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December 30, 2024

Drew Ross
Director of Public Information
Joint Committee Government & Finance
1900 Kanawha Boulevard, East
Building 1, Room MB-27
Charleston, West Virginia 25305

Re: PEIA Required Reporting to the West Virginia Legislature Joint Committee on Government and Finance for 2024 Pursuant to W. Va. Code Sections §5-16-9 – Business Intelligence Study

Director Ross:

Enclosed on behalf of Director Brian Cunningham, pursuant to W. Va. Code Section §5-16-9 is PEIA's Business Intelligence Study Report to the West Virginia Legislature's Joint Committee on Government and Finance.

Please let me know if you have any questions or concerns.

Respectfully,

Kasi L. Bell
PEIA Legal
ASA I

Enclosure(s): Hard Copy: Cover Letter

Cc: Brian Cunningham, PEIA Director
William B. Hicks, PEIA General Counsel
Jason Haught, PEIA CFO
Felice B. Joseph, PEIA Pharmacy Director

PUBLIC EMPLOYEES INSURANCE AGENCY

WEST VIRGINIA SENATE BILL 453 (2024 SESSION) REPORT

Prepared by Madalena Consulting, LLC with support from 3 Axis Advisors, LLC, and Nixon Peabody LLP
December 30, 2024

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Executive Summary

West Virginia Senate Bill 453 (SB453) implemented reimbursement and transparency requirements for the Prescription Benefits Manager (PBM) that has been engaged to manage the prescription benefits for West Virginians enrolled health plans administered by the Public Employees Insurance Agency (PEIA). In addition, SB453 established a requirement that PEIA conduct a review of PBM compliance with the requirements of SB453 as well issue a written report. The review commenced in November 2024 with a data request to Express Scripts, Inc. (ESI) and compilation of analysis materials. The review of the claims data and supplemental information revealed:

1) ESI supplied all requested supplemental information in a timely and complete manner.
2) The change in pharmacy reimbursement policy to National Average Drug Acquisition Cost (NADAC) for ingredient cost plus a $10.49 dispensing fee for independent pharmacies domiciled in West Virginia resulted in an overall increase of 2.57% per day of therapy. While NADAC derived reimbursement for brand drugs represent an increase on a per day of therapy basis, NADAC derived allowances represent a substantial decrease (-52.5%) for generic medications when comparing the 1st quarter of SFY 2025 to the 4th quarter of SFY 2024. It is recommended that PEIA continue to monitor these results as financial performance will ultimately be measured on an annual basis.
3) ESI properly passed through the total amount reimbursed by PEIA to a randomly selected set of pharmacies.
4) ESI is reimbursed for non-specialty maintenance medications at higher rates than participants in the Retail Maintenance Network. The analysis revealed that the difference (31.9% higher on a per day of therapy basis) is driven completely by the disproportionate share of days of therapy represented by generic drugs. Furthermore, non-ESI pharmacies have a higher generic dispensing rate (89.6% of days of therapy) than ESI pharmacies (85.0% of days of therapy) for maintenance fills.
5) Non-ESI pharmacies in the Precision Specialty Network are reimbursed for specialty medications at higher rates than ESI owned pharmacies in the Precision Specialty Network (.98% higher on a per day of therapy basis). On a per prescription basis, ESI is reimbursed 6.5% higher than non-ESI pharmacies for specialty medications. This difference is largely explained by specialty prescriptions having 7.6% more days of therapy at ESI specialty pharmacies than non-ESI specialty pharmacies.

In addition to the claim analysis, a review of contract between PEIA and ESI was performed. Key findings include:

1) Although standard contractual terms (i.e., contract term, termination, confidentiality, indemnification) are consistent with the market, several changes could be made to improve transparency and mitigate against potential hidden revenue streams in favor of ESI. These recommended improvements are described in more detail in the Appendix,

and they are most likely to be achieved by initiating a competitive request for proposal ("RFP") for a new contract to be effective July 1, 2026 (following end of the current contract's term). As part of that RFP process, we recommend that PEIA mandate that each RFP bidder to accept specific contractual terms and conditions as a prerequisite to submitting a proposal.

2) The contract gives ESI too much flexibility to manipulate various pricing components to its benefit. For example, for claim adjudication purposes, ESI applies an algorithm to determine a drug's brand/generic status rather than using an objective standard, such as Medi-Span. Further, although PEIA has some discretion to accept or reject formulary changes, any exercise of that discretion could trigger ESI's right to change pricing. Also, the agreement lacks maximum allowable cost (MAC) list controls or the ability to address issues such as product availability and out-of-market MAC pricing. Finally, provisions could be added to control ESI's ability to designate "house generics" or implement brand-for-generic interchange programs.
3) Although our review of contractual provisions did not check operational compliance with the contract, we did observe that ESI excluded from ingredient cost and rebate guarantees certain classes of drugs that are not listed as excluded in the contract. As ESI's application of this exclusion directly conflicts with the current terms of the contract, we recommend that PEIA address this with ESI immediately.

The complete review memorandum is included in the Appendix.

Introduction

PEIA, like its peers, faces a number of critical challenges as it acts as the health insurance Plan administrator for approximately 235,000 West Virginians. Total (medical and prescription drug) Plan expenditures continue to grow at rates of increase that are substantially larger than the rate of increase of resources (e.g., employer and employee premium contributions, member cost sharing, provider price concessions, etc.) that the Plan has available for the payment of claims and administrative cost. The following graph illustrates the increases in claim cost that PEIA has experienced since Fiscal Year 2015:

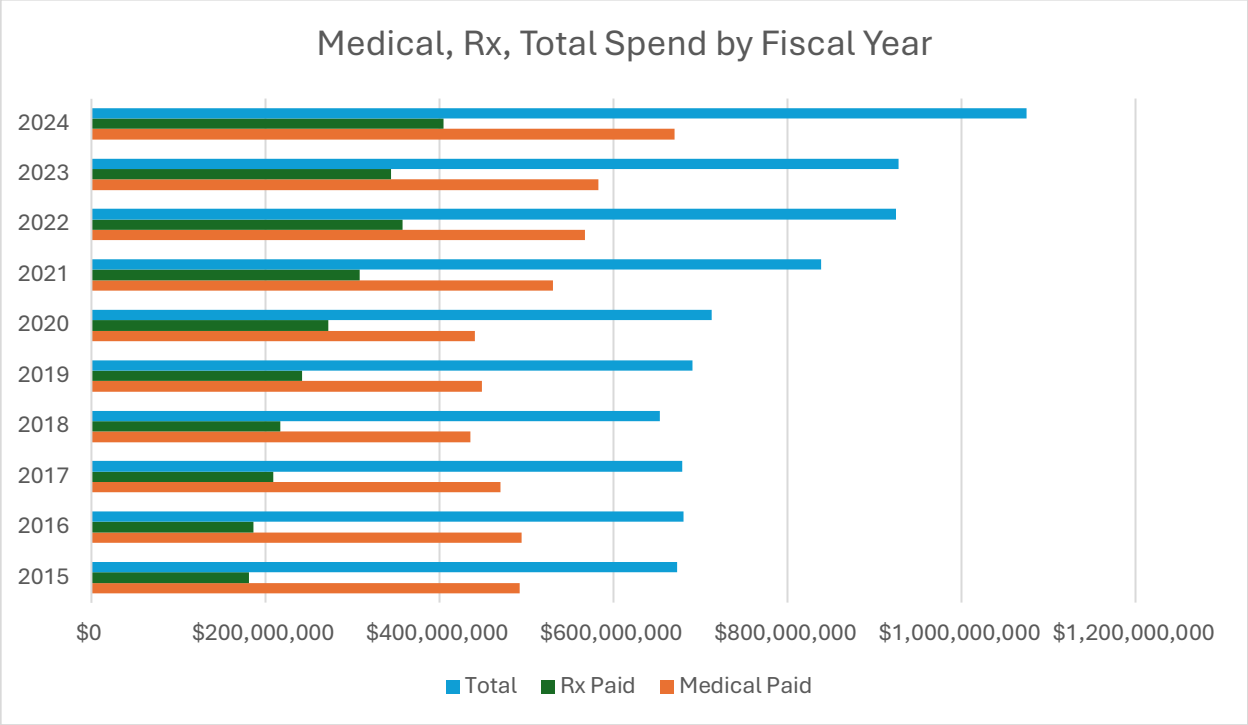

Figure 1 - Claim Trends and Distribution

Prescription drug claims, as a proportion of total claims, have grown significantly. The following chart illustrates the change:

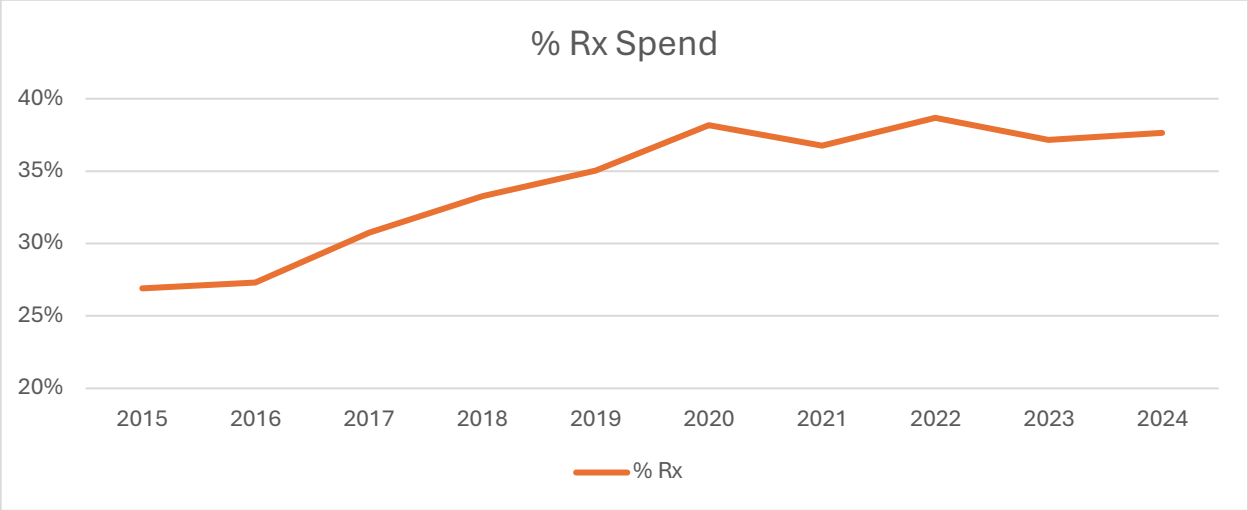

Figure 2 - Pharmacy as a Percent of Claims

Prescription drug benefits present unique challenges:

1) PEIA does not have a contractual or statutory relationship with pharmacies that dispense prescription drugs to PEIA members. Historically, there have been no pharmacy reimbursement adjustment methods available such as PEIA's ability to adjust reimbursement rates for hospitals and physicians. PEIA's sole source of change regarding cost containment was the RFP process that generally improved financial terms and conditions.
2) Not only are prescription drug claims increasing at a rate greater than the total Plan claims, the proportion of expenditures represented by prescription drug benefits is also increasing. From state fiscal year 2015, total claims have grown almost 60%. During that same period, medical claims increased slightly over 36% and prescription drug claims have increased approximately 124.5%. From FY2015 to FY2024, the percentage of total claims represented by prescription drugs increased from 27% to almost 38%.
3) The model of a Prescription Benefits Manager (PBM) as both an intermediary to the pharmaceutical industry on behalf of the plan sponsor and as a pharmacy has had significant negative effects on plan sponsors such as PEIA. The pharmaceutical industry's interests are protected in large part by mechanisms such as the Preferred Drug

Lists (PDL or sometimes referred to as a formularies), drug exclusion lists, and utilization management programs. These devices create substantial financial incentives and disincentives for the PBM to have certain levels of rigor with respect to its utilization management rules as well as allow specific drugs to be in pharmaceutical industry positive position on the PDL. In essence, the pharmaceutical industry has a strong preference for there to be as little barrier as possible to having their drugs dispensed and has been successful in limiting impediments. Furthermore, since the PBM is a dispensing pharmacy (for home delivery of both specialty and non-specialty medications), it has a clear financial incentive for a prescription to be dispensed. For the sake of completeness, it needs to be pointed out that both PEIA's plan design and the PBM contract do not require that the PBM has exclusive rights to fill specialty or non-specialty maintenance medications. Ultimately, very few West Virginia pharmacies participate in the Precision Specialty Network because of the very high cost of stocking specialty medications. As a result, in Plan Year 2024, 77.8% of PEIA specialty medication expenditures were made at PBM owned pharmacies. The opposite is true when considering non-specialty maintenance prescriptions: PEIA claim expenditures at non PBM owned pharmacies for this category accounted for 92.7% of claims in Plan Year 2024. Finally, with respect to pharmaceutical industry revenue, it is a contractual requirement that the PBM must pass through 100% of the revenues it receives from the pharmaceutical industry generated by PEIA utilization to PEIA. In addition, the PBM must provide detailed rebate reconciliation data to PEIA.

In summary, several substantive issues with the model are noted:

a. The contractual relationship between the PBM and the pharmaceutical industry substantially limits PEIA's ability to make coverage and policy decisions that are in its best interests. Typically, changes in formulary positioning or utilization management result in decreases in rebates paid to PEIA.
b. The rate of growth for rebates has not been sufficient to offset the rate of cost increases that PEIA has experienced for prescription drugs. In Plan Year 2024,

total PEIA pharmacy claim cost increased to $413.4 million from $332.2 million in Plan Year 2023 (an increase of $81.2 million or 24.4%). Rebates grew from $137.8 million in Plan Year 2023 to $143.9 million in Plan Year 2024 ($6.1 million or 4.4%). It is understood that while a number of factors have contributed to trend (e.g., inflation, new prescription drugs, new indications for prescription drugs, 340B rebate claw backs, decreases in membership, leverage against the plan design, etc.), the increased net cost trend of 44.2% (rising from $101.86 to $146.91 on a per member per month basis) to PEIA remains.

4) PEIA relies on a third-party administrator (ESI) to manage (in large part) prescription benefits as the Plan's PBM. ESI uses the typical industry methods (e.g., discounted prescription drug costs, dispensing fees, and pharmaceutical industry monetary offsets such as rebates) that other large, self-funded health insurance plans use to manage costs. Such approaches are fraught with well-documented risks. Contractual instruments with entities such as ESI tend to be complicated and lengthy. Such documentation is often subject to multiple interpretations, thereby prone to controversy. However, even if the contract itself is clear, the PBM must then be compliant with its contractual obligations with respect to:
    a. Achievement of guaranteed discounts and dispensing fees.
    b. Achievement of guaranteed pharmaceutical revenue payments (e.g., rebates) to PEIA.
    c. Achievement of pharmacy payment standards:
        i. Passthrough of the total amount invoiced to the Plan by the third-party administrator to participating pharmacies.
        ii. Equitable payment rates to participating pharmacies.

SB453, in addition to establishing reimbursement rate and dispensing fee standards, requires a business intelligence review that addresses the identified issues. The rest of this document describes the analyses and reviews performed on behalf of PEIA.

Methods and Source Data

Source data for the analysis included:

1) PEIA's contract with ESI for PBM services – The document defines all terms and conditions with respect to the services. It includes key definitions as to how performance guarantees are calculated (e.g., which prescriptions are excluded from calculations, limitations and conditions for rebate payments, audit rights, service guarantees, etc.).
2) The weekly paid claims file received from ESI - This dataset is used to validate and substantiate claim reimbursements made by PEIA to ESI. The file contains detailed information about the prescription such as quantity and cost of the medication; identification of the prescriber, filling pharmacy, and patient; and detailed information about the medication itself.
3) Supplemental datasets from ESI – SB453 set out requirements for reporting that PEIA's PBM must comply with. The datasets received from ESI for analysis are:
    a. Listing of West Virginia pharmacies that are reimbursed NADAC for medications and paid a dispensing fee of $10.49 per prescription.
    b. Listing of pharmacy National Provider Identification (NPI) numbers for pharmacies owned by ESI.
    c. Listing of pharmacy NPIs for pharmacies that participate in the PEIA specialty pharmacy network.
    d. Summary of prescriptions that are excluded from net effective discount (NED) and dispensing fee guarantees for FY2024.
    e. Detailed listing of rebate status for prescriptions filled in FY2024.

