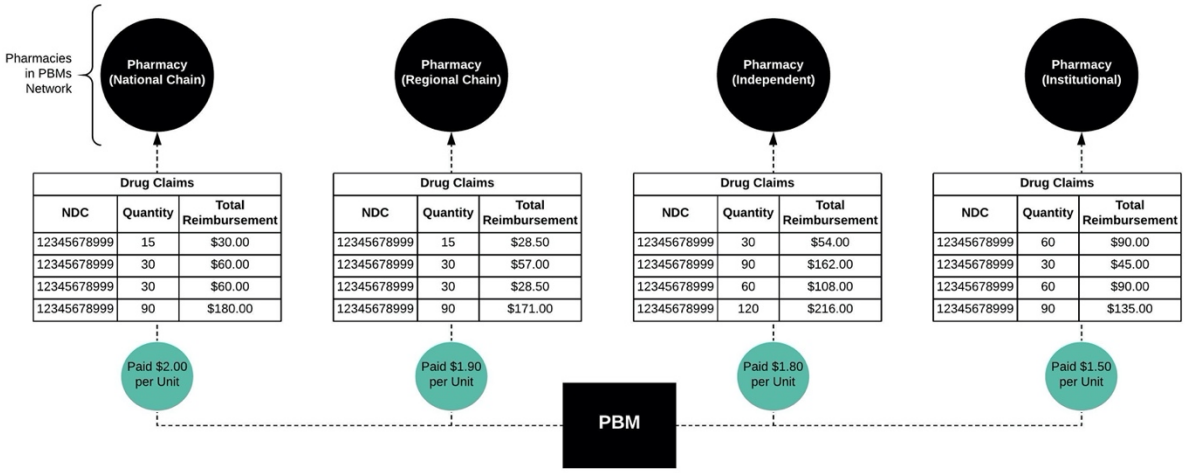
For the purposes of this audit, "differential reimbursement" refers to differences in reimbursement rates from the PBM to the pharmacies. The analysis compares the reimbursement of drugs down to the drug unit cost level (i.e. individual drug tablet, capsule, mg, etc.) between national, regional and independent pharmacies, as well as differences between pharmacies affiliated with the PBM, specifically CVS Caremark, and non-PBM affiliated pharmacies.

The purpose of the differential reimbursement analysis was to determine if the PBMs were providing reimbursement to certain pharmacies at higher reimbursement rate versus other pharmacies. Figure 3 provides an illustration of differential reimbursement.

[2] Direct and Indirect Remuneration (DIR) Performance and the Impact on Pharmacies Serving Medicare Part D Beneficiaries. A White Paper by INMAR Intelligence® February 2019, Revised July 2019. A White Paper by Inmar Intelligence, commissioned by NACDS (National Association of Chain Drug Stores). Accessed June 2020, https://www.nacds.org/pdfs/government/2019/DIR-Whitepaper.pdf.

Figure 3: PBM Differential Reimbursement Example

PBM Reimburses a Pharmacies a Different Rate for the Same Product



AUDIT PROCEDURES

DATA COLLECTION

Beginning in July 2019, data was requested from the Arkansas sponsored health plans and the PBMs that provide prescription benefit management to the health plans as detailed in Table 1.

The data requested included:

HEALTH PLAN

- PBM contracts and amendments.
- All pharmacy claims.
    - These claims were requested from the health plans, but provided, directly or indirectly, by the PBMs

PHARMACY BENEFIT MANAGERS (PBM)

- Complete and unredacted PBM management agreements, amendments, and appendices.
- A listing of all reimbursement agreements with pharmacies in the State of Arkansas.
- Complete and unredacted copies of all pharmaceutical rebate agreements between the PBM and pharmaceutical manufacturers.
- A complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019. This time frame was chosen because the AID assumed oversight of the PBMs on January 1, 2019.
- The pharmacy paid claims tape for each Arkansas health plan.
- A copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
- Pharmacy claims processing information for all Arkansas health plans.
    - Bank Identification Number (BIN)
    - Processor Controller Number (PCN)
    - Group #/Group ID

Pharmacies

A sample of 100 Arkansas pharmacies were chosen to receive the pharmacy data request. The data requested was for March 2019. This shortened timeframe was chosen to assist the pharmacies with the management of the volume of data requested. It was also determined that by reviewing a truncated timeframe, the information would still lead to confirmation of spread

pricing and clawback disparities. The pharmacies are not under the oversight of the AID, so any data submitted by the pharmacies was voluntary.

