

**Recent Lewin Group Study Touting Optimal Savings Opportunities in State Medicaid Pharmacy Programs Through Switch to Managed Care (Via PBMs) is Flawed Due to Inherent Bias, Counterintuitive Assumptions and Flawed Methodology.**

**I. Study Commissioned by the Pharmaceutical Care Management Association (PCMA). PBM Industry is Virtually Unregulated at the State or Federal Level and Has Long History of Enforcement Actions Including Allegations of Drug Switching.**

PCMA is the national association representing Pharmacy Benefit Management Associations including ExpressScripts, Medco, and CVS Caremark—the very companies that would stand to reap the benefits should states decide to administer their Medicaid pharmacy benefit through managed care via PBMs. In addition, the consulting firm that performed the study, the Lewin Group, is owned by United HealthCare, a healthcare conglomerate whose holdings include Prescription Solutions-- a PBM that serves over 10 million people. To further illustrate the inherent conflict of interest, a top executive of United Healthcare currently serves on PCMA's Board of Directors.

The PBM industry today is extremely concentrated and the “Big Three” PBMs manage the drug benefit for approximately 95% of Americans with employer-based prescription drug coverage. From 2003 to 2007, these three PBMs saw their profits climb nearly threefold, from over \$900 million to over \$2.7 billion. In addition, during this same approximately time period, numerous substantial enforcement actions were brought against these companies alleging fraudulent and deceptive conduct which resulted in over \$370 million in damages. These cases also shed light on some of the questionable widespread practices in the PBM industry, including drug switching, misuse of rebates and the submission of false claims

**II. Contrary to Lewin Group Study—The Use of PBMs/Managed Care Is Not Necessary to Optimize Use of Generics—Major Source of PBM Revenue Is Derived from Manufacturer Rebates and Driving Brand Market Share!**

NCPA has long held the position, and study after study, including one from IMS, have validated that increasing generic dispensing rates or adopting a Generics First” plan design is the most effective method of reducing the cost of the pharmacy benefit to plans and patients. An IMS study has proven that for every 1% that plans invest in generics, they receive 2% back in savings. These types of returns are virtually guaranteed to the plan. *However, it's important to note that PBMs are not a critical component to implementing these plan designs.* Recent GDRs of the Big 3 PBMs demonstrate that the retail channel effectively drives generics across all types of plans [<insert latest retail channel GDR numbers>](#). In 2009, all of the PBMs had significantly lower GDRs associated with their mail pharmacies where they were solely responsible for the GDR[<insert 2009 Mail GDRs for Big 3>](#).

The Lewin Group focuses solely on a projected increase in generic utilization rates under a managed care system. However, the study should focus on generic substitution rates. For 23 states, existing generic substitution rates are at least 90%. California has the lowest substitution rate at 83%. Taking these figures into consideration, it seems that the only way to increase

generic dispensing rates for states with higher generic substitution rates would be by decreasing the number of brands available in a given formulary. As an example, Texas has a utilization rate of 55%, but a substitution rate of 90%. Under the Lewin group sliding scale model, the utilization rate would rise to 65%. The only plausible way to hit that rate would be by decreasing the number of brands available in the formulary. Decreasing the generic utilization rates by decreasing the number of brands available without generic substitutions limits patient access to preventive medicines and will likely result in higher long run health care costs.

The Lewin group study finds that 47% of the cost savings associated with switching from a Medicaid FFS system to a Medicaid managed care system results from increased generic drug utilization. They calculate that the generic dispense rate is 68% under the FFS system and would be 80% under a managed care system. Generally, the Lewin Group claims that the FFS generic dispense rate would rise into 70% to 80% range if managed under a managed care system. To get precise results, the Lewin Group uses a sliding scale model, in which they assume that if generic drug utilization is 65% under FFS, it will rise to 70% under a MCO plan. Moreover, they assume that if generic drug utilization is 70% under FFS, then it will rise to 73% under MCO. The higher the existing generic drug utilization rate under an FFS plan, the lower the increase under an MCO plan.

