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April 1, 2013

Ms. Barbara Maxwell
Deputy Director
Texas Association of Health Plans
1001 Congress Avenue, Suite 300
Austin, TX 78701

RE: Revised Pharmacy Savings Estimates

Dear Barb:

You asked us to provide you with revised estimates of the potential impact of moving to MCO-defined formularies for the Texas Medicaid and CHIP programs. Our original estimates were contained in a report dated February 4, 2013. We have developed revised estimates to incorporate additional information provided by the Texas Health and Human Services Commission (HHSC). The additional information was provided by HHSC and its actuaries at a meeting of March 6 and in an email dated March 22 in response to our March 12 data request. This letter contains the results of the analysis, as well as a description of the underlying assumptions and methodology.

Results

The revised savings estimate scenario is attached as Exhibit 1. It produces a savings of $73.7 million for the 2014 – 2015 biennium, including administrative cost savings. It does not include additional savings or offsets from the ACA Health Insurance Issuer Tax or state premium tax revenue. Therefore, it compares to HHSC's savings estimate for initiative 6a of $64.0 million. It is critical to note that these savings estimates assume that there are no exceptions or overrides to the plans' proposed formularies, the State does not impose restrictions that would limit the formulary design, and that the drug shifts would take place immediately. While we believe these are achievable targets, they should be characterized as aggressive targets.

Methodology and Assumptions

We applied the following methodology and assumptions changes to our original estimates:

- Used the "100% formulary savings" produced by our formulary analysis (representing "High" savings as compared to the "Best" and "Low" savings estimates shown in our report of February 4, 2013);
- Applied the generic and brand rebate percentages "with and without PDL mandate" provided by HHSC on March 22 in the file "HHSC PDL Study Assumptions rw.xls";
- Grossed up the starting cost estimate for the biennium to the level assumed in the HHSC savings estimates;

- Assumed retention loading of $1.80 PMPM, 1.75% for premium tax, and 2.0% for profit margin

The savings components are shown in the exhibit.

Comparison to HHSC Key Results

The method produces similar ingredient cost savings (of 22.0%) as HHSC's study (23.5%), as well as similar generic dispensing rates (84.5% vs. HHSC estimate of 84.9%). It produces a higher overall rebate percentage after the change than does HHSC's method (39.0% vs. 36.3%), due to differences in the generic/brand cost mixes. The resulting total savings are approximately $10 million greater than the HHSC estimate. We consider this to be a reasonable difference (representing less than .2% of total "Before" drug costs) given the difference in approaches and underlying data used by HHSC's actuaries compared to the approach and data used by Milliman.

Impact Estimate for Initiative 6d – More Restrictive State-Managed PDL

We note from the additional information provided by HHSC that the savings estimate for initiative 6d did not apply any change to the rebate percentage, while assuming a 4% ingredient cost savings. If we assume a reduction in rebates that is proportionate to the impact in 6a, we produce the savings estimates in Exhibit 2. We did not assume a difference in timing in the two scenarios. The savings estimate in this case is about $5.1 million. This compares to the "Total HHSC Savings" of $40.7 million.

Third Party Distribution

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Data Reliance

In performing this analysis, we relied on data and other information provided by HHSC, in addition to the data described in our report of February 4. Please see that report for additional detail and caveats.

Variability of Results

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Qualification Statement

I, Susan K. Hart, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and I meet the qualification standards for performing the analyses in this report.

Sincerely,

Susan K. Hart, F.S.A.

SKH/pc

Milliman High Mix Savings, HHSC Rebate % for Brand/Generic Before and After
With Administrative Costs and Premium Tax Estimate Added

	Before	Pre-Rebate savings	After	Difference
Cap to MCOs - drug costs	4,329,426,859	22.0%	3,378,962,998	950,463,861
Administrative expenses	139,812,599		139,812,599	
Risk margin	2.00%		2.00%	
Premium tax	1.75%		1.75%	
Total Cap	4,643,365,671		3,655,870,750	987,494,921
Rebates	50.1%		39.0%	
Net of rebates	2,475,850,270		2,338,005,004	
Federal share	0.593		0.593	
Cost to state	1,007,671,060		951,568,037	56,103,023
GDR			84.54%	
Compare: "Utilization" line:				
Above "cost to state"	1,007,671,060		951,568,037	
HHSC worksheet	1,323,666,427		1,259,569,962	
Ratio	1.31		1.32	

Above with Caseload Grossed Up to HHSC

	Before	Pre-Rebate savings	After	Difference
Cap to MCOs - drug costs	5,687,090,966	22.0%	4,438,571,332	1,248,519,634
Administrative expenses	183,656,404		183,656,404	
Risk margin	2.00%		2.00%	
Premium tax	1.75%		1.75%	
Total Cap	6,099,477,787		4,802,314,531	1,297,163,256
Rebates	50.1%		39.0%	
Net of rebates	3,252,251,664		3,071,179,528	
Federal share	0.593		0.593	
Cost to state	1,323,666,427		1,249,970,068	**73,696,359**