The 100 pharmacies were sent a letter requesting pharmacy claims processing data specific to the information above. The purpose of the pharmacy data request was to acquire the pharmacies claim system level data so that it could be compared to the data provided by the PBMs. Beginning February 20, 2020, a letter was sent to the pharmacies requesting the following data:

- Claims level detail for each of the Arkansas sponsored insurance companies (carriers or PASSE entities) that were processed by the pharmacy during the month of March 2019. Key data points that were requested included:
    - Processing information (BIN/PCN/Group ID) to identify the PBM that covered the claim.
    - All payment information (e.g. patient copay, amount paid by carrier, total received by the pharmacy, dispensing fee paid to pharmacy).
    - Any retroactive fees (DIR, etc.) assessed on the pharmacy by the PBM.
- Unredacted copies of pharmacy contracts with each of the PBMs evaluated by the audit, namely CVS Caremark, OptumRx and Express Scripts.
- The name and contact information for the pharmacy contact person.

The data received or omitted from the Health Plans and the PBMs included:

HEALTH PLANS

- Arkansas Blue Cross Blue Shield (CVS Caremark)
    - Provided PBM contracts and amendments
    - Provided full set of claims, but data set was provided to health plan by CVS Caremark
- Empower (CVS Caremark)
    - All data was provided by CVS Caremark
- Centene
    - All data was provided by CVS Caremark
- QualChoice (Optum Rx)
    - Provided PBM contracts and amendments
    - Provided full set of claims, but data set was provided to health plan by OptumRx

- Summit (Express Scripts)
    - All data provided by Express Scripts

PHARMACY BENEFIT MANAGERS

- CVS Caremark
    - Provided copies of PBM agreements with health plans (BCBSAR, Empower, Centene)
    - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas
    - Provided complete and unredacted copies of all agreements between the PBM and pharmaceutical manufacturers regarding rebates. However, these were not provided until May 28, 2020 (requested in July of 2019)
    - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019
    - Provided pharmacy paid claims tape for each Arkansas health plan
    - Provided a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019
    - Provided processing information for all Arkansas health plans
    - Processing information (BIN/PCN/Group ID) for CVS Caremark plans:
        - Arkansas BCBS
            - 004336/ADV/RX3961
            - 004336/-/RX3956
        - Centene
            - Ambetter – 004336/-/RX5448
            - Arkansas Total Care – 004336/MCAIDADV.RX5476
        - Empower
            - 004336/ADV/RX2798
- OptumRx
    - Provided copies of PBM agreements with health plan, however all specialty pricing was redacted from contracts and amendments
    - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas
    - Provided copies of agreements between the PBM and pharmaceutical manufacturers regarding rebates. These documents were uploaded May 26, 2020 (Requested in July of 2019). Due to timing, these documents have *not* been reviewed for completeness.
    - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019.

  - Did *not* provide pharmacy paid claims tape for each Arkansas health plan.
  - Provided a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
  - Provided processing information for all Arkansas health plans.
  - Processing information (BIN/PCN/Group ID) for OptumRx plans:
    - QualChoice
      - 005947/-/QCAQHP
      - 005947/-/QCA

- Express Scripts
  - Provided copies of PBM agreements with health plan (Summit), however all specialty pricing was redacted from contracts and amendments.
  - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas.
  - ESI did *not* provide any manufacturer rebate agreements stating that there are no rebates for PASSE entities.
  - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019. However, this data was *not* provided in the format (24 data fields) or with the terminology requested. Rather, the claims were submitted in a set with 284 individual data fields using ESI terminology, which added complexity to the audit due to having to identify the data fields relevant to the analysis.
  - Provided pharmacy paid claims tape for each Arkansas health plan.
  - Did *not* provide a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
  - Provided processing information for all Arkansas health plans. However, the spreadsheet provided had 123,872 individual BIN/PCN/Group ID combinations. Upon discussion with one of the pharmacies in our subset, auditors were informed that there was only one BIN/PCN/Group ID combination relevant to the State funded plan.
  - Processing information (BIN/PCN/Group ID) for ESI plans:
    - Summit
      - 020107/NS/WPKA

PHARMACY SUBSET

- Thirty-six (36) of the 100 pharmacy companies (representing 51 pharmacies), to whom data requests were sent provided meaningful responses (claims and/or contracts) to the data request.

