

OFFICE OF THE CITY CONTROLLER



**HUMAN RESOURCES DEPARTMENT
CIGNA- PHARMACY BENEFIT MANAGEMENT**

**DRUG BENEFIT ANALYSIS OF
CONTRACT #4600010853**

Ronald C. Green, City Controller

David A. Schroeder, City Auditor



OFFICE OF THE CITY CONTROLLER
CITY OF HOUSTON
TEXAS

RONALD C. GREEN

October 16, 2013

The Honorable Annise D. Parker, Mayor

**SUBJECT: REPORT #2014-01
HUMAN RESOURCES DEPARTMENT (HR), DRUG BENEFIT PERFORMANCE REVIEW**

Dear Mayor Parker:

The Office of the City Controller's Audit Division has completed a Performance Audit/Review of the City of Houston's Drug Benefit Program component of the Health Benefits Self-Insurance Program managed by the Human Resources Department (HR). The engagement scope was from the period of May 1, 2011 through April 30, 2012. Our original objective was broadly defined to:

1. Evaluate the drug benefit terms, conditions, pricing, discounts and rebates and compare to industry practice for a similar entity.
2. Identify and estimate the cost-impact, savings opportunities and recommend improvements to the terms and conditions that reflect a highly competitive program rather than the original CIGNA bundled (all one vendor) program.

NOTE: This was not an audit of compliance with contract terms, but where any observations relevant to them came to our attention, we noted them in the report.

As a result of our analysis and assessment, we concluded the following:

- Terms and conditions for drug costs were not competitive in drug ingredient costs and rebates, which resulted in the City and plan participants paying higher costs by not optimizing the City's buying power.
- Terms and conditions for generic medications in the CIGNA contract allowed spread pricing (CIGNA charging the City one price for a medication, remitting less to the pharmacy for the same medication and capturing /retaining the "spread.") Based on the information reviewed, we estimate that the City of Houston and plan participants could have obtained savings of approximately **\$3,717,018** (**\$1,535,197**, from Rebates and **\$1,947,428** from Ingredient Costs (less Dispense Fees) and **\$234,393** from difference in associated administration costs/fees) by using one of several other competitive Pharmacy Benefit Management (PBM) vendors (e.g.: Catamaran, Prime Therapeutics, Kroger, Pharmaceutical Technologies, Inc. or Maxcare)

We appreciate the time and efforts extended to the Audit Division during the course of the project and the expedient turnaround in reviewing the information and offering responses to this report by the HR Director, management and staff.

Respectfully submitted,

Ronald C. Green
City Controller

cc: Omar Reid, Director, Human Resources Department
City Council Members
Chris Brown, Chief Deputy City Controller
Waynette Chan, Chief of Staff, Mayor's Office
Ramiro Cano, Deputy Director, Human Resources Department
David Schroeder, City Auditor

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INTRODUCTION

The Office of the City Controller's Audit Division (AD) has completed an analysis of the drug benefit program as administered by CIGNA per the terms of the original agreement (City of Houston Contract #4600010853). The purpose of this audit is to review and assess the reasonableness of the pricing and terms of the drug benefit component of the CIGNA administrative agreement. This project was a result of a review of primary risk factors as stated in the original contract and was performed as a comparison following performance auditing standards. The underlying risk assessment for this scope of work was performed as a part of performance audit of the CIGNA Benefits and Claims audit (see Report 2014-02)

NOTE: This was not an audit of compliance with contract terms, however where any observations relevant to them came to our attention, we noted them in the report.

AUDIT

METHODOLOGY

The audit was performed in accordance with *Generally Accepted Government Auditing Standards* as promulgated by the Government Accountability Office (GAO) and the engagement was conducted in conformance with *the International Standards for the Professional Practice of Internal Auditing* as issued by the Institute of Internal Auditors (IIA). Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

AUDIT SCOPE AND OBJECTIVES

The engagement scope was from the period of May 1, 2011 through April 30, 2012. Our original objective was broadly defined to:

1. Evaluate the drug benefit terms, conditions, pricing, discounts and rebates and compare to industry practice for a similar entity.
2. Identify and estimate the cost-impact, savings opportunities and recommend improvements to the terms and conditions that reflect a highly competitive program rather than the original CIGNA bundled (all one vendor) program.