Estimate of 6d Impact With Change to Rebates

HHSC ingredient cost savings, HHSC caseload

	Before	Pre-Rebate savings	After	Difference
Cap to MCOs - drug costs	5,687,090,966	**4.0%**	5,459,607,327	227,483,639
Administrative expenses	183,656,404		183,656,404	
Risk margin	2.00%		2.00%	
Premium tax	1.75%		1.75%	
Total Cap	6,099,477,787		5,863,131,150	236,346,638
Rebates	**50.1%**		**48.0%**	
Net of rebates	3,252,251,664		3,239,840,276	
Federal share	0.593		0.593	
Cost to state	1,323,666,427		1,318,614,992	**5,051,435**

Projected Impact of Formulary Carve-In for Texas Medicaid and CHIP Programs

Prepared for:
Texas Association of Health Plans

Prepared by:
Susan K. Hart, FSA, MAAA

Brian N. Anderson, MBA

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February 4, 2013

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EXECUTIVE SUMMARY

Milliman was engaged by the Texas Association of Health Plans (TAHP) to evaluate the expected impact of moving from a single statewide formulary in the Texas Medicaid and CHIP programs to formularies specified by each managed care organization (MCO). We estimate that the State can save $57.5 - $124.8 million in the 2014 – 2015 biennium by making this change to the program, representing 4.9% - 10.5% of the State's share of projected drug costs managed by the MCOs. This is in addition to savings the State may be currently realizing through the initial carve-in that took place in March of 2012. The savings estimate represents the State's share of drug benefit costs included in the STAR, STAR+PLUS and CHIP programs, after estimated rebates.

Effective March 1, 2012, prescription drugs were carved in to Medicaid managed care contracts in Texas and capitation rates were adjusted accordingly. However, while the MCOs are now taking risk for this population, they are not able to apply the pharmacy management tools typically utilized in a managed care environment in order to fully control costs. The Vendor Drug Program (VDP) retains responsibility for maintaining a single statewide formulary that all MCOs are required to apply. This study estimates the potential impact of moving responsibility for formulary maintenance to the MCOs (i.e., moving from a single formulary to multiple formularies, or formulary carve-in).

In order to develop our results, we evaluated actual drug utilization and costs at a detailed level from data provided by MCOs participating in the study. We modeled the change to the drug mix and resulting costs by applying anticipated formularies, step therapies, and other pharmacy management tools the plans would expect to implement with a full carve-in. These changes are expected to result in an increase in the generic dispensing rate, leading to lower average costs per prescription and lower costs in the aggregate. We estimated the savings that would have been achieved if the MCOs had had complete control of their formularies in the first six months that pharmacy benefits were carved into the Medicaid capitation rates. We then extrapolated that savings to the 2014 – 2015 biennium.

While actual results will vary from these estimates, we have developed a range, which we consider to be appropriate and somewhat conservative. Prior studies, described in this report, have also projected savings for formulary carve-in. This study generally aligns with the findings of those previous studies by applying proposed formularies to actual data from the Texas Medicaid and CHIP managed care programs.

INTRODUCTION

Milliman was engaged by the Texas Association of Health Plans (TAHP) to evaluate the expected impact of moving from a single statewide formulary in the Texas Medicaid and CHIP programs to formularies specified by each Texas Medicaid Managed Care Organization (MCO). The Texas Health and Human Services Commission (HHSC) maintains a single statewide formulary through the Texas Medicaid/CHIP Vendor Drug Program (VDP). TAHP member health plans are seeking the ability to apply their own formularies, clinical edits, step therapies, and prior authorization guidelines. This report contains Milliman's independent analysis evaluating the potential impacts of implementing these pharmacy management tools in Texas Medicaid and CHIP.

The report includes our key findings, methodology, and assumptions. It includes a description of previous studies addressing the potential impact of a carve-in model and our conclusions.

Scope of Study

In order to complete this project, we obtained detailed pharmacy utilization and cost data from four MCOs in the state from the second half of state fiscal year (SFY) 2012. We estimate that this data represents over 60% of MCO pharmacy costs in the time period. Each MCO provided us with its proposed formulary (which they would expect to use in the formulary carve-in scenario). Based on internal Milliman proprietary models, we estimated the impact that the use of the MCO-specified formularies would have, compared to the VDP formulary, on pharmacy utilization by drug. We estimated the net cost impact on a percentage basis due to this resulting shift in drug mix. The cost impact estimates include the effect of potentially lower rebates to the State, also caused by this drug mix change. All savings expressed on a dollar basis represent only the State share of pharmacy costs; in other words, they are net of the federal match.