    ESI was cooperative and produced all requested data in a complete and timely fashion.

4) NADAC pricing – Datasets maintained by the Centers for Medicare and Medicaid Services (CMS) that list NADAC statistics for all reported National Drug Codes (NDC).

NADAC is calculated based on a survey of retail acquisition cost reported by community and retail pharmacies. NADAC is updated regularly and does not include any rebates received by the reporting pharmacy.

Using the source data listed above, the following analyses have been completed:

1) Financial effect of reimbursement paid to West Virginia domiciled independent pharmacies.
2) Equity of reimbursements made to retail pharmacies for maintenance, non-specialty medications compared to ESI owned pharmacies.
3) Equity of reimbursements made to pharmacies for specialty medications compared to ESI owned pharmacies.
4) Review of PEIA's contract with ESI for PBM services. The review includes:
    a. Contractual language as well as terms and conditions.
    b. Review of pharmacy payment passthrough.

Report Analyses

This section of this document is focused on the analyses performed using the source data described in the previous section. Any assumptions or parameters specific to an analysis are stated in the applicable section.

Effect of July 1, 2024 Pharmacy Reimbursement Changes

To calculate the financial effects of the July 1, 2024 pharmacy reimbursement policy change (NADAC allowance for ingredient cost plus $10.49 dispensing fee as opposed to ESI contractual rates for discounted Average Wholesale Price (AWP) plus a dispensing fee), the claims for the 272 distinct pharmacy NPIs were isolated for two time periods: April 1, 2024 to June 30, 2024 and July 1, 2024 to September 30, 2024. In summary, PBM reimbursement to pharmacies is comprised of these two elements: an amount for the medication (referred to as ingredient cost) and an amount for the professional service of filling the prescription (referred to as dispensing fee).

The rationale for the comparison is straightforward: a comparison of pharmacy reimbursement in the calendar quarter prior to the change and the 1st calendar quarter the change was in effect. The following table summarizes targeted pharmacy reimbursement for those periods:

Dispense Dates April 1, 2024 to June 30, 2024								
		Total			Per RX		Per Day of Therapy	
Drug Type	RX Count	Ingredient Cost	Dispensing Fees	Days of Therapy	Ingredient Cost	Dispensing Fees	Ingredient Cost	Dispensing Fees
Single Source Brands	17,164	$ 27,528,069.89	$ 181.40	897,205	$ 1,603.83	$ 0.01	$ 30.6820	$ 0.0002
Multi Source Brand	992	$ 355,838.23	$ 2.00	62,672	$ 358.71	$ 0.00	$ 5.6778	$ 0.0000
Generics	140,971	$ 4,224,534.24	$ 5,936.85	7,319,264	$ 29.97	$ 0.04	$ 0.5772	$ 0.0008
	159,127	$ 32,108,442.36	$ 6,120.25	8,279,141	$ 201.78	$ 0.04	$ 3.8782	$ 0.0007

Dispense Dates July 1, 2024 to September 30, 2024								
		Total			Per RX		Per Day of Therapy	
Drug Type	RX Count	Ingredient Cost	Dispensing Fees	Days of Therapy	Ingredient Cost	Dispensing Fees	Ingredient Cost	Dispensing Fees
Single Source Brands	15,852	$ 28,167,274.29	$ 157,404.73	840,207	$ 1,776.89	$ 9.93	$ 33.5242	$ 0.1873
Multi Source Brand	850	$ 306,251.43	$ 8,570.33	55,866	$ 360.30	$ 10.08	$ 5.4819	$ 0.1534
Generics	135,012	$ 1,955,302.40	$ 1,361,453.93	7,136,106	$ 14.48	$ 10.08	$ 0.2740	$ 0.1908
	151,714	$ 30,428,828.12	$ 1,527,428.99	8,032,179	$ 200.57	$ 10.07	$ 3.7884	$ 0.1902

Figure 3 - Effect of 7/1/2024 Pharmacy Reimbursement Changes

The results are presented on two bases: per prescription and per day of therapy. With respect to per prescription basis, total pharmacy reimbursement (ingredient cost plus dispensing fee) has increased from $201.82 to $210.63 (4.4%). The driver of the increase is solely the dispensing fee. Dispensing fees on a per prescription basis increased from approximately $0.04 to $10.07 (an increase of over 26,000%). Ingredient cost results are mixed: for single source brands, per

prescription reimbursement increased 10.79% while per prescription reimbursement for generic drugs decreased 51.69%. It is critical to note that while generics make up the vast majority of prescriptions (88.99% for the target pharmacies in the 1st quarter of FY2025), brand drugs are most of the cost (93.77% of ingredient cost in the 1st quarter of FY2025).

The relevance of per day of therapy analysis is best explained by the graph below:

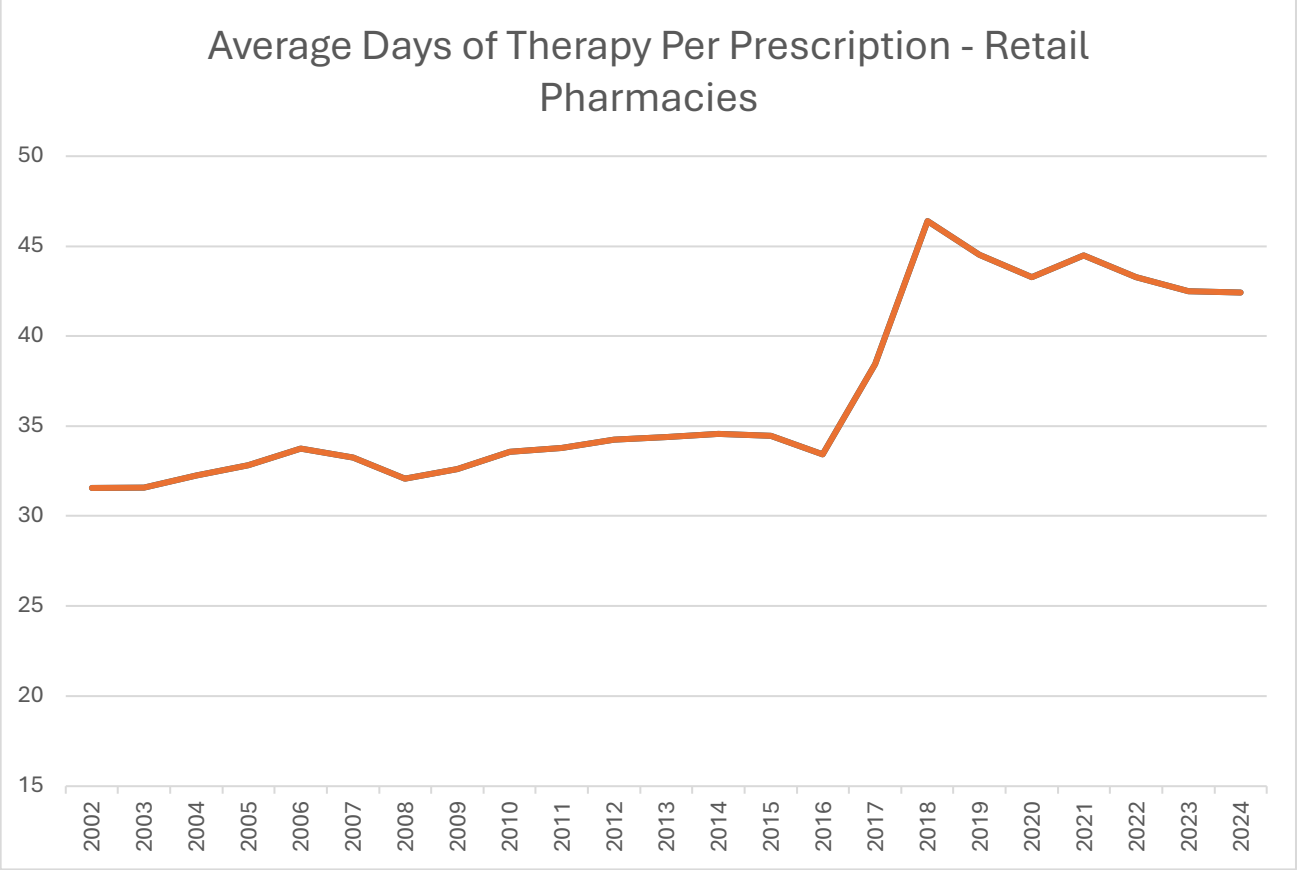

Figure 4 - Average Days of Therapy for Retail Pharmacy Claims

PEIA implemented a requirement midyear in FY2018 that members fill maintenance medications for 90 days at a participating retail maintenance pharmacy. Members are permitted two 30 day fills as a transition to the maintenance fill. The intent of the change was cost savings (e.g., greater discounts from AWP, lower dispensing fees, and increased rebates) but it also had the effect of increasing the retail pharmacy prescription size from 33.43 days of therapy in 2016 to 38.45 days in 2017 and 46.39 days in 2018.

Based on a per day of therapy basis, total pharmacy reimbursement for the West Virginia domiciliated independent pharmacies increased from $3.88 to $3.98 (2.57%). Ingredient cost per day decreased from $3.88 to $3.78 (-2.32%) while dispensing fees per day increased from $.0007 per day to $.19 (25,624% increase).

To test effect sensitivity, per day effects were also calculated holding mix constant between the study periods based on Medi-Span's generic product identifier (GPI) hierarchy. Assuming the mix of prescription drugs that were dispensed from April 1, 2024 to June 30, 2024 and the reimbursements paid from July 1, 2024 to September 30, 2024:

1) Total reimbursement (based on per day of therapy) increased 2.9% (from $3.84 to $3.95).
2) Ingredient cost per day of therapy decreased 2.08% (from $3.84 to $3.76).
3) Dispensing fees per day increased 37,736% (from $.0005 to $.19)

ESI's determination of NADAC based ingredient cost was validated by repaying pharmacy claims with dispense dates of July 1, 2024 to September 30, 2024 independently. A total ingredient cost of $30,428,828.12 was recorded on the claims data. The repriced dataset indicated ingredient cost of $30,398,786.34 or 99.901% of the ingredient cost indicated based on the source claims.

Payment Equity – Non-Specialty Maintenance Medications

To test the equitable payment to retail pharmacies for non-specialty maintenance prescriptions, days of therapy, AWP, ingredient cost, and dispensing fees were isolated for the period of July 1, 2024 to September 30, 2024. Maintenance prescriptions were then separated into utilization at ESI-owned pharmacies and non-ESI owned pharmacies. Per day of therapy metrics were then calculated for the medication name (for brand drugs) and chemical name (for generic drugs). The following table lists the top 20 medications filled at ESI-owned pharmacies (based on total AWP):

Drug Name	ESI AWP	Non ESI AWP	ESI Ingredient Cost Per Day	Non ESI Ingredient Cost Per Day	ESI Dispensing Fee Per Day	Non ESI Dispensing Fee Per Day	ESI Total	Non ESI Total
MOUNJARO	$ 966,023.70	$ 9,637,144.80	$ 33.92	$ 35.09	$ -	$ 0.04	$ 33.92	$ 35.13
OZEMPIC	$ 856,556.15	$ 9,288,462.32	$ 30.66	$ 31.44	$ -	$ 0.04	$ 30.66	$ 31.48
ROSUVASTATIN CALCIUM	$ 333,423.97	$ 5,277,106.06	$ 0.23	$ 0.19	$ -	$ 0.04	$ 0.23	$ 0.23
JARDIANCE	$ 268,395.12	$ 3,767,822.60	$ 18.10	$ 18.09	$ -	$ 0.03	$ 18.10	$ 18.12
ATORVASTATIN CALCIUM	$ 258,998.85	$ 4,847,012.39	$ 0.19	$ 0.16	$ -	$ 0.04	$ 0.19	$ 0.19
OMEPRAZOLE	$ 223,845.51	$ 4,557,745.08	$ 0.18	$ 0.15	$ -	$ 0.04	$ 0.18	$ 0.19
FARXIGA	$ 182,360.70	$ 2,514,947.36	$ 17.24	$ 17.57	$ -	$ 0.04	$ 17.24	$ 17.60
MONTELUKAST SODIUM	$ 157,310.26	$ 2,753,774.48	$ 0.25	$ 0.24	$ -	$ 0.04	$ 0.25	$ 0.27
PANTOPRAZOLE SODIUM	$ 148,137.47	$ 2,765,826.09	$ 0.18	$ 0.19	$ -	$ 0.04	$ 0.18	$ 0.22
TRESIBA FLEXTOUCH U-20	$ 136,908.31	$ 1,243,644.86	$ 27.68	$ 25.54	$ -	$ 0.04	$ 27.68	$ 25.58
EZETIMIBE	$ 116,920.43	$ 1,520,956.72	$ 0.35	$ 0.31	$ -	$ 0.04	$ 0.35	$ 0.35
TRULICITY	$ 112,598.40	$ 1,808,611.80	$ 31.01	$ 32.09	$ -	$ 0.04	$ 31.01	$ 32.13
DEXCOM G7 SENSOR	$ 97,351.65	$ 546,022.40	$ 11.28	$ 11.40	$ -	$ 0.03	$ 11.28	$ 11.43
BUPROPION XL	$ 95,317.17	$ 1,740,583.97	$ 0.31	$ 0.43	$ -	$ 0.03	$ 0.31	$ 0.46
XARELTO	$ 94,322.60	$ 1,449,565.51	$ 16.87	$ 17.16	$ -	$ 0.04	$ 16.87	$ 17.20
JANUVIA	$ 92,826.00	$ 1,347,008.40	$ 16.97	$ 17.35	$ -	$ 0.04	$ 16.97	$ 17.39
DULOXETINE HCL	$ 88,920.69	$ 2,277,888.77	$ 0.33	$ 0.38	$ -	$ 0.04	$ 0.33	$ 0.41
ARIPIPRAZOLE	$ 82,191.60	$ 1,526,376.52	$ 0.71	$ 0.34	$ -	$ 0.03	$ 0.71	$ 0.38
ELIQUIS	$ 81,313.92	$ 1,496,592.25	$ 17.60	$ 17.68	$ -	$ 0.03	$ 17.60	$ 17.72
ESCITALOPRAM OXALATE	$ 75,019.67	$ 1,832,557.88	$ 0.17	$ 0.18	$ -	$ 0.03	$ 0.17	$ 0.21

Figure 5 - Top 20 Maintenance Drugs

The following table summarizes reimbursements in total for maintenance prescriptions by drug type:

Drug Type	ESI AWP	Non ESI AWP	ESI Ingredient Cost Per Day	Non ESI Ingredient Cost Per Day	ESI Dispensing Fee Per Day	Non ESI Dispensing Fee Per Day	ESI Total	Non ESI Total
Single Source Brand	$ 4,214,565.70	$49,786,574.56	$ 18.11	$ 19.22	$ -	$ 0.03	$18.11	$ 19.25
Generic	$ 4,054,864.19	$71,837,792.23	$ 0.36	$ 0.37	$ -	$ 0.04	$ 0.36	$ 0.41
Multisource Brand	$ 13,444.58	$ 513,378.42	$ 3.01	$ 2.98	$ -	$ 0.04	$ 3.01	$ 3.02

Figure 6 - Maintenance Medications by Drug Type

In totality, a disparity of -31.9% exists between the reimbursement to ESI-owned pharmacies (effectively ESI's home delivery pharmacies) for maintenance medications fills compared to non-ESI pharmacies. In composite, ESI-owned pharmacies were reimbursed a total of $2.98 per day of therapy while Retail Maintenance Pharmacies were reimbursed $2.26 per day of therapy. ESI-owned pharmacies are reimbursed less per day for brand medications ($18.11 vs. $19.25) as well as for generics ($0.36 for ESI pharmacies and $0.41 per day for non ESI pharmacies). Further analysis indicates that the paradox of higher reimbursement per day for all drug types for non-ESI pharmacies yet a significantly lower overall per day reimbursement is resolved by generic drugs. ESI owned pharmacies exhibited a generic dispensing rate of 85.0%. By comparison, non-ESI owned pharmacies produced a generic dispensing rate of 89.6% during the same period. In essence, the heavy weighting of generic drugs (as a proportion of days of therapy) is even more pronounced at non-ESI pharmacies.