The scope of our work did not constitute an evaluation of the overall internal control structure of the HR contract negotiating processes, nor that of the drug claims process of CIGNA. Management is responsible for establishing and maintaining a system of internal controls to ensure that financial activity is accurately reported and reliable. The objective is to provide management with reasonable, but not absolute assurance that the controls are in place and effective.¹

PROCEDURES PERFORMED

In order to obtain sufficient evidence to achieve engagement objectives and support our conclusions, we performed the following:

- Performed detailed analysis of the following:
 - Detail Prescription Drug claim file for May 1, 2011 to April 30, 2012
 - Average Wholesale Pricing (AWP) information as defined by Medi-Span
 - Drug classifications and branding decisions (Preferred vs. Generic, etc.)

¹ This audit was not a financial audit; a financial audit provides reasonable assurance through an opinion (or disclaim an opinion) about whether an entity's financial statements are presented fairly in all material respects in conformity with generally accepted accounting principles (GAAP), or with a comprehensive basis of accounting other than GAAP.

**BACKGROUND AND
HIGHLIGHTS**

On May 1, 2011, the City of Houston (City) changed its healthcare format from fully insured to self-funded. Connecticut General Life Insurance Company (CIGNA) was selected as the Third Party Administrator (TPA). On April 5, 2011, the City and CIGNA entered into an \$84 million 3-year Administrative Services Agreement (ASA) (Contract #4600010853) that processes information and adjudicates health benefit and drug claims that estimated to total approximated \$750 million to \$1 Billion. The ASA's effective dates are May 1, 2011 through April 30, 2014, with two 1-year renewals.

The City effectively became its own insurance company when it chose to become self-funded. This requires the City to be fully responsible for ensuring that only eligible employees, their spouses and dependents are covered under the City's health insurance. The contract packaged all services to be administered by CIGNA, including drug benefits.

Since the time we considered this Rx review project, the city's current vendor (CIGNA) announced that they were moving all their Rx pharmacy benefits management (PBM) business from their own PBM to an independent PBM named Catamaran.

See the following:

[Bloomberg 6-10-2013](#)

This would suggest that CIGNA's recent decision to discontinue their own PBM program in favor of an outsourced vendor is evidence that CIGNA's PBM program is not competitive.

**ANALYSIS AND
ASSUMPTIONS**

The file reviewed contained approximately 517,497 claims ranging in dates of service from approximately May 2011 through April 2012. The generic dispensing rate was approximately 78%. NOTE: 280 claims for compounds, 1 claim for an obsolete product and 3,100 specialty pharmacy claims were not considered for this review.

The file appeared to have claims that bridged a change in pricing methodology from the incumbent PBM. Most notably, it appeared that during the time-period of review, the PBM moved from pre-AWP settlement discounts to post AWP settlement discounts. This change presented some challenges for evaluation so steps were taken to accommodate a comparison to pre settlement pricing in order to make the comparison as accurate as possible with the scope of this project.

Because we did not have the complete membership history data (not completely necessary for our purposes), the following assumptions were made on the initial counts:

Limited network plan:	11,565
Retirees:	382
Open Access:	11,183
Consumer Driven Health Plan (CDHP):	2,571

Claims *are not* reduced for copays or deductibles so what is being evaluated is the "allowed" cost of the medications which reflects the current vendor's negotiated pricing. The copays and deductibles should be the same for both the incumbent and the market pricing model, consequently the savings should be accurately portrayed. The city would reap the majority of the savings benefit. On the smaller population where there are copays and deductibles (CDHP), employee would reap the majority of the savings benefit.

***Ingredient
Cost***

BRAND DRUGS

In evaluating drug pricing, there are many potential variables which need to be understood in order to provide accurate results and thus make sound decisions. When reviewing the city's data it appeared that the incumbent changed pricing methodology for Ave. Wholesale Pricing during the period of the claim's data in order to comply with pricing requirements as stipulated in a legal decision having taken place in 2011. To accurately reflect current prices we adjusted the market discount rates to allow a consistent data set for comparison.