Note that in this report, we are not estimating the full potential savings of going from pharmacy carve-out to carve-in. Rather, we are focusing our estimate on the potential savings of moving from the current partial carve-in (the MCOs take risk for pharmacy costs) to full carve-in, allowing multiple formularies, and giving the plans the ability to apply other pharmacy management tools. Therefore, we used data from the period from March 1, 2012 to August 31, 2012 as the base period in our analysis.

We have not quantified potential savings from lower overall utilization due to medical management on the part of MCOs or lower dispensing fees paid by MCOs, because these savings can be realized in the current partial carve-in. We have assumed on a drug-by-drug basis that the ingredient cost will not change. The savings estimates only include the drug cost savings and do not include the potential impact on administrative costs.

Caveats

This report has been prepared for the use of TAHP. It may not be released to other parties without the prior written permission of Milliman, Inc. If Milliman grants permission to distribute this report to third parties, the report should be distributed in its entirety. Any user of the report must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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The enclosed projections reflect financial consequences that will result if the underlying assumptions are realized precisely. Actual results will differ from the projections due to a variety of influences, including random variation in the need for healthcare services. The formularies modeled are based on the formularies provided to us by the vendors, and may or may not be the identical formularies that vendors implement. While we have provided a potential range of results, actual results may be outside of this

range. We recommend that you monitor actual experience as it develops and adjust the projections accordingly.

In performing this analysis, we relied on data and other information provided by MCOs who are TAHP member companies and their Pharmacy Benefit Managers (PBMs), as well as public sources of data such as that available on the HHSC, VDP, and the Centers for Medicare and Medicaid Services (CMS) websites. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment. This report is subject to the terms of the Consulting Services Agreement between TAHP and Milliman, Inc. dated September 19, 2012.

Qualification Statement

I, Susan K. Hart, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and I meet the qualification standards for performing the analyses in this report.

BACKGROUND

Prior to passage of the Affordable Care Act (ACA), Texas was one of 13 states to "carve-out" prescription drugs in Medicaid, i.e., the risk for pharmacy claims was not passed on to the MCOs and the expected costs were not included in the capitation rates. A major driver of Texas's approach was pharmaceutical rebates; while states were eligible to receive federal manufacturer rebates when paying for these costs on a fee-for-service basis, drugs purchased through MCOs were not eligible for rebates. The rebate percentages negotiated through federal agreements are substantial, averaging 36% of gross drug costs in federal fiscal year 2011 based on CMS-64 reports and the VDP website.

Provisions of the ACA changed this dynamic, specifying that drugs provided to Medicaid recipients through MCOs would now be eligible for federal rebates. This change occurred with the effective date of the law, March 23, 2010.

Effective March 1, 2012, drugs were carved in to Medicaid contracts in Texas for STAR, STAR+PLUS (Medicaid only populations) and CHIP. Capitation rates were adjusted accordingly. Formulary management was retained by the VDP.

Medicaid and CHIP MCOs must use a PBM to process prescription claims. Across the state, 19 MCOs have contracted with a total of seven different PBMs – some PBMs are contracted with multiple MCOs. The PBMs currently administer the Formulary and Preferred Drug List (PDL). The Formulary and PDL are subject to the following items:

- All Medicaid PBMs must adhere to the HHSC Medicaid formulary and PDL.
- All CHIP PBMs must adhere to the HHSC CHIP formulary (no PDL for CHIP).
- Prescribers may use their e-prescribing software to view the Medicaid/CHIP formularies or to find preferred drugs and alternatives to non-preferred drugs.
- Texas Medicaid and CHIP formularies and Medicaid PDL are available on smartphone and web at www.epocrates.com – a free subscription service.

Outpatient prescription drugs are a benefit of each Medicaid managed care program, STAR, STAR+PLUS, and STAR Health. CHIP is also a managed care program for which outpatient drugs are a benefit. Pharmacies must be contracted with the Vendor Drug Program before they can participate in any managed care network. A list of the MCOs and PBMs, by service area, is available at the Vendor Drug website, http://www.txvendordrug.com/claims/managed-care.shtml.

Refer to the glossary of Rx terms, which includes definitions of STAR, STAR+PLUS, and CHIP.