Payment Equity – Specialty Medications

To test the equitable payment to Precision Specialty Network pharmacies for specialty prescriptions, days of therapy, AWP, ingredient cost, and dispensing fees were isolated for the period of July 1, 2024 to September 30, 2024. Specialty prescriptions were then separated into utilization at ESI owned pharmacies and non-ESI owned pharmacies. Per day of therapy metrics were then calculated for the medication name (for brand drugs) and chemical name (for generic drugs). The following tables separately lists the top 10 brand and generic medications filled at ESI owned pharmacies (based on total AWP):

Drug Name	ESI AWP	Non ESI AWP	ESI Ingredient Cost Per Day	Non ESI Ingredient Cost Per Day	ESI Dispensing Fee Per Day	Non ESI Dispensing Fee Per Day	ESI Total	Non ESI Total
HUMIRA(CF) PEN	$ 5,823,307.58	$ 2,766,278.18	$ 299.18	$ 303.78	$ -	$ 0.37	$ 299.18	$ 304.15
STELARA	$ 3,732,661.75	$ 1,486,808.20	$ 440.22	$ 549.57	$ -	$ 0.21	$ 440.22	$ 549.78
SKYRIZI PEN	$ 2,875,174.62	$ 327,870.79	$ 262.29	$ 285.01	$ -	$ 0.15	$ 262.29	$ 285.16
TREMFYA	$ 2,746,814.40	$ 149,826.24	$ 251.31	$ 237.20	$ -	$ 0.15	$ 251.31	$ 237.34
DUPIXENT PEN	$ 2,318,430.72	$ 638,937.60	$ 138.45	$ 145.05	$ -	$ 0.35	$ 138.45	$ 145.40
TALTZ AUTOINJECTOR	$ 1,991,726.40	$ 248,965.80	$ 246.86	$ 254.42	$ -	$ 0.37	$ 246.86	$ 254.80
OTEZLA	$ 1,829,958.19	$ 125,380.50	$ 161.54	$ 161.13	$ -	$ 0.35	$ 161.54	$ 161.48
TRIKAFTA	$ 1,752,035.99	$ 31,855.20	$ 957.93	$ 948.07	$ -	$ 0.37	$ 957.93	$ 948.45
DUPIXENT SYRINGE	$ 1,305,258.24	$ 205,372.80	$ 131.16	$ 118.93	$ -	$ 0.30	$ 131.16	$ 119.23
RINVOQ	$ 1,300,132.47	$ 508,836.03	$ 221.51	$ 234.18	$ -	$ 0.35	$ 221.51	$ 234.54

Figure 7 - Top 10 Brand Specialty Medications

Drug Name	ESI AWP	Non ESI AWP	ESI Ingredient Cost Per Day	Non ESI Ingredient Cost Per Day	ESI Dispensing Fee Per Day	Non ESI Dispensing Fee Per Day	ESI Total	Non ESI Total
TERIFLUNOMIDE	$ 292,562.70	$ 30,171.19	$ 57.87	$ 0.48	$ -	$ 0.35	$ 57.87	$ 0.83
FINGOLIMOD	$ 244,306.92	$ 75,977.13	$ 148.06	$ 9.18	$ -	$ 0.35	$ 148.06	$ 9.53
AMBRISENTAN	$ 163,249.07	$ 31,419.27	$ 254.38	$ 38.40	$ -	$ 0.35	$ 254.38	$ 38.75
ABIRATERONE ACETATE	$ 157,534.60	$ 124,112.00	$ 219.45	$ 24.25	$ -	$ 0.35	$ 219.45	$ 24.60
IMATINIB MESYLATE	$ 127,525.18	$ 66,485.41	$ 193.22	$ 1.97	$ -	$ 0.35	$ 193.22	$ 2.32
GLATIRAMER ACETATE	$ 44,241.77	$ 138,414.32	$ 163.11	$ 47.22	$ -	$ 0.37	$ 163.11	$ 47.59
CAPECITABINE	$ 37,902.83	$ 129,322.81	$ 52.90	$ 1.64	$ -	$ 0.46	$ 52.90	$ 2.10
DALFAMPRIDINE ER	$ 31,267.50	$ 16,042.56	$ 48.45	$ 0.89	$ -	$ 0.35	$ 48.45	$ 1.24
TOBRAMYCIN	$ 30,959.31	$ 17,443.83	$ 33.82	$ 69.90	$ -	$ 0.32	$ 33.82	$ 70.22
FONDAPARINUX SODIUM	$ 19,291.50	$ 1,286.10	$ 71.84	$ 69.94	$ -	$ -	$ 71.84	$ 69.94

Figure 8 - Top 10 Generic Specialty Medications

Drug Type	ESI AWP	Non ESI AWP	Ingredient Cost Per Day	Ingredient Cost Per Day	Dispensing Fee Per Day	Dispensing Fee Per Day	ESI Total	Non ESI Total
Single Source Brand	$49,051,429.44	$15,733,453.16	$270.23	$305.64	$0.00	$0.29	$270.23	$305.93
Generic	$2,703,605.30	$896,873.26	$200.61	$23.06	$0.00	$0.33	$200.61	$23.39
Multisource Brand	$240,151.57	$116,724.71	$241.44	$228.02	$0.00	$0.35	$241.44	$228.36

Figure 9 - Specialty Medications by Drug Type

Specialty Precision Network pharmacies that are not owned by ESI were reimbursed .98% more per day in total than pharmacies owned by ESI. In composite, ESI owned pharmacies were reimbursed a total of $266.55 per day for specialty medications. Non-ESI owned pharmacies were reimbursed a total of $269.17 per day of therapy during the same period. A significant difference between ESI owned pharmacy and non-ESI pharmacies (-88.5%) in per day generic reimbursement exists. Since generics only account for 8.6% of specialty days of therapy, the disadvantage is more than completely eliminated because non-ESI owned pharmacies enjoy substantially greater per day of therapy reimbursement for brand specialty medications ($305.93 per day for non-ESI owned pharmacies as compared to $270.23 per day for ESI owned pharmacies). On a per prescription basis, ESI is reimbursed 6.5% higher than non-ESI pharmacies for specialty medications. This difference is largely explained by specialty

prescriptions having 7.6% more days of therapy at ESI specialty pharmacies than non-ESI specialty pharmacies.

As was the case in non-specialty maintenance medications, the implementation of NADAC pricing on generics had a negative effect on West Virginia domiciled independent pharmacies. It should be noted that as of January 1, 2025, ESI owned pharmacies will be reimbursed for all specialty medications based on NADAC for ingredient cost plus a $10.49 dispensing fee.

Contractual Features Review

Contractual Instrument

Please see Appendix for legal review memorandum.