- Pharmacies that responded to the data request represented a mix of independent pharmacies and regional pharmacy chains. *No* national chains responded to the request.
- Summary of responses provided:
    - Claims data - 51 pharmacies provided claims data with PBM payment information
    - DIR/Clawback data - Only one regional pharmacy chain was able to provide DIR/Clawback data
        - Multiple pharmacies contacted the auditors stating that the PBMs had locked the pharmacies out of accessing this information on their access portals.
    - PBM Contracts - Only 10 pharmacy companies provided copies of their PBM contract
        - Several pharmacies contacted the auditors stating that the PBMs had instructed them that their contracts were proprietary and that they were not allowed to share the contracts with auditors under threat of contract termination.

DATA NORMALIZATION

Data files from PBMs by carrier were uploaded to a secure Citrix ShareFile site for the auditors to analyze. All claims data sets were converted to Excel spreadsheets, if necessary. Claims data from each PBM were converted into a standard and consistent data layout and formatting.

Negative claims (reversals and rejections) were removed along with the matched positive claims to net only fully adjudicated claims. For the Optum claims set, a large number of reversed claims did not have an equal number of positive (e.g. processed) claims. As an example, RX number 129140 had 20 reversals at the same pharmacy on 3/8/2019, but no positive processed claim in the data set. This did not affect our analyses as there were net positive claims to match the pharmacy data set. However, this does affect the overall summary of net claims. After data normalization was performed, the individual pharmacy claims sets were combined into a single claims data set.

For the purposes of the differential pricing analysis, pharmacies in the PBM data set were classified as either an Independent (I), National Chain (N), or a Regional Chain (R).

An independent pharmacy was defined as a pharmacy that had 3 or less locations. A national chain was defined as a company with pharmacies equally distributed throughout the United States (e.g. CVS, Walgreens, Wal-Mart). A regional chain was defined as a pharmacy company not defined as a national chain with more than 3 locations in the state of Arkansas.

Claims from March 2019 were isolated from each of the PBM data sets for the Spread Pricing and DIR/Clawback Analysis.

DATA ANALYSIS APPROACH

During the audit analysis, it was discovered that a portion of claims information received from the health plans included claims that were outside the Arkansas Works plans. The auditors were able to obtain from the Arkansas All-Payer Claims Database (APCD) the percent of claims from each health plan that were applicable to Arkansas Works plans.

The APCD data was applied to the total data set of claims submitted by Blue Cross Blue Shield of Arkansas (CVS), Centene (CVS), Empower (CVS) and QualChoice (Optum) to estimate the actual number and total spend of AR Works claims. It should be noted that Summit (Express Scripts) participates in the PASSE program only and does not participate in AR Works.

While the auditors did not use the insurers' National Association of Insurance Commissioners (NAIC) Annual Statement data for the analysis, the NAIC statement information is available publicly and contains information regarding market penetration for pharmacy data.

DIFFERENTIAL PRICING

For each PBM data set, claims were calculated to the unit cost level for each drug product national drug code (NDC) (e.g. NDC 00597015230 - JARDIANCE TAB 10MG, Claim Quantity 90, Total paid = $1375.04, Calculated Unit Cost = 15.28 ($1375.04/90)) to accurately compare the amount paid to the pharmacy for each drug product. Claims for each drug vary by the quantity dispensed so the unit cost calculation normalizes the data for comparison of reimbursement across drugs and pharmacies.

The auditors categorized the pharmacies associated with each claim into "Pharmacy Type" categories to compare the reimbursement of the individual drug unit costs based upon the type of pharmacy. These categories were:

- National chain pharmacy.
- Regional chain pharmacy.
- Independent pharmacy.
- Specialty pharmacy, and
- Institutional pharmacy (e.g. hospital pharmacies and native American tribal pharmacies).

The focus of the differential pricing analysis was to compare the PBMs' reimbursement for each drug between national chain pharmacies, regional chain pharmacies, and independent pharmacies operating within Arkansas. Claims for specialty pharmacies and institutional pharmacies were excluded from the differential pricing analysis since the normal drug reimbursement for these types of pharmacies have inherent high volatility across pharmacies and by drug type.

Comparative analytics were completed based upon the pharmacy type (national chain pharmacies, regional chain pharmacies, and independent pharmacies) and the corresponding unit cost for each drug product dispensed across the pharmacies.