Current Plan	\$20,748,168
Market Comparison	<u>\$20,587,203</u>
Difference	\$ 160,965

The difference in ingredient costs for brand claims were fairly competitive (approximately **\$160,965**, with a net cost savings potential of **\$116,069** when considering the affect of dispensing fees). however, the fact that the city is not receiving market rebates puts the current model at a significant disadvantage when comparing the net cost of other comparable groups (See [REBATES](#) section)

GENERIC DRUGS

Generic effective discount percentage comparison:

Plan	Market
Ave. Wholesale Price – 70.4%	Ave. Wholesale Price – (from 75% - 82%)
<i>For this comparison, we assumed the market was: Average Wholesale Price – 76.1%.</i>	

Current Plan	\$10,411,412
Market Comparison	<u>\$ 8,441,162</u>
Difference	\$ 1,970,250

NOTE: 77.9% of total claims were generic claims.

The incumbent's ingredient cost was **\$1,970,250** higher than the market rate ingredient cost. The repricing analysis indicates an overall net savings of over **\$1,831,359** (*when considering the affect of dispensing fees on this component*). This savings figure assumes that a higher dispensing fee would be paid to participating pharmacies, lowering the net savings slightly.

With the Generic review there were several items of note:

1. In the CIGNA ASO agreement, guaranteed an Average Wholesale Price (AWP-74%) that appears to better than the price actually delivered (AWP-70.4%) If this proves to be a valid number it may result in a refund to the City of over **\$1,081,992**.
2. The difference in price we identified may be allowable under the contract. (CIGNA contract Exhibit S item 2.3). The industry refers to this as "spread," CIGNA refers to it as "positive margin." It is not customary for a PBM to capture this additional income on a group the size of the City of Houston.
3. The PBM is using its own internal rules to determine which drugs qualify as generics and which qualify as a brand. This is not a standard practice. This practice could allow for price manipulation and additional "spread" capture that would be difficult to track.

***Dispensing
Fee***

Brand Drugs

The data indicates that the dispensing fee for retail 30 claims is \$0.90 per claim, which is somewhat low and not supported by market conditions. Average retail 30 dispensing fees range between \$1.25 and \$2.00. For purposes of this study a retail dispensing fee of \$1.34 was assumed.

Generic Drugs

The data indicates that the incumbent’s dispensing fee for retail 30 claims was \$0.84 per claim. This is also suspect, as market conditions support generic dispensing fees of \$1.00 to \$3.00 per claim. For this evaluation we assumed a retail 30 generic dispensing fee of \$1.34.

NOTE: A higher dispensing fee is an incentive for participating pharmacists to acquire and dispense drugs at competitive rates, particularly when there may be a cost differential between available covered and preferred medications. Due to data and scope limitations, we did not calculate an estimated impact of the differing Dispensing Fees.

Rebates

Rebates are almost always paid to larger clients by Pharmacy Benefit Management (PBM) firms. Rebates are a significant part of the business and have become a fact of life for plan sponsors. Rebates are paid mostly on preferred multi-source brand name drugs. The selected preferred drug is placed in the “Tier 2” category which are on the plan’s “formulary” or preferred list. Tier 2 status means more utilization of the tier 2 medication because employees are given a financial incentive to use the preferred drug (see below). There is strong competition for which drug becomes the “preferred drug.” Certain plan designs optimize the availability of manufacturer drug rebates. By definition, “Qualifying rebates” means the Rx plan has a benefit design that optimizes the rebating amounts from the manufacturers, such as; “plans will have at least a \$15 dollar copay differential between tiers 1, 2 and 3.” The City of Houston’s pharmacy component has a benefit design that fits the qualifying criteria, yet the City is not receiving market or expected rebates. There is a unique contract provision, not common to a TPA agreement of this type, that uses the term “consideration sharing”, which has the effect of a rebate by returning some money/consideration to the City based on volume. However, this does not provide a benefit at the level or significance that is proportional to the purchasing activity/volume of the City.