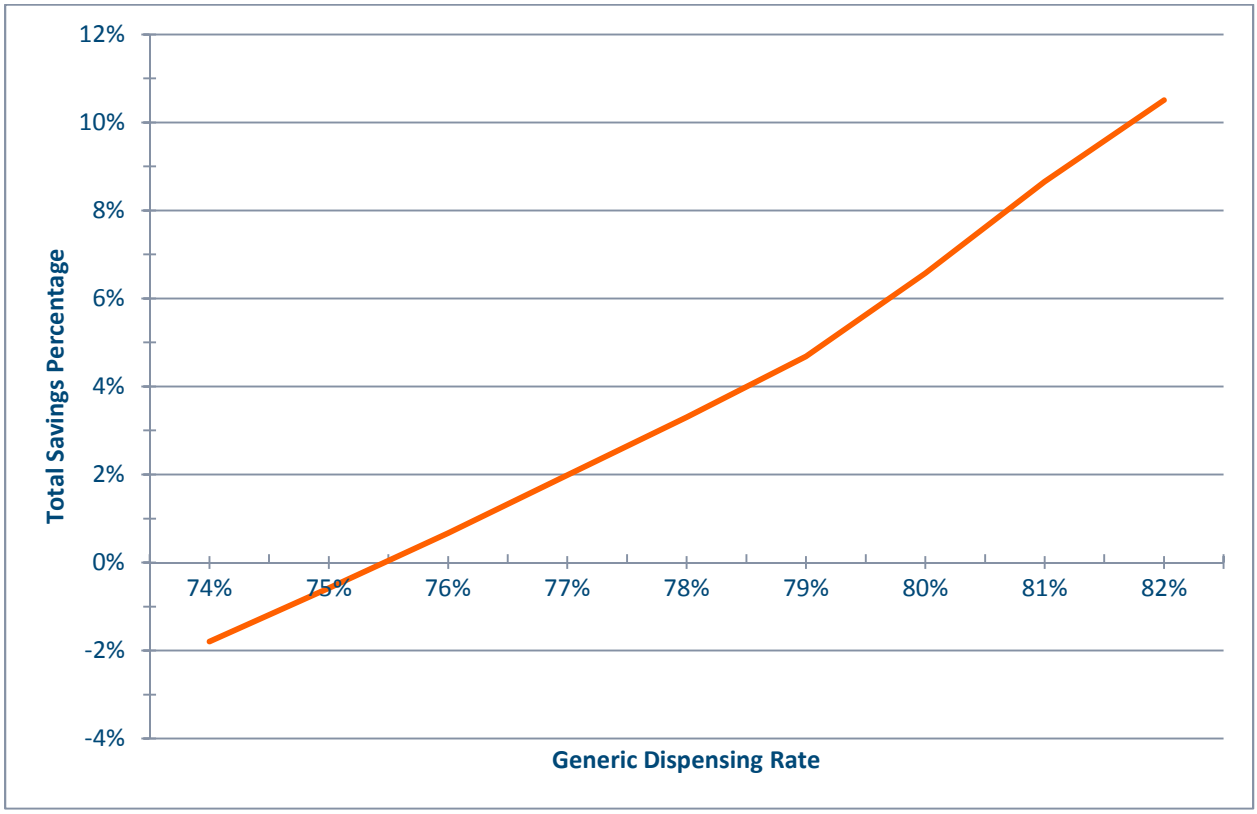
COST IMPACT RESULTS

We estimate that the State can save $57.5 - $124.8 million in the 2014 – 2015 biennium by making the proposed change to the pharmacy program, representing 4.9% - 10.5% of the State's share of projected drug costs managed by the MCOs. The savings estimate represents the State's share of drug benefit costs included in the STAR, STAR+PLUS and CHIP programs, after estimated rebates.

We estimate that the formularies submitted by the participating MCOs and their PBMs would have resulted in approximately $25.0 million in savings to the State for the six month period from March 1, 2012 to August 31, 2012 under our best estimate assumptions. A more conservative set of assumptions, labeled as "Low Savings" in the exhibits, produces savings of $11.7 million. The savings dollars represent only the State share of savings (after Federal match), after rebates. Exhibits 1a and 1b show the summary of the savings estimate for this time period under the two scenarios. Exhibit 2 shows the development of the biennium savings produced by applying the savings percentages to projected costs for state fiscal years 2014 and 2015.

In the best estimate scenario, the generic dispensing rate (GDR) moves from 73.8% in the base period to 81.9% after applying the formulary. In the low scenario, the GDR moves to 79.2%. The savings rate increases with the change to the GDR result. The chart below shows a continuum of projected cost savings compared to GDR, developed by interpolating the results between the current level and the best estimate.

Impact of Generic Dispensing Rate on Total Savings Percentage



Note that the results above include the impact of rebate assumption changes which vary in different scenarios, so if the MCOs would be unable to impact the GDR, this would produce negative savings under other low savings assumptions.

METHODOLOGY AND ASSUMPTIONS

In developing our results, we completed the following steps:

- Completed a formulary analysis applied to each MCO and product, assuming 100% enforcement of the submitted formulary;
- Extrapolated the results from the sample to statewide costs;
- Applied a range of potential results;
- Adjusted for the expected impact of rebates and the State share of savings; and
- Projected results to the biennium.