#### **IV. Lewin Group Study Ignores Issues of Medicaid Beneficiary Access—Makes Simplistic Argument to Simply Cut Dispensing Fees and Ingredient Reimbursement Payments to Pharmacies.**

The Lewin Group contends that Medicaid managed care will result in decreased dispensing fees and decreased ingredient reimbursement payments to pharmacies. The Lewin Group falsely assumes that the supply of pharmacies is independent of decreases in dispensing fees and ingredient cost reimbursements. It seems unlikely that one could reduce dispensing fees and ingredient cost reimbursements, while the supply of pharmacies remains unchanged. Reducing dispensing fees and ingredient cost reimbursements through a managed care system imposes downward profit pressures on pharmacies. If pharmacy profits under a managed care system are too low, then pharmacies will be unable remain in business, particularly if they have a large Medicaid patient population. Accordingly, many of these pharmacies will close shop and patients will lose access to pharmacy care providers and necessary drugs in violation of federally mandated Medicaid patient access standards. Under 42 U.S.C. 1396a(30)(A), an agency's payments "must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." If the state does not provide adequate reimbursement, there may be a significant disparity in the access of Medicaid recipients to pharmacy providers and needed medications as opposed to other state residents. In turn, this could lead to an increased need for other health care services at significant additional cost to the state.

**V. Expansion of Medicaid Beneficiary Rolls and Emphasis on Wellness Under Federal Healthcare Reform Will Require Additional Pharmacies to Participate as Medicaid Providers and Serve as Safety Net Healthcare Providers**

The Medicaid patient population poses unique challenges for pharmacists that private insurance patient populations do not present. Many times pharmacists dealing with the Medicaid patient population may not always receive the co-pays for which Medicaid patients are responsible. In addition, many Medicaid patients take multiple medications and frequently require an increased level of oversight and care on the part of the pharmacist to ensure that the patient is utilizing the medications properly and adhering to their treatment regimens. Under the health care reform law, Medicaid will expand with a large influx of new Medicaid patients. This large influx of Medicaid patients places a demand on the health care system that ultimately will require more providers, not less providers. At the same time, if pharmacists refuse to accept Medicaid patients due to decreased reimbursement and payment under Medicaid managed care, then the patient population will be expanding at the same that the provider/supplier side of Medicaid contracts, creating a supply and demand crisis.

**VI. Lewin Group Study Argues that Managed Care/PBMs Will Decrease Drug Utilization of Medicaid Beneficiaries---Fails to Connect PBM Usage to Decrease in “Unnecessary Drug Usage” and Ignores Critical Downside to the Undertreatment of Various Medical Conditions**

The Lewin Group argues that decreasing drug utilization is a positive outcome under Medicaid managed care and cites several causes for “unnecessary and inappropriate prescription drug usage including fraud, prescription drug abuse, inefficient prescribing and other factors.” These stated “causes” seem to be directly attributable to prescriber practices rather than having any direct correlation to pharmacy services. . Physicians, physicians’ assistants and nurse practitioners have more control over the number of medications prescribed to a Medicaid patient than pharmacists do. Accordingly, it is unclear how imposing managed care concepts within the Medicaid pharmacy benefit would alter the level of patient drug utilization. In addition, drug utilization is sometimes tied to the preventive value of drugs. If Medicaid patients decrease their drug utilization by decreasing their utilization of preventive medications, then in the long run Medicaid costs may spike as these patients require future expensive hospital care that could have been avoided. The Lewin Group fails to account for the offset of increased long run hospitalization costs caused by a decrease in preventive drug utilization.

**VII. Study Methodology Flawed –Attempts to Extrapolate Savings Under Managed Care Pharmacy under Medicare Part D**

The Lewin Group assumes that if states change the Medicaid pharmacy benefit from a FFS benefit to a managed care benefit, then the realized cost savings will be the same as those cost savings realized in using managed care for pharmacy benefits under Medicare Part D. The Lewin Group fails to account for differences between the Medicare and Medicaid

program that may impact the cost savings outcome, as well as differences between each state's respective Medicaid program.

The Lewin Group's study model is not the best model for studying differences between a Medicaid FFS pharmacy benefit and a Medicaid managed care pharmacy benefit. A better approach would have been to find a case study under which a Medicaid FFS plan was switched to a managed care system, and to examine the before and after results. Doing so would have allowed the Lewin Group to make a more accurate prediction about what will happen to dispensing fees, generic utilization rates, ingredient cost reimbursements and drug utilization when Medicaid moves from a FFS system to a managed care system.