Passthrough to Pharmacies

Spread pricing is the prescription-level practice where a PBM will reimburse a pharmacy an amount that is less than the amount that the plan sponsor reimbursed the PBM (with the PBM retaining the differential as revenue). Passthrough pricing, where the amount paid to the pharmacy is the same as the amount paid by the plan sponsor to the PBM, is a requirement of PEIA's contract with ESI. To validate that ESI is fulfilling its contractual obligation, five West Virginia domiciled pharmacies were randomly selected, and remittance advice was requested. The remittance data was merged with the paid claim dataset that is used to substantiate ESI invoices. Of the five pharmacies randomly selected, four had claims activity for PEIA members from July 1, 2024 to September 30, 2024. The table below summarizes the merged claims and pharmacy remittance advice:

Pharmacy Name	Amount Billed to PEIA	Amount Paid to Pharmacy	Spread Amount
CLAY FAMILY PHARMACY	$ 2.41	$ 2.41	$ -
PHILLIPS DRUG	$ 8.66	$ 8.66	$ -
CARL WALKER'S DRUG STORE	$ 1,720.39	$ 1,720.39	$ -
FOUR SEASONS PHARMACY	$ 7,049.75	$ 7,049.75	$ -
			$ -
Totals	$ 8,781.21	$ 8,781.21	$ -

Figure 10 - Passthrough Validation

For the claims examined in the analysis study, full invoice amounts were passed through the pharmacy.

340B Program

The 340B Drug Pricing Program is a federal program that allows eligible healthcare organizations, such as hospitals and clinics serving low-income or rural populations, to purchase prescription drugs at significantly reduced prices. The program was designed to stretch pharmaceutical expenditure budgets while enhancing access to medications thereby improving health for underserved communities. 340B eligible healthcare organizations can either dispense prescriptions themselves or contract with a licensed pharmacy to fill prescriptions for eligible members.

The 340B program is not directly funded by the government or taxpayers. Instead, it is funded through substantial mandatory discounts that drug manufacturers are required to provide to eligible healthcare organizations as a condition of participating in Medicaid and Medicare Part B. These discounts effectively reduce the revenue drug companies earn from participating providers, allowing the providers to purchase medications at lower costs. These discounts are provided as a substitute for rebate payments. In other words, drug manufacturers do not pay rebates on prescriptions that are dispensed under the 340B program.

Historically, the typical 340B healthcare providers were Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and Critical Access Hospitals (CAH). As the program has expanded to include other eligible healthcare provider types (e.g., hospitals that participate in the Disproportionate Share Hospital (DSH) program), the negative financial effect on PEIA has also grown. The following hypothetical example adjudication of an Ozempic prescription illustrates how PEIA is disadvantaged:

	340B	Non 340B
Prescription AMP Price	$ 1,000.00	$ 1,000.00
340B Discount (23.1%)	$ 231.00	$ -
Pharmacy Net Price	$ 769.00	$ 1,000.00
PBM Contractual Rate	$ 960.00	$ 960.00
Pharmacy Profit on Contract Rate	$ 191.00	$ (40.00)
Rebate (60% of WAC/AMP)	$ -	$ 600.00
PEIA Net Cost	$ 935.00	$ 335.00

Figure 11 - 340B Example

While PEIA has been successful in negotiating a cap on 340B rebate reductions for SFY 2025, other methods of managing PEIA's disadvantage should be considered in the long run. 340B exclusions are the largest in terms of volume for both discount and minimum rebate guarantees.

Appendix

Review Memorandum

CONFIDENTIAL

To:	Madalena Consulting, LLC	**From:**	Damian A. Myers Annie Zhang
RE:	West Virginia PEIA PBM Agreement Review	**Date:**	December 23, 2024

I. Executive Summary

Madalena Consulting, LLC has retained Nixon Peabody LLP ("NP") to conduct a comprehensive review of the pharmacy benefit management agreement (the "PBM Agreement") entered into between West Virginia Public Employees Insurance Agency ("PEIA") and Express Scripts, Inc. ("ESI") for PEIA's pharmacy benefit plan (the "Plan"). NP has a dedicated team of attorneys who are highly experienced in negotiating pharmacy benefit management agreements for public organizations and private entities of all sizes. The primary purpose of our review is identifying potential contractual risks and limitations that should be corrected in connection with a future request for proposals ("RFP") or the next ESI contract renewal.

This memorandum describes the results of our review, and it is organized to align with the structure of the PBM Agreement, starting with definitional matters, administrative clarifications, and so on. This memorandum is not intended to be a critical review, but rather, it sets forth objective observations that PEIA can use to inform RFP positioning and future contract negotiations. Our commentary generally focuses on three main issues: improvements in transparency to ensure PEIA is fully equipped to make design and administrative decisions, updates to reflect recent trends in the marketplace, and proposing potential language modifications or new language to limit ESI's flexibility to manipulate administration and pricing so as to mitigate against ESI's ability to artificially achieve financial guarantees or to generate hidden revenue.[1] Unless otherwise specified herein, capitalized terms have the meanings set forth in the PBM Agreement.

Recommendations: Overall, our recommendation is to implement a competitive RFP to coincide with the final year of the PBM Agreement's term, with the goal of having a new contract (with ESI or otherwise) in place as of July 1, 2026. The current PBM Agreement is based on ESI's standard template agreement, which is designed to favor ESI's financial position. Therefore, as part of the RFP process, we recommend that PEIA include its own independently developed pharmacy benefit management agreement (with favorable contractual terms described in this memorandum) on which the RFP participants must design and underwrite their bids.

II. PBM Agreement Review Commentary

A. Definitional Improvements

i. 340B Claim Definition. Although the current definition of "340B Claim" is generally consistent with the market standard, its usage in the PBM Agreement is driven by financial guarantee exclusions related to such claims. As explained below, despite the market-standard definition of "340B Claim," ESI nevertheless has the ability to manipulate pricing guarantees through its designation of certain claims as 340B Claims. The market trend is to eliminate 340B Claim exclusions from

[1] Note that our review did not include an assessment of ESI's operational compliance with the PBM Agreement. However, we did request lists of pricing exclusions that ESI applies to compare them to the lists set forth in the PBM Agreement. As described below, it appears that ESI is improperly excluding claims from ingredient cost and rebate guarantees, and this issue should be addressed by PEIA.

pricing guarantees, and we recommend that PEIA take this approach in connection with a future RFP or ESI contract renewal.

ii. Average Wholesale Price ("AWP") Definition. The current definition of "AWP" gives ESI broad discretion to determine and change the pricing source. Although ESI must give PEIA notice of a pricing source change, and must certify to PEIA that the change is beneficial and cost neutral to PEIA, the preferred approach would be to permit a pricing source change only when mutually agreeable. We recommend that PEIA take this approach in connection with a future RFP or ESI contract renewal and for future contracts to add additional AWP protections (e.g., restrictions on repackaging).

iii. Brand/Generic Algorithm ("BGA") Definition. ESI's BGA is used to determine whether a drug is a Brand Drug or a Generic Drug for claim adjudication purposes. Medi-Span MNOY classifications are used for financial guarantee purposes. We recommend that PEIA reject use of ESI's BGA for any purpose and require Medi-Span's MNOY classifications for all purposes. The BGA is unnecessarily opaque, and using an objective standard will improve transparency. Corresponding changes would need to be made to definitions of "Brand Drug" and "Generic Drug."

iv. Covered Drug Definition. The definition of "Covered Drug" indicates that a drug's covered or excluded status is determined by so-called "Set-Up Forms." Ultimately, the terms and conditions of the Plan should control, not Set-Up Forms that may or may not have been signed by PEIA. See the commentary on the Set-Up Forms definition below.

v. Exclusive or Limited Distribution Product Definition. As described below in the Specialty Product Pricing paragraph of subsection E, the market trend is to eliminate separate pricing or exclusions for Exclusive or Limited Distribution Products. We recommend that PEIA take this approach in connection with an RFP or ESI contract renewal, in which case, this definition would be obsolete.

vi. Formulary Definition. In general, the definition for "Formulary" grants PEIA the ability to reject any Formulary change, which is the preferred approach. We recommend that PEIA consider adding language to require advance notice of Formulary changes so that it can properly evaluate the financial and utilization impact of the change before implementation. Further, the definition indicates that any rejection of a Formulary update would be considered a "Formulary change" that would trigger ESI's right to propose re-pricing under the PBM Agreement. In connection with an RFP or ESI contract renewal, we recommend including language in the agreement to protect PEIA from pricing changes that do not maintain the relative economic position of the parties.