These steps are described in more detail below.

Formulary Analysis

The MCOs submitted detailed pharmacy claims data for the period from March 1, 2012 to August 31, 2012, along with their proposed formularies. We summarized the MCO claims experience using Medi-Span® fields including product names and therapeutic classes. We then compared the current coverage status based on the Texas Medicaid Drug Formulary to the coverage assuming they were to implement their own custom formulary with strict clinical management programs. Within each "therapeutic class 2" as identified by Medi-Span®, non-covered drug utilization is reallocated to other comparable drugs that are covered within that therapeutic class.

Formulary Analysis Model

We projected the relative costs of prescription drug benefits under each formulary using a proprietary formulary model developed by Milliman. The model was designed for the specific purpose of projecting the impact of formulary changes on Medicaid prescription drug benefit costs. The model considers the following ways that a formulary can influence drug costs:

- Drugs excluded from (not covered under) the formulary
- Step therapy programs, whereby a member must first try a lower cost (i.e., generic) drug before a higher cost drug will be covered by the plan
- Prior authorization requirements to be eligible for coverage for certain drugs

In order to analyze the effect of making individual drug level changes to the vendor preferred drug list, we used claim history to calculate a per-day cost of using each drug based on the total cost and number of days supply that were dispensed. Using this calculated number and total utilization, the model demonstrates the potential cost savings if the utilization of a high cost drug that is deemed as not covered was shifted to other lower cost drugs that are covered in the same therapeutic class. The model calculates the shift of the utilization from drugs being taken off the formulary to remaining covered drugs within the same therapeutic class. The shifting of utilization is based on a weighted average of the remaining drugs utilization, where weights are given by days supply.

Note that copay or rebate impacts of specific benefit plans have not been reflected at the drug level in the formulary analysis. In other words, we evaluated the formularies with an implicit assumption of a current plan design, which excludes the impact of rebates. The model uses historical data and does not model the impact of certain utilization management programs, such as quantity limits.

The model focuses on gross drug spend by product name (i.e., combining all national drug codes (NDCs) for a given product name) identified by the NDC or the generic product indicator (GPI) assigned by Medi-Span® provided in the formulary flat file. The model does not recognize the effect of brand drugs losing patent protection between the base experience period and the projection period.

Data and Key Assumptions

The data and key assumptions used in the analysis included the formulary files, formulary supporting documentation, feedback from the PBM vendors, and assumptions about clinical programs.

In performing our work, we relied on the following information provided by the MCOs, VDP website, or PBM vendors:

- Claims data
- Formularies
- Step therapy and pre-authorization rules
- Feedback and clarification during the formulary modeling process
- Eligibility to plan type crosswalks

Our projections were made using actual claims data collected by Milliman. The claims experience of the other Medicaid MCOs might differ, resulting in different formulary valuations.

Extrapolation to Statewide Results

The analysis described above resulted in potential savings for the MCOs participating in the study, separately for STAR, STAR+PLUS, and CHIP for the first 6 months of the carve-in period. We estimate that this data represents over 60% of MCO pharmacy costs in the time period. We extrapolated these results to produce statewide savings. We developed assumed total statewide costs before the formulary changes based on data on the HHSC website, including actuarial pricing memos and MCO enrollment counts. The development is included as Exhibit 3.

We then applied the submitted MCOs' generic dispensing rates and average costs per script in order to allocate costs to brand and generic and develop the number of assumed prescription counts. This was done within program (e.g. STAR), and then totaled to produce the total savings potential.

Development of Range of Results

The formulary analysis assumes that there are no exceptions or overrides to the stated formularies, the State does not impose restrictions that would limit the formulary design, and that the drug shifts would take place immediately. We do not consider this a likely scenario at the onset of implementation because of the need for transition policies to mitigate member disruption. Therefore, we tempered the total savings to produce a more conservative range of results. We developed our best estimate assuming that the MCOs would achieve generic dispensing rates (GDRs) 75% of the way from the current level to the full potential level. For the lower estimates, we assumed the MCOs would achieve GDRs half way between the current and full potential levels.

Rebates and State Share of Savings Adjustments

In order to estimate the impact of the shift from brand to generic drugs on rebates, we assumed that total federal rebates average 36% of gross costs. In our best estimate, we assumed generic rebates average 5% of costs, and then backed into the assumed brand rebate percentage. In the expected results after applying the MCO formularies, we applied the same average rebates within brand and generic as in the base, but the composite rebate goes down as generic utilization goes up. In the lower estimates, we assumed generic rebates average 0% of costs, again backing into the generic rebate percentage by assuming a 36% total rebate.