SPREAD PRICING

The individual PBM datasets from March 2019 were combined with the pharmacy data, matching claims based on prescription number, fill number and date filled. To identify the presence of "spread", the "total paid" to the pharmacy from the pharmacy claims data set was subtracted from the "total paid" to the pharmacy from the PBM claims data set. Any difference between the "total paid" numbers was defined as "spread".

Spread is reported both as a total amount, as well as the percentage of total paid of the claims in the matched data set. Percent of claims with spread pricing is also presented.

The pharmacy data set represents claims from a subset of pharmacies from a single month of the audit timeframe. The results from this subset analysis was extrapolated to estimate the total spread amount from January 1st through June 30th, 2019.

DIR/CLAWBACK

"DIR/Clawback Fees" was a data field in both the PBM and the Pharmacy data request. Claims with DIR reported were totaled and reported as the percentage clawed back compared to the total spent.

The pharmacy data set represents claims from a subset of pharmacies from a single month of the audit timeframe. The results from this subset analysis was extrapolated to estimate the total spread amount from January 1st through June 30th, 2019.

AUDIT RESULTS

DATA DEMOGRAPHICS

PBM DATA

The claims data submitted by the PBMs is summarized in Table 2 below.

Table 2. PBM Data Demographics (Claim Records)

PBM	CVS Caremark			OptumRx	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims	1,626,536	705,177	144,476	318,724	110,003
Total Claims by Pharmacy Type					
Independent	490,998	196,380	55,121	73,001	40,757
Regional Chain	281,090	119,818	57,506	53,376	24,147
National Chain	833,393	380,040	29,865	184,860	42,096
Other	21,055	8,939	1,984	7,487	3,003

Claims from CVS Caremark-covered health plans accounted for most claims (85.16%) from Arkansas Works plans. Due to incomplete data, the reported claims were removed from the Express Scripts (6,207 claims) and OptumRx (70,208 claims).

PHARMACY DATA

The claims submitted by the pharmacies are summarized in Table 3 below.

Table 3. Pharmacy Data Demographics (Claim Records)

	All Plans	CVS Caremark			OptumRx	Express Scripts
		BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims	32,257	16,600	5,427	3,470	3,901	1,730
Claims with Clawback Data	5,203	2,806	482	1,134	0	798

Fifty-one (51) pharmacies submitted a total of 32,257 claims for the timeframe of March 1st through March 31st, 2019. A small number of claims (1,129) were submitted by pharmacies that were from marketplace plans not part of Arkansas Works plans. These claims were excluded.

LIMITATIONS OF DATA:

- PBM Data.
  - There were zero DIR/Clawback fees reported by the PBMs for the audit timeframe.
- Pharmacy Data
  - Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set.
  - No national chain pharmacies submitted claims data, so that section of retail pharmacies could not be evaluated.
  - Only one pharmacy company submitted DIR/Clawback data. That data set does not include any claims from OptumRx, so auditors are unable to evaluate DIR/Clawback results for OptumRx.

DIFFERENTIAL PRICING ANALYSIS RESULTS:

The results of the differential pricing analysis are summarized in Table 4 below. The analysis uses negative numbers to represent pharmaceutical pricing approaches that favor certain pharmacy types over another (e.g. favors National Chain Pharmacies over Independent Pharmacies).

Pharmacies participate in the PBMs pharmacy network by contractual agreement. The agreement defines the guaranteed average wholesale price (AWP) and maximum allowable cost (MAC) reimbursement rates in which the PBM will reimburse the pharmacy for claims submitted for PBM members. The PBMs agreements with pharmacies will vary in regard to the reimbursement rate guarantees based upon the number of pharmacies participating, estimated volume of PBM member claims processed and timing (i.e. when the agreement was signed). PBMs may apply different contractual language in the agreement with the pharmacy which allows the PBM to classify certain drug products differently (i.e. brand versus generic) and/or apply different MAC lists. Overall, the difference in reimbursement rates between pharmacies should be minimal, differing by only a few percentage points. The auditors consider differential reimbursement of 5% or greater to be material.