Houston’s copays by Tier - Limited Network Plan

Tier 1 = Generic	100% after \$10 copay
Tier 2 = Preferred Brand	100% after \$45 copay
Tier 3= Single Source / Non Preferred Drug	100% after \$60 copay

Houston’s copays by Tier – Open Access Plan

Tier 1 = Generic	100% after \$10 copay
Tier 2 = Preferred Brand	20% \$45 min \$100 max then 100%
Tier 3= Single Source / Non Pref Drug	40% \$55 min \$150 max

As drug manufacturers become more competitive with one another, there is a focus of resources on whose drugs get on the tier 2 preferred list. For purposed of this study, we assumed the rebates below (taken from similarly situated groups):

Per brand script 2013 Qualifying plan

Mail	\$ 88.38
Retail 30	\$ 29.46
Retail 90	\$ 73.65

Per brand script 2013 Qualifying plan CDHP

Mail	\$ 39.29
Retail 30	\$ 15.71
Retail 90	\$ 41.30

Based on the brand Rx usage, we estimate that rebates of approximately **\$3,767,717** vs. the guaranteed amount of **\$2,232,520** could have been obtained based on the city's utilization for the period reviewed, which results in a potential loss of rebate opportunity of: **\$1,535,197**. The guaranteed rebate or "consideration sharing" as it is referred to in the CIGNA contract is set a \$16.50 per retail brand script, \$50 per brand mail script.

NOTE: We did not attempt to evaluate the formulary used in selecting the tier two category. While this is important, it fell outside the scope of this review. There are several methods PBMs determine which medications are placed on Tier 2 and receive the coveted "preferred status" where members receive a better benefit to use the preferred medication. There may be 2 to 10 or more different manufacturers competing for the preferred status slot. Plan sponsors (CIGNA in the case of the City) use several methods to determine which medications are given preferred status:

1. Efficacy or effectiveness of the medication
2. Cost / benefit ratio of the medication
3. The amount of rebate paid to the PBM or sponsoring entity, without regard to the efficacy or cost of the drug.

It is therefore possible that the selection of a preferred drug is made on the basis of the rebate paid to PBM and not the efficacy of the medication. It is important to note that CIGNA makes the sole determination of the formulary for the City of Houston. On groups of similar size, it is not uncommon for the group (the City) to have significant input on which drugs are given preferred status.

SUMMARY OBSERVATIONS:

The following are areas that represent unmitigated risk and have an economic impact, which provide the opportunity for the City to improve in it's endeavor to change the business model for health benefits program design, implementation, and management of health benefits

- Terms and conditions for drug costs were not competitive in drug ingredient costs and rebates, which resulted in paying higher costs and failing to optimize the City's buying power. (Audit Objective 1)
- Terms and conditions for generic medications in the CIGNA contract allow spread pricing (charging the City one price for a medication, remitting less to the pharmacy for the same medication and capturing the "spread." (Audit Objective 1)Based on the information reviewed, we estimate that the City of Houston and plan participants could have obtained savings of approximately **\$3,717,018** (**\$1,535,197**, from Rebates and **\$1,947,428** from Ingredient Costs (less Dispense Fees) and **\$234,393** from difference in associated administration costs/fees) by using one of several other competitive PBM vendors (e.g.: Catamaran, Prime Therapeutics, Kroger, Pharmaceutical Technologies, Inc. or Maxcare). (Audit Objective 2 See Table 1)

Based on the structure of the agreement, rather than focus on individual component costs being evaluated and scrutinized for the City's highly complicated benefit program, this and other key components were included in an overall "package price" which is not common for groups the size of the City of Houston.