Based on CMS-64 data for federal fiscal year 2011, we assumed a current state supplemental rebate percentage of 2% for all scenarios. We assumed that the MCOs' supplemental rebates would average 1% and in the best estimate scenario and 0% in the lower savings scenario.

In order to arrive at total dollar savings, we applied the state share of costs (equal to 1 minus the federal matching rate in Texas for FY 2013 of 59.3%).

Projection to Biennium

To project the savings in the biennium period, we applied the savings percentages assumed above to the total projected costs in SFY 2014 – 2015. This calculation of the savings is shown in Exhibit 2, using total projected costs in the biennium calculated in Exhibit 3.

Additional Details and Potential Limitations

Following are additional details regarding underlying assumptions and potential limitations associated with the analysis.

- The data analyzed is for the period of March 1, 2012 through August 31, 2012 therefore the data could not represent any potential seasonal drug claims that could be prescribed in other parts of the year. In addition, transition requirements during this period could influence the utilization. However, the percentage savings should be a valid indicator of how the proposed formulary will influence the costs; these savings percentages are applied to projected full year costs for future periods. While data was available for earlier time periods, we did not consider it to be a good representation of a "base period" due to it being prior to carve-in and due to new populations such as the Hidalgo area being rolled in to managed care as of 3/1/2012.
- Drugs that were listed as not covered on the current formulary were not analyzed as part of the total cost or utilization for the current formulary. The assumption here is that only covered drugs should be dispensed.
- Our analysis distributes drugs not covered in the MCO formulary to other covered drugs within the same Therapeutic Class 2 based on the number of days that were prescribed for those drugs. In other words, there will be the same total number of days prescribed regardless of which formulary is used.
- We have excluded therapeutic classes from our analysis where there were no covered drugs in the claim data provided for the entire therapeutic class.
- Drug coverage status for the base period data was indicated by drugs that were covered in the current formulary in place with Texas Medicaid. Drugs that were listed with a "Non-PDL – PA Required" status were not covered in our analysis. This methodology is consistent across all PBM formularies. This does not take into account any more stringent step therapies or prior authorizations that might be in place with that MCO.
- This analysis does not account for any potential savings for drugs that were not filled during the evaluation period. If the PBMs' proposed formulary indicates coverage for drugs that were not filled in the evaluation period, the potential savings associated with these drugs are not calculated.
- Our savings calculations are solely based on changing the formulary for a Medicaid plan. This savings does not account for any changes in ingredient cost discounts dispensing fees, or rebates associated with the new mix of drugs within brand or generic.
- Rebate percentages were assumed to stay the same within brand and within generic before and after formulary carve-in. Since rebates will vary by drug, there is likely to be some change to the percentages within those categories. We have performed sensitivity testing on this assumption and note that if, as an example, the rebate within brands goes down by 5% and the rebate within generics goes up by 5% from our best estimate assumptions, the resulting savings percentage would be 7.8% rather than 10.5%, which is above the Low estimate savings.
- The projection from the experience period to the biennium is not precise and will not recognize all potential changes to cost structure in the projection period. For example, the methodology does not recognize varying trends for unit costs and utilization with brands and generics, which may influence the results.

- In our analysis, we estimated the impact on state costs within the Medicaid and CHIP managed care programs. We have not considered the potential impact on costs for remaining FFS claims or on other state programs if Texas leverages its drug purchasing with other programs.
- The scope of our assignment was limited to the evaluation of cost considerations and did not include potential operational and patient care considerations.

PRIOR STUDIES AND EXPERIENCE IN OTHER STATES

There are a number of publicly available studies that estimate the impact of pharmacy carve-in for Medicaid programs. We are not aware of any that specifically are looking at only the formulary carve-in aspects (as opposed to movement from carve-out to carve-in). However, some of these studies provide sufficient information to allow us to extract the portion of savings resulting from drug mix changes under carve-in.

Medicaid Health Plans of America - Lewin

A March 2011 report by the Lewin Group[1] estimated savings that may result for each of the 13 states that, at that time, had full carve-out of prescription drugs. Projected results are included by state. The report estimated net potential savings for Texas that started at 20.5% in 2012, going up to 26.8% in 2021, for a 10-year total of 24.1%.

We replicated the calculations included in the Lewin development in order to separately identify the net savings percentage due solely to risk mix change. In other words, we removed the savings associated with changes to overall utilization and changes to costs including dispensing fee reductions, as these can be experienced with the current partial carve-in. Based on our understanding of the assumptions and methodology, we estimate the mix change savings at 13 – 15% in the years from 2012 to 2015.

Texas HHSC

In February 2011, HHSC estimated the general revenue impact to the state of carve-in under two options: with a single formulary or with multiple formularies[2]. They concluded that the savings for the 2012 - 2013 biennium under single formulary would be $51.0 million, while it would be $72.7 million under multiple formularies, suggesting that the formulary impact would be $21.7 million.

