STATE HEALTH PLAN – CVS Contract Fact Sheet

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer
Treasurer Dale R. Folwell, CPA

Per the request of the Board of Trustees at the October board meeting, we are supplying the following information.

The State Health Plan (Plan) has proposed six options for reasonable utilization management and five different programs we could add to the utilization management process which would allow us to focus our limited resources on members with the greatest need for GLP-1s. The answer from CVS Caremark, the Plan's pharmacy benefit manager (PBM), remains that none of the options we have proposed would allow us to keep any portion of the rebates. The only option they would entertain is a program they offer that would not limit utilization or cost but would provide additional services at an additional cost.

A summary of the six utilization management options we have discussed is below:

Utilization Management Updates	Rebate Impact
1. Change BMI criteria/addition questions a. BMI of at least 40 kg/m2 or b. BMI of at least 35 kg/m2 and 1+ or 2+ chronic conditions c. Add questions to process to better manage off-label use	- 100% rebate loss - State of California utilizes this with CVS
2. $20,000 lifetime maximum coverage a. Mayo clinic is initiating this 1/1/24	-100% rebate loss -anything that deviates from the FDA labelling and changes utilization pattern
3. Limited provider network: Require ABOM certified providers to prescribe AOM	-100% rebate loss -anything that deviates from the FDA labelling and changes utilization pattern
4. Duration of therapy limit: -Via medical criteria handled by the medical plan (such as reduced A1C, reduced LDL, etc). If member is not meeting clinical endpoints, can determine whether to allow continued coverage.	-100% rebate loss -anything that deviates from the FDA labelling and changes utilization pattern
5. Step therapy (step up) a. Require that patients try and fail a non-GLP-1 medication weight loss drug in the previous 6 months before approval of GLP-1 weight loss medication	-100% rebate loss -anything that deviates from the FDA labelling and changes utilization pattern
6. Step therapy (step down) a. After 52 weeks of GLP-1 weight loss medication use members must step down to lower cost option	-100% rebate loss -anything that deviates from the FDA labelling and changes utilization pattern

The program options we have reviewed are below. Using any of these five programs would also lead to 100% loss of rebates on the GLP-1s for weight loss.

1) Required Nutrition Visits
2) Wellframe App Weight Loss Program
3) Eat Smart, Move More, Weigh Less (ESMMWL)
4) Flyte Program (Connecticut)
5) Medically supervised weight loss / weight management program.

The Plan uses a PBM to manage and administer prescription drug benefits to teachers and state employees. We use a "pass-through" model for our PBM contract.

Pass-through PBMs offer the most transparency among PBM models. They pass 100% of all rebates and discounts back to the plan sponsor. Pass-through PBMs can do this since their only source of revenue is an administration fee. They typically provide full financial and operational disclosure and offer full audit rights down to the claim and invoice level so plan sponsors can verify the transactions.

When it works correctly, this model incentivizes the PBM to focus on lowering overall drug spending with the right drug mix and selective rebates. This also helps Plan sponsors achieve a better prescription drug financial trend and maintain a low Per Member Per Month (PMPM) cost. This design also helps to prevent the practice of spread pricing where we would be charged more by the PBM than the pharmacy that serviced the claim received.

Current Contract Requirements

- The Plan's current contract is with CVS Caremark and was awarded for an initial 3-year term (1/1/2023-12/31/2025) with options to renew for two additional one-year terms (2025 & 2026).
- The Plan has a closed formulary, meaning that not all Food and Drug Administration (FDA) approved drugs are covered. Formulary changes are reviewed by the Pharmacy & Therapeutics (P&T) Committee. However, we have a medical necessity exception process that does include all FDA approved drugs. Thus, for a drug to not be covered in the exception process, the Board of Trustees would have to exclude it as a benefit.
- Pricing is based on a pre-planned percentage discount from Average Wholesale Price (AWP), for each year of the contract.
- Requires CVS Caremark to "aggressively manage" drug inflation and drug mix within the formulary throughout the contract term.
- The annual percentage increase in the "ingredient cost" of the formulary year over year is required to not exceed 2%, with penalties applying if the cost exceeds this guarantee.

- All administrative fees are on a Per Member Per Month (PMPM) basis. For example, our recent administrative invoice from CVS for the month October 2023 was for $891,283. That figure included:
    - $1.46 PMPM administration fee for 570,830 members
    - Processing of 1,274 formulary exception requests at $30.00 each
    - $0.70 Retiree Drug Subsidy (RDS) processing fees for 30,329 members
    - A minor correction of $1,579 in our favor due to an audit finding.
    - These fee amounts are specified in the contract and are paid as line items and not netted off rebates.
- CVS Caremark must report all financial guarantees (e.g., discounts, fees, and rebates) within forty-five (45) calendar days of the end of each quarter. Failing to do so incurs a penalty of $2,500.00 for each day the reporting is late.

Requires transparent pass-through one hundred percent (100%) of negotiated discounts with network pharmacies at the point-of-service.

- The Plan's auditing protocol enables tracking of individual claims back to original pharmacy network contract documents. (However, rebates are not directly tied back to individual claims.)
- CVS Caremark is required to disclose details of all programs and services generating financial remuneration from outside entities.
- Utilizes one consistent pricing source for determining AWP information for use in claims pricing and discloses its source to the Plan. (CVS Caremark uses "Medi-Span" as the consistent pricing source for the Plan.)
- Uses the same Maximum Allowable Cost (MAC) pricing product list for retail, mail order, and specialty pharmacy claims.

- CVS Caremark must provide quarterly rebate payments equal to one hundred percent (100%) of pass-through actual rebates.
    - Requires annual reconciliation of rebates paid to the minimum guarantees within one hundred eighty (180) days of the end of each year. Any shortfalls due shall be paid within two hundred ten (210) days of the contract year end.
    - Must include all brand claims dispensed in the calculation of minimum rebates due with the exceptions of directly submitted member claims, 340B claims, and Coordination of Benefits (COB) claims.
    - CVS Caremark must provide the Plan on an annual basis all paid rebate amounts by drug NOC number, which the Plan shall use for the sole purpose of validating the cost effectiveness of formulary drugs and for formulary decision-making purposes.
    - Must include any price protection amounts received from manufacturers in rebates paid to the Plan.
    - CVS Caremark is required to remit all rebate dollars to the plan within forty-five (45) days of rebates being received. Failing to do so incurs a penalty of $5,000.00 for each day after day sixty (60) that the payment is late.