Table 4. Differential Pricing Analysis Summary

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs National					
All Claims	-3.69%*	-3.69%*	-17.70%*	0.70%#	0.09%#
Brand Claims	-0.36%*	-0.36%*	-12.79%*	-12.74%*	-17.60%*
Generic Claims	-4.76%*	-4.76%*	-24.56%*	3.20%#	1.78%#
Specialty	-0.56%*	-0.56%*	-2.49%*	-20.51%*	N/A
*Independent Pharmacies were Paid Less than National Chains, # Independent Pharmacies were Paid More than National Chains					

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs. Regional					
All Claims	-0.30%*	-0.30%*	-8.86%*	-9.80%*	-18.86%*
Brand Claims	0.00%	0.00%	-26.44%*	-4.47%*	-2.63%*
Generic Claims	-0.54%*	-0.54%*	-5.20%*	-10.58%*	-20.18%*
Specialty	-2.89%*	-2.89%*	-1.38%*	-5.31%*	N/A
*Independent Pharmacies were Paid Less than Regional Chains, # Independent Pharmacies were Paid More than Regional Chains					

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Regional vs. National					
All Claims	-4.56%*	-4.56%*	-21.60%*	-4.66%*	-0.78%*
Brand Claims	0.58%#	0.58%#	-3.38%*	-8.99%*	-2.03%*
Generic Claims	-6.04%*	-6.04%*	-26.94%*	-3.84%*	-0.66%*
Specialty	-0.27%*	-0.27%*	-12.78%*	-6.26%*	N/A
*Regional Pharmacies were Paid Less than National Chains, # Regional Pharmacies were Paid More than National Chains					

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs. CVS-Owned					
All Claims	-0.71%*	-1.16%*	28.80%#	N/A	N/A
Brand Claims	-1.62%*	1.25%#	0.19%#	N/A	N/A
Generic Claims	-0.49%*	-1.73%*	33.34%#	N/A	N/A
Specialty	-0.44%*	-4.48%*	N/A	N/A	N/A
*Independent Pharmacies were Paid Less than CVS Pharmacies, # Independent Pharmacies were Paid More than CVS Pharmacies					

For the BCBSAR and Centene plans (both CVS Caremark), the data set shows a small preference in pricing toward the National Chain and Regional Chain pharmacies over the Independent Pharmacies. The auditors consider the difference to be acceptable. However, the Regional Chain pharmacies were paid less (-6.04%) than National Chain pharmacies for generic claims which is considered material as the difference is greater than 5%.

For the Empower (CVS Caremark), QualChoice (OptumRx) and Summit (ESI) data sets, the pricing advantage to the larger pharmacy entities (i.e. National Chains) is much more pronounced versus Regional Chains and Independent Pharmacies. The auditors consider the difference to be material since it is greater than 5%.

Overall, the BCBSAR and Centene plans (both CVS Caremark) data sets demonstrated a small reimbursement difference based upon the pharmacy type which is considered normal and acceptable. The exception is Regional Chain pharmacies were paid less (-6.04%) than National Chain pharmacies for generic claims which is considered material as the difference is greater than 5%. Please refer to Table 4.

Empower (CVS Caremark), QualChoice (OptumRx), and Summit (ESI) almost always reimbursed national pharmacies at higher rates than the rates at which they reimbursed regional or independent pharmacies. Not only were national pharmacies reimbursed at higher rates, Table 4 illustrates that the difference in rates usually resulted in national pharmacies being compensated for the same drug at a rate often 5% higher, if not more than 5% higher, than the rate provided to regional or independent pharmacies.

The auditors also compared the reimbursement between Arkansas operating CVS Caremark owned pharmacies (CVS Pharmacies) versus Arkansas Independent Pharmacies to determine if CVS Caremark was reimbursing its' owned pharmacies more than locally owned and operated Arkansas pharmacies. The difference in reimbursement for the BCBSAR and Centene data sets

is considered acceptable. For the Empower data set the Independent Pharmacies were paid significantly more than the CVS Pharmacies.

LIMITATIONS OF ANALYSIS

- Auditors were unable to obtain copies of contracts between PBM and pharmacy to assess whether pricing is in line with individual pharmacies contracted pricing.
- No "specialty" indicator on ESI claims to assess differences in pricing.
- For CVS Caremark and OptumRx data set, the number of matching specialty NDC's between pharmacy types was extremely small.

SPREAD PRICING ANALYSIS

The results of the spread pricing analysis are summarized in Table 5 below by health plan and PBM.