Initial Carve-In Experience in New York

The state of New York carved prescription drugs into its Medicaid capitation on October 1, 2011, including MCO-specified formularies. Based on Mercer's review of experience in the first 6 months of carve-in, they concluded, "health plans have achieved GDRs that *far exceed* the assumptions used to develop the regional average premiums during the first six months of the carve-in"[3]. For example, for TANF Children, the premium development assumed a GDR of 77.8% for retail drugs (non-protected class, non-specialty), while the experience rate was 82.1%. For TANF Children, the premium development assumed a GDR of 71.9% for retail drugs compared to 78.3% actual experience.

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[1] www.mhpa.org/_upload/MHPAPaper**PharmacyCarve-In**.pdf

2 http://www.hhsc.state.tx.us/news/presentations/2011/Senate-Appropriations-0211.pdf

3 Mercer - Katherine Long, ASA, MAAA, Ron Ogborne, FSA, CERA, MAAA, Mike Zucarelli, BS, PharmD September 11, 2011. FISCAL YEAR 2011–12 MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS PHARMACY REVIEW

CONCLUSIONS

Based on the analysis in this report, we estimate that there is potential for material savings in the Texas Medicaid and CHIP programs for moving from a single statewide formulary to MCO-specified formularies. We estimate that the State can save $57.5 - $124.8 million in the 2014 – 2015 biennium by making this change to the program, representing 4.9% - 10.5% of the State's share of projected drug costs managed by the MCOs. The savings estimate represents the State's share of drug benefit costs included in the STAR, STAR+PLUS and CHIP programs, after estimated rebates.

GLOSSARY

The following is a partial glossary of terms that are commonly used in the pharmacy industry or in this report.

Average wholesale price (AWP): A published national average of list prices charged by wholesalers to pharmacies. AWP is sometimes referred to as a "sticker price" because it is not the actual price that large purchasers or PBMs normally pay.

Children's Health Insurance Program (CHIP): Provides health insurance for children in families whose income is too high to qualify for Medicaid.

Drug tiers: Drug tiers are coverage levels for drugs. This level determines how much you might pay out of pocket for a drug.

Exclusion: Exclusion means that a drug, product or service that is not covered by your plan.

Formulary: A preferred list of drug products that typically limits the number of drugs within a therapeutic class available to plan members. Some health plans develop closed formularies (only listed drug products are covered or reimbursed) whereas others develop open formularies or impose restrictions such as higher patient cost sharing for non-formulary drugs.

Generic drug: A generic drug has the same basic ingredients as the brand drug. In addition, the U.S. Food and Drug Administration have found that it is just as safe and effective as the brand drug.

Mail order: A participating pharmacy that provides home delivery services through common carriers, as well as other services described in the PBM contract.

Maximum allowable cost (MAC): The maximum cost allowed for a generic drug product as set by the PBM.

Over-the-counter drugs: Over-the-counter drugs are medications that can be bought without a prescription. They are not covered under most prescription plans.

Retail pharmacy: Also known as "network," this refers to a negotiated contract list of available pharmacies. The retail network can include both national chain pharmacies and independent pharmacies.

Specialty pharmacy: A contracted pharmacy providing prescription items that require special handling or administration. A PBM usually contracts the discounts, administrative fees, and dispensing fees at a rate different from other discounted arrangements.

STAR: STAR is a Medicaid managed care plan in Texas. This plan helps family members of any age. Pregnant women can also be covered by STAR.

STAR+PLUS: The STAR+PLUS program integrates acute care and long-term services and supports into a Medicaid managed care delivery system for the people over age 65, or who are blind or have disabilities.

Step-therapy: A step therapy means your doctor may need to prescribe certain drugs first, before another drug will be covered. The drugs prescribed first work the same and treat the same condition.

Exhibit 1a
Best Savings Estimates

ALL PRODUCTS COMBINED, 3/1/2012 - 8/31/2012

	Before Applying Formulary					After Applying Formulary				
	Total Cost	Number of Scripts	Cost per Script	Federal Rebate %	Cost Net of Rebates	Total Cost	Number of Scripts	Cost per Script	Federal Rebate %	Cost Net of Rebates
Brand	$738,017,042	3,581,677	$206.05	44%	$ 412,160,799	$ 553,128,340	2,518,184	$219.65	44%	$ 308,873,612
Generic	$194,097,122	10,084,413	$19.25	5%	$ 184,392,266	$ 231,160,704	11,359,972	$20.35	5%	$ 219,602,668
Total	$932,114,164	13,666,090	$68.21	36%	$ 596,553,065	$ 784,289,043	13,878,156	$56.51	33%	$ 528,476,280
Generic % Cost / GDR	20.82%	73.8%				29.47%	81.9%			
Supplemental Rebates					2%					1%
Final Net Cost					$ 584,622,003					$ 523,191,517
Final Savings %										**10.5%**
Savings Total $s										$ 61,430,486
State Share										40.7%
State Savings										$ 25,002,208