vii. MAC List Definition. We recommend that future contracts include provisions to provide PEIA greater control and oversight of the MAC List. For instance, with respect to the "MAC List" definition, we recommend clarifying that the MAC List sets the maximum amount that can be charged to the Plan (for retail and mail order prescription drugs). Additionally, we recommend limiting the number of MAC Lists that can be used for the Plan. When multiple MAC Lists are used (e.g., one for retail and one for mail order), protections should be added to cap the price increase with mail order prescription drugs. Additional MAC List protections are described below in the General Pricing Terms paragraph of subsection E.

viii. Set-Up Form Definition. As noted above, ESI considers Set-Up Forms to be the controlling documents for purposes of its administration of the Plan, even if the Set-Up Forms are inconsistent with the terms and conditions of the Plan document. The preferred approach would be to eliminate all Set-Up Forms and require any document governing the administration of the Plan by ESI (or a successor pharmacy benefit manager (PBM)) to be part of the PBM Agreement. Alternatively, Set-Up Forms can be used, but the Plan documents control in all respects. To the extent that Set-Up Forms remain in place, we recommend that future contracts require that ESI (or a successor PBM) maintain a Set-Up Form "binder" that serves as a repository for all forms that govern the administration of the Plan. PBMs are notorious for deeming obscure

communications as Set-Up Forms, so maintaining the actual forms in a single location is important.

ix. Specialty Product List Definition. The PBM Agreement's current definition gives ESI too much discretion to decide which drugs are included on the Specialty Product List, including which drugs are designated as Exclusive or Limited Distribution Products. This discretion enables ESI to unilaterally move drugs on and off the list for the purpose of satisfying performance guarantees or to mitigate against excessive overperformance. In future contracts, we recommend requiring (a) the Specialty Product List to be attached as an exhibit to the agreement, (b) that PEIA must approve any change to the Specialty Product List, except for additions of new to market specialty drugs or to reflect line extensions that satisfy the criteria set forth in the Specialty Product definition, and (c) that all historical Specialty Product Lists be maintained by ESI (or successor PBM). Additional controls related to Specialty Products are described below in the Specialty Product Pricing paragraph of subsection E.

B. Administrative Clarifications

i. Pharmacy Network Provisions. The Participating Pharmacy provisions require that ESI notify PEIA of any network change that impacts PEIA members, and if PEIA is not agreeable to the change, PEIA can terminate the PBM Agreement. In a future contract, we recommend that ESI (or successor PBM) be required to issue an annual report of all retail pharmacies removed from the pharmacy network. Further, the current PBM agreement lacks standard retail pharmacy oversight requirements, including audit requirements and overpayment recoveries. Finally, future contracts should add controls on the ability of any pharmacy (retail, mail order, or specialty) to process drug interchanges that produce higher net costs to the Plan.

ii. Prior Authorization. Based on the current PBM Agreement, it appears that PEIA has established coverage guidelines that ESI is required to apply when evaluating prior authorization requests. Developing independent coverage guidelines is a market-forward approach and it should remain in any future contract. To the extent that ESI has any other policies and procedures related to prior authorization or any other utilization management program, those policies and procedures should be reviewed and approved by PEIA.[2] We also recommend requiring annual reports showing outcomes related to ESI's utilization program (e.g., prior authorization requests approved and denied) so that PEIA can monitor compliance with coverage guidelines. Finally, in future contracts, we recommend continuing the right to outsource utilization management to independent third-parties without penalty to PEIA.

iii. PEIA Audit Rights. Please see below for commentary related to the audit protocol in subsection G.

C. Commercial Terms

i. Confidential Information. Currently, the PBM Agreement allows PEIA to disclose confidential information only to its attorneys and accountants. SB453 mandates such expanding disclosure to pharmacy consultants and data analysts going forward.

ii. Fiduciary Acknowledgements. ESI disclaims any fiduciary responsibility with respect to the Plan, and although this is relatively common, we recommend that future contracts establish a standard of care that closely tracks the requirements under the Employee Retirement Income Security Act

[2] Our understanding is that ESI is responsible for applying prior authorization to specialty drugs only. Non-specialty drug prior authorization reviews have been delegated to the West Virgina University School of Pharmacy Rational Drug Therapy Program.

of 1974 ("ERISA"). Although the Plan is not subject to ERISA, establishing a comparable standard of care is the market standard for non-ERISA plans.

iii. Term and Termination. For the most part, the termination provisions contained in the PBM Agreement are consistent with the market standard. However, both parties have the right to terminate the PBM Agreement without cause upon 30-day advance notice. This presents a significant enterprise risk for PEIA because if ESI terminates the PBM Agreement with only 30-day notice, it would be nearly impossible to have a replacement pharmacy benefit manager in place within 30 days. Commonly, pharmacy benefit managers are required to give 180-day advance notice, whereas plan sponsors must give notice 30-60 days in advance. This provision should be reevaluated in future contracts.

Additionally, ESI has the right to terminate the PBM Agreement upon 48 hours' written notice if PEIA fails to pay any amount due to ESI. The market standard approach is to permit termination upon 48 hours only when there is a failure to fund claims reimbursements. Failure to pay other fees, including administrative fees, typically triggers termination after 30-day written notice.

D. Miscellaneous Pricing Terms (Exhibit A-1)

i. Market Check. Overall, the market check provision is favorable to PEIA, with annual market checks permitted and a 1% pricing change trigger. Note that in the event the parties disagree with the results of a market check, the only recourse is to terminate the PBM Agreement. In connection with an RFP or ESI contract renewal, PEIA should consider requiring mandatory arbitration of any market check-related dispute.

ii. Pricing Conditions. The three primary pricing conditions are relatively narrow, and ESI has agreed to only adjust the pricing to maintain the relative economic position of the parties. ESI also has the right to propose pricing changes upon several other events, including for unexpected releases of generic drugs, changes in law, other market conditions, etc. As currently drafted, ESI only has the right to propose changes, not mandate changes, but it is unclear what the implications are if PEIA rejects the proposal. Given the current 30-day termination without cause right described above, PEIA's rejection of any such proposal presents the risk that ESI will terminate the PBM Agreement. In future contracts, we recommend removing these ambiguous pricing conditions.

E. Claims Reimbursement Rates (Exhibit A-2)

i. Specialty Product Pricing. Section 3 of Exhibit A-2 sets forth Specialty Product pricing and administrative rules. In connection with an RFP or ESI contract renewal, we recommend that PEIA consider the following:

a. Explicitly providing in the contract that Specialty Product must be dispensed at a maximum supply of 30-days unless PEIA expressly approves a larger supply or if packaging requires a larger amount to be dispensed. Our understanding is that PEIA does limit Specialty Product full quantity as described above, but we nevertheless recommend adding it o thee contract to avoid disputes.

b. Eliminate separate pricing guarantees for Exclusive or Limited Distribution Products. There is no economic reason to require separate pricing guarantees, as ESI (or a successor PBM) can easily underwrite a deal that reflects including Exclusive or Limited Distribution Products claims in guarantees. Further, given the control that ESI currently has of the Specialty Product List and which Specialty Products are deemed to be Exclusive or Limited Distribution Products, ESI has the ability to manipulate the Specialty Product List and Exclusive or Limited Distribution Products list to ensure guarantees are satisfied or to mitigate overperformance.

ii. General Pricing Terms. Section 5 of Exhibit A-2 sets forth ESI general pricing terms that apply to the ingredient cost and dispensing fee guarantees. These pricing terms largely track ESI's standard terms and conditions. In connection with an RFP or ESI contract renewal, we recommend that PEIA consider the following:

a. Add language to clarify that other extraneous plan savings from ESI (or successor PBM) cannot be used to artificially enhance ESI's (or successor PBM's) pricing discount performance. These extraneous savings include member copayment penalties, other member cost sharing, clinical program savings, drug manufacturer payments, subsidies, coupons, invoice credits, etc.