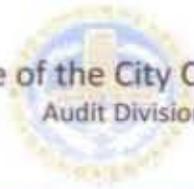
Table 1										
City of Houston Health Plan - Comparison of actual RX claims pricing vs. pricing that could be obtained in the market.										
Claims	Current				Market					
	Files' Ingredient Cost	Files' Disp Fee	Guaranteed Rebates	Files' cost plus fee	Mkt Ing Cost Adjusted	Mkt Disp Fee	Mkt Cost plus fee	Market Rebates	Market Pricing	
Brand	113379	\$ 20,748,169	\$ 92,185	\$ (2,232,520)	\$ 18,607,834	\$ 20,587,203	\$ 137,081	\$ 20,724,284	\$ (3,767,717)	\$ 16,956,567
Generic	400738	\$ 10,411,413	\$ 337,165		\$ 10,748,578	\$ 8,441,163	\$ 476,056	\$ 8,917,219		\$ 8,917,219
Total	514117	\$ 31,159,581	\$ 429,350	\$ (2,232,520)	\$ 29,356,412	\$ 29,028,366	\$ 613,137	\$ 29,641,503	\$ (3,767,717)	\$ 25,873,786
Plus incumbent rx ASO Fees										\$ 234,393
Potential Savings (incumbent less market plus ASO fees of \$234,393)										\$ 3,717,018
CIGNA - consideration sharing (aka: rebates)					Cigna's RX PSPM fee is .76 PSPM * 25,701 * 12 = \$234,393.					
\$16.50/script retail brand										
\$50/script mail order brand										

SUMMARY

RECOMMENDATIONS:

The City should negotiate drug benefit pricing in the same manner as other organizations of similar size and attributes. The City should prepare an RFP using actual data and ask potential PBM vendors to respond in a very specific format so all the important variables can be properly evaluated and compared. The savings generated from this process should yield most of the benefit back to the City and plan participants.

The goal of self-insurance is to incur the risk and reap the rewards of decision-making associated with mitigation and strategic changes in structure. Because the City is ultimately assuming the risk, it should have professionals on staff that are intimately familiar with drug compounds, branding, tier decisions, pricing, economic influences, industry standards, regulatory changes and impacts. Having professionals on staff internally would provide the needed expertise to properly manage the risk the City accepted by being self-insured and would help ensure the best possibility of financial success, while providing for a high quality, stable health benefits package for employees.



***ACKNOWLEDGEMENT
AND SIGNATURES***

The Audit Team would like to thank HR management for their cooperation, time and efforts throughout the course of the engagement. Also, we would like to recognize Mr. Ronald M. Hansen of the professional services firm – Experis for his invaluable contribution of technical knowledge, research, and data analysis that provided the evidence contained in this report.

A handwritten signature in black ink, appearing to read "D. Schroeder", is written over a horizontal line.

David Schroeder, CPA, CISA
City Auditor



CITY OF HOUSTON

Human Resources
Department

Interoffice

Correspondence

To: David Schroeder, City Auditor

From: Omar C. Reid, Director
Human Resources

Date: October 11, 2013

Subject: **City Auditor's Draft Audit
Cigna Prescription Drug Program**

Human Resources has reviewed the draft report that the City Auditor performed on the City's Prescription Drug Program that is integrated with the medical plan and administered by Connecticut General Life Insurance Company (Cigna). Human Resources receives all plan performance evaluations as opportunities to re-assess processes and agreements to improve both the financial viability of the plan and its value to the City and covered members. Steps are also taken to reconsider vendor partnerships. However, given the brevity of time during which to appraise and respond to the draft audit report, Human Resources is silent on many comments, estimates and assumptions that it details, including application of market rebates, ingredient costs, disparity in plan average wholesale price compared to market, etc.

External Auditors

Human Resources engaged The Segal Company, a leading independent benefits, compensation, and human resources consultancy, to audit the prescription drug program. Segal utilized an electronic file detailing prescriptions for City members for the period May 1, 2011 – April 30, 2012. Segal's analysis reviewed data associated with the total plan population. Key data elements and findings were compared both to Segal's benchmarks, where appropriate, and contractual performance guarantees. Segal financial report was designed to:

- Identify areas where Cigna is exceeding or falling short of industry benchmarks and contractual guarantees.
- Validate Cigna's administration of the City's plan design and review overall PBM effectiveness.
- Identify key dispensing performance measures between major retail chains and the mail service pharmacy.