Table 5. Arkansas Works/PASSE PBM Analysis Summary – Pharmacy Data Set March 2019

PBM	CVS Caremark			OptumRx	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Matched Claims - Pharmacy Data	13,342	4,995	2,910	1,522	1,542
Claims w/ Spread	63	14	4	1	1,290
Total $ Spread	$8,299	$593	$65	$2	$29,363
Total PBM Spend	$669,469	$1,304	$227,558	$4.94	$160,976
% Spread	**1.24%**	**45.45%**	**0.03%**	**47.77%**	**18.24%**
% of Claims w/ Spread	**0.47%**	**0.28%**	**0.14%**	**0.07%**	**83.66%**

Overall, the auditors did not see significant spread pricing practices with CVS Caremark or OptumRx plans.

Conversely, there was significant spread pricing found in the ESI-administered PASSE plan. More than 83% of claims in the pharmacy data subset showed spread pricing practices. This spread accounted for more than an 18% difference between the amount that the health plan was charged and the amount the pharmacy was paid.

These results were extrapolated to the full claims set from the six-month audit timeframe to provide an estimate of spread pricing over the entire audit period. The results are summarized in Table 6 below.

Table 6. Arkansas Works/PASSE PBM Analysis Summary - January 1st-June 30th, 2019

PBM	CVS Caremark			Optum	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims in Data Set	1,626,536	705,177	144,476	248,516	106,637
Total Health Plan Spend	$133,285,068	$52,894,989	$13,089,025	$14,637,357	$11,793,275
Average $/RX	$81.94	$75.01	$90.60	$58.90	$110.59
% AR Works	66.00%	67.00%	67.00%	66.00%	100%
Approximate RX's – ARW	1,073,514	472,469	96,799	164,021	106,637
Total Health Plan Paid ARW	$87,968,145	$35,439,642	$8,769,647	$9,660,655	$11,793,275
Approximate Claims w/ Spread	5,069	1,324	133	105	89,210
Estimated Total Spread Amount	**$5,149**	**$45,146**	**$3.46**	**$6,347.34**	**$1,799,632**
Percent of Total Spend	**0.004%**	**0.085%**	**0.000%**	**0.043%**	**15.26%**

LIMITATIONS OF ANALYSIS

- Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set.
- No claims were submitted by any national chain pharmacies.

DIR/CLAWBACK PRICING ANALYSIS

The results of the DIR/Clawback pricing analysis are summarized in Table 7 below.

Table 7. Arkansas Works/PASSE PBM Analysis Summary – Pharmacy Data Set March 2019

PBM	CVS Caremark			Optum	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Claims w/ DIR Reported (>/ $0.05)	2,319	400	891	0	592
Total Clawbacks Assessed	$12,224	$2,951	$73,957	0	$3,748
Total PBM Spend on Claims w/ DIR Fees	$124,820	$30,841	$7,241	0	$82,436
% Clawback Assessed	9.79%	9.57%	9.79%	N/A	4.55%

Only one pharmacy submitted DIR/Clawback information. There were no claims covered by OptumRx in this pharmacy's claims dataset. Therefore, no DIR/Clawback analysis can be completed for OptumRx.

Both CVS Caremark and ESI assessed DIR/Clawback fees on the pharmacies during the audit timeframe. Across the 3 Arkansas Works plans, CVS Caremark's average DIR/Clawback fees were 9.72% of the total amount paid by the applicable health plan. ESI's average DIR fees averaged 4.55% over the sample period.

These results were extrapolated to the full claims set from the 6-month audit timeframe to provide an estimate over the entire audit period. The results are summarized in Table 8 below.

Table 8. Arkansas Works/PASSE PBM Analysis Summary - January 1st-June 30th, 2019

PBM Health Plan	BCBSAR	CVS Caremark Centene	Empower	Optum QualChoice	Express Scripts Summit
Total Claims in Data Set	1,626,536	705,177	144,476	248,516	106,637
Total Health Plan Spend	$133,285,068	$52,894,989	$13,089,025	$14,637,357	$11,793,275
Average $/RX	$81.94	$75.01	$90.60	$58.90	$110.59
% AR Works	66.00%	67.00%	67.00%	66.00%	100%
Approximate RX's - ARW	1,073,514	472,469	96,799	164,021	106,637
Total Health Plan Paid ARW	$87,968,145	$35,439,642	$8,769,647	$9,660,655	$11,793,275
Estimated Total Clawback	**$8,614,934**	**$3,390,666**	**$858,560**	**N/A**	**$536,124**

LIMITATIONS OF ANALYSIS

- Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set. Only one pharmacy submitted DIR/Clawback data for analysis, which further reduced the sample size.
- No DIR/Clawback data was available for OptumRx plans so no analysis could be performed on that PBMs pricing practices.
- No claims were submitted by any national chain pharmacies.