b. With respect to the MNOY guarantee methodology, the language is generally consistent with market standard, but ESI includes a broad statement that the "application of brand and generic pricing may be subject to certain 'dispensed as written' (DAW) protocols and WV PEIA or plan defined plan design and coverage policies for adjudication and Member Copayment purposes." This vague statement gives ESI wide latitude to manipulate pricing. It is market standard for DAW 5 (house generics) claims to be priced as generics, and DAW 9 claims are typically priced as brands (but with a generic copayment from the member). Any other protocols should be specifically listed in the PBM Agreement.

c. The exclusions listed in Section 4.6 of Exhibit A-2 are comparable to what we see with plans of this type. However, the market trend is moving away from exclusions altogether and requiring PBMs to underwrite pricing based on no, or very few, exclusions. As noted above, 340B claims exclusions have become increasingly problematic as PBMs usually have flexibility to improperly deem claims as 340B claims even when the contract language attempts to establish an objective standard (as the PBM Agreement does). **Note that a list of drug categories being excluded by ESI from ingredient cost guarantees was provided by Madalena Consulting. This list included "COVID vaccines/Test Kit," which is not listed as a permitted exclusion in the PBM Agreement.**

d. As noted above, controls over the PBM's use of MAC Lists could be added to the PBM Agreement. These include: (1) limiting the number of MAC Lists that can be used for the Plan and specifying that number in the PBM Agreement, (2) requiring that the drug composition of each MAC List used by the Plan be the same, though prices may differ slightly, (3) requiring that each NDC for a MAC drug have only one MAC unit price per MAC list, (4) requiring that the MAC unit price for any drug (by NDC) filled through mail order be lower than the MAC unit price through retail, (5) requiring MAC List market competitiveness and giving PEIA the right to challenge MAC List pricing using data analytics, and (6) requiring disclosure of MAC Lists annually and upon request.

e. For mail order pricing, the PBM Agreement could require that the discounted ingredient cost charged to the Plan for a generic maintenance drug from the PBM's mail order pharmacy (90-day supply) cannot be higher than the lowest discounted ingredient cost charged to the Plan for a 90-day supply of the same drug at retail. Further, PEIA should have the right to monitor mail order discounts for non-MAC generics and require the PBM to increase discounts (without penalty to PEIA) if discounts are materially lower than the market standard.

f. Greater disclosure, transparency, and controls related to house generics could be added. For instance, PEIA should receive advance notice of any drug that will be treated as a house generic. Further, all house generics must be coded as DAW 5 so that PEIA can monitor house generic utilization. Finally, the PBM Agreement should make clear that the AWP discounted price of a house generic will always be less than the AWP discounted price of its generic equivalent, and that utilization of a house generic will not have an adverse net financial impact to the Plan.

g. Similar language can be applied to DAW 9 and PBM Brand for Generic Programs such that any substitution of a brand for a generic drug will not have an adverse net financial impact to the Plan.

iii. SaveOnSP Program Performance Guarantee. The SaveOnSP Program guarantee is generally fine, though when evaluating an RFP or ESI contract renewal, we recommend that PEIA also consider independent third-party coupon maximization solutions as an alternative to PBM-affiliated programs. These third-parties are often as effective and charge lower fees. Additionally, in recent years, there have been a number lawsuits alleging that PBMs are operating affiliated coupon savings programs in a manner that adversely impacts both health plans and covered members. While the outcome of the litigation in progress has not been decided, programs such as SaveOnSP may be at risk in the future.

F. Rebate Provision Improvements (Exhibit A-3)

i. Rebate Payment Terms. The current PBM Agreement provides that overperformance on rebates within a rebate category can be used to offset underperformance in another rebate category. The current market standard practice is to require stand-alone rebate guarantees that do not permit overperformance offsetting.

ii. 340B Clawbacks - The most recent contract amendment with ESI has limited the amount of rebates that can be clawed back as the result of the 340B program.

iii. Rebate Conditions. Section 3 of Exhibit A-3 sets forth several conditions to PEIA's right to receive rebates. In connection with an RFP or ESI contract renewal, we recommend that PEIA consider the following:

a. ESI includes its standard language regarding legal right to Rebates. It should be made clear that any Rebate that is also based on a contract between ESI's GPO and a drug manufacturer is also payable to PEIA.

b. Similar to ingredient cost guarantees, the market trend is to permit no, or very few, rebate guarantee exclusions. Eliminating or reducing the permitted exclusions improves transparency and avoids disputes during reconciliation. **Note that a list of drug categories being excluded by ESI from rebate guarantees was provided by Madalena Consulting. This list included "non-drug," "NPF exception," and "non-participating pharmacies" as excluded claims, none of which are listed as permitted exclusions under the PBM Agreement.**

c. The current PBM Agreement gives ESI the right to unilaterally adjust Rebate guarantees if Rebate revenue materially decreases because of unexpected events such as a Brand Drug moving off-patent or due to a Change in Law. Unlike other pricing conditions in the PBM Agreement (including the general pricing conditions in Exhibit A-1), there is no requirement here that the adjustment be limited to what is necessary to maintain the relative economic standing of the parties. In connection with an RFP or ESI contract renewal, we recommend that PEIA limit ESI's (or successor PBM's) control by requiring mutual agreement for any changes. Note that given the increasing release of biosimilars, we expect that PBMs will continue to push for these types of pricing conditions.

d. The PBM Agreement prohibits PEIA from directly contracting with any drug manufacturer for Rebates. A recent trend among large plans is to establish that the plan sponsor has the right to directly contract with drug manufacturers. To the extent that PEIA wants to establish this right, ESI (or successor PBM) will likely require pricing adjustments when direct contracting is utilized.

e. Similar to our recommendation regarding ingredient cost guarantees, language could also be added to clarify that other extraneous plan savings from ESI cannot be used to artificially enhance ESI's rebate performance. These extraneous savings include member copayment penalties, other member cost sharing, clinical program savings, drug manufacturer payments, subsidies, or coupons, invoice credits, etc.

G. Audit Protocol (Exhibit B)

i. The PBM Agreement includes ESI's standard audit protocol, with some modifications in favor of PEIA. In connection with a RFP or ESI contract renewal, we recommend adopting a similar audit protocol with the following clarifications and enhancements:

a. The protocol should specify the information expected to be provided to the auditor, including claims data with field codes that enable the auditor to identify (1) all claims excluded from any pricing or minimum rebate guarantees, (2) all house generics and any other DAW 5 drug interchanges, (3) all other drug interchanges, including all DAW 9 or other generic to brand interchanges, (4) all 340B Claims, (5) all Specialty Product claims, (6) all Exclusive or Limited Distribution Products, (7) all zero balance due claims, (8) all MAC List claims, and (9) all claims in which a specialty copayment couple was applied. The auditor should also have access to all MAC Lists and files showing payments made to pharmacies with respect to each claim.

b. The protocol should make clear that rebate agreement audits extend to agreements between the ESI's (or successor PBM's) GPO and the drug manufacturer, with limited to no redactions of the GPO rebate agreement.

c. The current audit protocol permits a 36-month lookback, which is generally sufficient. However, we recommend adding language allowing PEIA to extend the review period if material or systemic errors are discovered.

Agency Report Submission

Your information has been successfully submitted.

Agency: Public Employees Insurance Agency (PEIA)

Please name your report **P08_CY_2024_.pdf**

REPLY ALL to this email and ATTACH the renamed PDF file.

If you have any technical questions, contact: webmaster@wvlegislature.govYour form had errors! Click (here) to go back to the form.

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INTER-DEPARTMENT DELIVERY

NOTE - CROSS OUT ENTIRE LINE WHEN RECEIVED AND RE-USE UNTIL ALL LINES ARE FULL.

DATE	DELIVER TO	DEPARTMENT	SENT BY	DEPARTMENT
01/02/2025	Drew Ross Director of Public Information Joint Committee Government & Finance 1900 Kanawha Boulevard, East Building 1, Room MB-27 Charleston, West Virginia 25305		Kasi Bell, ASA I Legal Department Public Employees Insurance Agency (PEIA) 601 57th Street, SE, Suite 2 Charleston, WV 25304-2345	