*Equals 1 - FMAP% for FY 2013 for Texas from http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4 accessed 12/16/2012

Exhibit 1b
Low Savings Estimates

ALL PRODUCTS COMBINED, 3/1/2012 - 8/31/2012

	Before Applying Formulary					After Applying Formulary				
	Total Cost	Number of Scripts	Cost per Script	Federal Rebate %	Cost Net of Rebates	Total Cost	Number of Scripts	Cost per Script	Federal Rebate %	Cost Net of Rebates
Brand	$738,017,042	3,581,677	$206.05	45%	$ 402,455,943	$ 618,879,617	2,876,589	$215.14	45%	$ 337,454,758
Generic	$194,097,122	10,084,413	$19.25	0%	$ 194,097,122	$ 218,418,209	10,930,878	$19.98	0%	$ 218,418,209
Total	$932,114,164	13,666,090	$68.21	36%	$ 596,553,065	$ 837,297,826	13,807,467	$60.64	34%	$ 555,872,967
Generic % Cost / GDR	20.82%	73.8%				26.09%	79.2%			
Supplemental Rebates					2%					0%
Final Net Cost					$ 584,622,003					$ 555,872,967
Final Savings %										**4.9%**
Savings Total $s										$ 28,749,036
State Share										40.7%
State Savings										$ 11,700,858

*Equals 1 - FMAP% for FY 2013 for Texas from http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4 accessed 12/16/2012

Exhibit 2
2014 - 2015 Biennium Savings Estimate

Total Projected Costs Before Rebate, Includes State and Federal Share:		$	4,329,426,859

Scenario			Best Estimate		Low Estimate
Average Rebate %			32.6%		33.6%
Projected Costs Net of Rebates		$	2,917,291,044	$	2,874,259,647
% Savings			10.5%		4.9%
Total Savings		$	306,540,988	$	141,342,944
State Portion	40.7%	$	124,762,182	$	57,526,578

Exhibit 3
Calculation of Total Starting Statewide Costs Before Formulary Change and Rebates*

From HHSC Rx Pricing Memo for 3/1/12 - 8/31/12

	CHIP	Star	Star Plus	Total
Projected PMPM	$21.94	$31.97	$364.17	$50.24
Projected MM's	3,500,334	12,556,006	1,046,461	17,102,801
Projected $s	$76,813,905	$401,380,994	$381,091,404	$859,286,303
Actual MM's	3,476,246	14,850,744	1,046,461	19,373,451
Use for $s	$76,285,300	$474,737,459	$381,091,404	$932,114,164

Note: For Star Plus, capitation only applies to Medicaid Only, so above member months only relate to the MO groups. We do not have actual statewide MM's for MO so assumed = projected.

From HHSC Rx Pricing Memo for 9/1/12 - 8/31/13

	CHIP	Star	Star Plus	Total
Projected PMPM	$22.27	$34.14	$373.95	$52.24
Projected MM's	7,257,456	26,339,953	2,157,875	35,755,284
Projected $s	$161,610,607	$899,215,461	$806,948,077	$1,867,774,145
Adjusted MMs*	7,257,456	29,701,488	2,157,875	39,116,819
Use for $s	$161,610,607	$1,013,974,369	$806,948,077	$1,982,533,053

Note: For Star Plus, capitation only applies to Medicaid Only, so above member months only relate to the MO groups. We do not have actual statewide MM's for MO so assumed = projected.
*assumed max of HHSC projected and 2 x prior 6 months

Projection for Biennium

2014

	CHIP	Star	Star Plus	Total
Assumed PMPM Trend	5%	5%	5%	
Assumed MM Increase	1.9%	6.8%	3.6%	
Projected PMPM	$23.38	$35.85	$392.65	$54.53
Projected MM's	7,393,803	28,130,728	2,235,049	37,759,579
Projected $s	$172,879,150	$1,008,367,958	$877,597,972	$2,058,845,080

2015

	CHIP	Star	Star Plus	Total
Assumed PMPM Trend	5%	5%	5%	
Assumed MM Increase	1.9%	6.9%	3.5%	
Projected PMPM	$24.55	$37.64	$412.29	$56.89
Projected MM's	7,533,460	30,066,755	2,313,871	39,914,087
Projected $s	$184,951,784	$1,131,654,702	$953,975,293	$2,270,581,779
Total Drug Costs For Biennium	$357,830,934	$2,140,022,660	$1,831,573,265	$4,329,426,859

*Includes State and Federal share