CONCLUSIONS

The differential pricing analysis showed that National Chain pharmacies were reimbursed more (defined as greater than 5% difference) than Regional Chain and Independent Pharmacies for the same drug product unit (i.e. tablet, capsule).

The spread pricing analysis showed that one of the 3 PBMs being audited, Express Scripts Inc., was employing significant spread pricing practices during the audit time frame. Specifically, ESI was charging the health benefit plan an estimated 15.26% more than was being paid to the pharmacies.

The DIR/"clawback" analysis showed that both CVS Caremark (9.71%) and Express Scripts Inc. (4.55%) assessed DIR or "clawback" fees to the pharmacy during the audit timeframe. OptumRx's clawback pricing could not be evaluated.

While the report focuses on several pharmaceutical pricing practices, it does not provide a complete picture of pharmacy costs and PBM compensation. There are a number of additional factors that impact PBM revenues and pharmacy reimbursements that were either outside of the scope of this report or unavailable due to the lack of PBM response. These additional factors include rebates, additional insurer fees, and pharmacy fees.

ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations [3], promulgates Actuarial Standards of Practice for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct [4], to observe the ASOPs of the ASB when practicing in the United States. ASOP No. 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

1. IDENTIFICATION OF THE RESPONSIBLE ACTUARY

The responsible actuaries are:

- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal at Lewis & Ellis, Inc.

The actuaries are available to provide supplementary information and explanation.

2. IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 27, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 28, 2020.

3. DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Arkansas Insurance Department. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the PBMs under examination. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the AID with the limited financial examination of Pharmacy Benefit Managers.
- The responsible actuary identified above is qualified as specified in the Qualification Standards of the American Academy of Actuaries.

[3] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[4] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of any subsequent events that may have a material effect on the findings.

4. ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

5. METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions, and data used by the actuary can be found in the body of this report.

6. ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations, and other legally binding authority.

7. RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuary does not disclaim responsibility for material assumptions or methods.

8. DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuary does not believe that material deviations from the guidance set forth in an applicable ASOP have been made.

APPENDICES

APPENDIX 1. EXAMINER VERIFICATION

APPENDIX 2. BCBSAR (CVS CAREMARK) SUMMARY DATA TABLES

APPENDIX 3. CENTENE (CVS CAREMARK) SUMMARY DATA TABLES

APPENDIX 4. EMPOWER (CVS CAREMARK) SUMMARY DATA TABLE

APPENDIX 5. SUMMIT COMMUNITY CARE (EXPRESS SCRIPTS) SUMMARY DATA TABLE

APPENDIX 6. QUALCHOICE (OPTUM RX) SUMMARY DATA TABLE

APPENDIX 1. EXAMINER VERIFICATION

State of Texas)

)ss

County of Collin)

EXAMINER VERIFICATION

David Dillon being first duly sworn, upon his oath deposes and says; that he is an Examiner engaged by the Insurance Department of the State of Arkansas; that an examination was made of the affairs of:

Arkansas Health Plan	PBM
Arkansas Total Care	CVS Caremark
Celtic Insurance Company d/b/a/ Arkansas Health & Wellness	CVS Caremark
Empower Healthcare Solutions	CVS Caremark
QCA Health Plan	OptumRx
QualChoice Life and Health Insurance Company	OptumRx
Summit Community Care	Express Scripts (ESI)
USAble Mutual Ins Co d/b/a/ Arkansas Blue Cross Blue Shield	CVS Caremark

authorized under the laws of the State of Arkansas, pursuant to authority vested in a Certificate of Authority issued by Alan McClain, Insurance Commissioner of the State of Arkansas; that he was the Examiner of said examination and that the enclosed report of examination is a true and complete report.

David Dillon

Examiner in Charge

Subscribed and sworn before me this

27th Day of July, 2020.

NOTARY PUBLIC STATE OF TEXAS
DEBRA WEBB
Notary ID # 853801
My Commission Expires
November 26, 2020

Debra Webb

Notary Public