Important Findings

Segal's overall assessment is that Cigna's administration of the program almost always meets or exceeds both contractual guarantees and Segal's benchmarks or industry standards. Segal's summary of finding and recommendation stated:

- Overall, Cigna over-performed the non-specialty contractual discount and dispensing fee guarantees, resulting in a surplus of approximately \$1,005,673.
- Cigna's contractual guarantees for 2011 were within or exceeded Segal's benchmark ranges.
- Cigna over-performed retail discount guarantees and mail generic guarantees, generating a combined surplus of \$1,188,015.

- The achieved mail specialty generic discount fell short of the minimum contractual guarantee, while the achieved mail specialty brand discount exceeded the minimum contractual guarantee, resulting in an overall surplus of \$79,182.
- The achieved non-specialty retail mail brand discount fell short of the minimum contractual guarantee of AWP-24%, resulting in a shortfall of \$181, 244.
- Retail and mail rebate guarantees per prescription are within Segal's benchmark ranges for non-specialty products.
- Retail dispensing fee guarantees per prescription are within Segal's benchmark ranges. Mail dispensing fee guarantees are in line with industry standards for mail pricing for non-specialty products.

The report cited further significant administrative measures and financial outcomes for other components of the program, with some emphasis on utilization within each plan, Limited Network Plan, Open Access Plan, Consumer Driven Health Plan, and the Retirees of Texas Plus Plan (for retirees.) However, as previously noted, there is always room for improvement and Segal did identify potential shortfalls, with minimal impacts, in the performance of the program.

Rebates and Penalties

Cigna had a performance standard that guaranteed a specific percentage off the Average Wholesale Price (AWP) for covered generic drugs. The standard was AWP-74%; Cigna delivered AWP-73.1% and paid a penalty of \$286,333. Yet, the draft audit report uses assumptions that support Cigna's delivery of AWP-70.4% and could owe \$1,081,992 to the City. On the other hand, Segal's use of claims data supports Cigna having over-performed the minimum contractual guarantee of AWP-74%, generating a surplus of \$411,881. These dissimilar conclusions should garner additional investigation.

Cigna delivered prescription drug rebates of \$1.9 million for May 1, 2011 through December 31, 2011 and about \$3,100,600 for January 1, 2012 – December 31, 2012, for slightly more than \$5 million. However, comprehensive evaluation of the relationship among Consideration Sharing or Manufacturers' Formulary Payments, Cigna, and the City's (probable) receipt of the market value of Consideration Sharing requires further analysis and perhaps a different prescription drug vendor relationship.

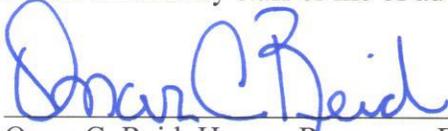
(I pause to note that Cigna reviewed and offered comments on Segal's report in areas in which administrative deficiencies were noted.)

Other Comments

- Human Resources concurs that greater financial efficiencies may be derived from a market review of the prescription drug program. Therefore, a Request for Proposal has been issued so that interested Prescription Benefit Managers may submit proposals, providing leverage for the City to aggressively negotiate drug benefits prices. The outcome could be separation of the medical plan from the prescription drug benefit.
- Human Resources concurs that having direct access to professionals who have knowledge of and can advise on drug compounds, branding, tier decisions, pricing, economic influences, etc. will be beneficial to the program. However, an alternative to staff personnel is having a local contractual as-needed pharmaceutical advisor or consultant.

Human Resources agrees that the prescription drug program requires review and has begun the process through release of the Request for Proposal. Human Resources will present a recommendation presented to the Administration in early 2014.

Please inform my staff or me of additional information that you may require.



Omar C. Reid, Human Resources Director

Audit Division Assessment of Management Responses:

The Audit Division recognizes receipt of the management responses contained within this exhibit and will follow-up on the action items as noted per professional standards. We further acknowledge HR's commitment to utilize information contained within this report as a basis for future Requests for Proposals and executed agreements related to Health and Drug Benefit programs.

EXHIBIT 1
HR - MANAGEMENT RESPONSES AND
AUDIT DIVISION ASSESSMENT OF RESPONSES