STATE OF TEXAS
VENDOR DRUG PROGRAM

FORMULARY CONTROL
STATE VS. MCO

Prepared for:
Texas Health and Human Services Commission

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I. Executive Summary

At issue is whether HHSC or the MCOs will be responsible for the development and management of the formulary, preferred drug list (PDL) and prior authorization (PA) requirements under the Texas Medicaid pharmacy carve-in program. This report summarizes our analysis of the overall cost difference between the current mandate scenario (State control) and the no mandate scenario (MCO control).

Our analysis modeled Texas pharmacy utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid drug utilization by therapeutic category to utilization experience from other states that operate pharmacy carve-in programs using a no mandate model. The other states used in our analysis were California, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Jersey, New York, Ohio, Virginia and Washington.

We assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The difference in the utilization will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on the utilization data from the other states.

To each of these two utilization distributions, we then applied the net cost (gross pharmacy cost less federal and supplemental rebates) per script for each of the drugs. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the impact on net pharmacy cost.

Our analysis assumes that under the no mandate scenario, HHSC will require the MCOs to provide open access to the protected drug classes as in the case under the current mandate scenario, i.e., all protected class drugs are available without prior authorization. Based on input from VDP, we believe this is the most likely scenario.

Based on our assumptions, the total net pharmacy cost under the no mandate scenario is 1.8% less costly than that under the current mandate scenario. In addition to the pharmacy claims cost, other expense items such as administrative expense, risk margin, premium tax and ACA Health Insurance Providers Fee were considered in order to estimate the overall financial impact to HHSC. The overall cost to HHSC under the no mandate scenario would be approximately $40 million (General Revenue) less per year than that under the current mandate scenario after considering the impact of all expense items for the FY2019 through FY2021 period. Please note this estimate does not include the cost impact of premium tax revenue to the state.

II. Introduction

Managed Care Organizations (MCOs) in the Texas Medicaid program are financially responsible for the delivery of prescription drug services and appropriate provision for these services is included in the MCO capitation rates. However, the Vendor Drug Program (VDP) of the Health and Human Service Commission (HHSC) retains control over the formulary and responsibility for the management of federal and supplemental rebates.

Critical components of the management of any pharmacy benefit program are the development and administration of the formulary, preferred drug list (PDL) and prior authorization (PA) requirements. S.B. 7 (of the 82nd Legislature, 1st Called Special Session) required HHSC to retain the responsibility for these functions and mandated that the participating MCOs utilize the schedules and protocols developed by the Vendor Drug Program (VDP). This has been a controversial issue since the MCOs believe that they can manage the program more cost-effectively if they are allowed to use their own formulary, PDL and PA requirements rather than those mandated by HHSC.

A key issue in the formulary control debate is the collection of rebates. Under Section 1927 of the Social Security Act, drug manufacturers participating in the Medicaid program must have a federal rebate agreement with the State. In general, federal rebates for brand drugs are much higher than those for generic drugs. The State's focus in managing the PDL is having the lowest net cost (after rebates) drugs on the PDL. On the other hand, the MCOs believe that the savings from shifting utilization to generic drugs will more than offset the reduction in federal rebates. The MCO's focus when it comes to management of the PDL is having the lowest gross cost (prior to rebates) drugs on the PDL.

In response to this controversy, HHSC has requested that Rudd and Wisdom, Inc. review the current situation, evaluate the cost impact and explain the advantages and disadvantages of each option. For purposes of this analysis we will refer to the current arrangement (where HHSC dictates the formulary, PDL and PA requirements) as the "mandate" scenario and the arrangement whereby the MCOs develop and use their own program tools as the "no mandate" scenario.

Please note that this report is intended to present a comparison of the overall cost difference between the mandate and no mandate scenarios and should not be used for any other purpose.

III. Definitions

This section presents a working definition or explanation for several terms used in this report.

Federal Rebates. Federal rebates are based on statutory formula and are only available to state agencies. In general, federal rebates are much higher for brand than generic drugs. Federal rebates account for over 90% of the total rebates collected by HHSC. Federal rebates differ in both concept and magnitude from prescription drug rebates in the commercial sector which are more similar to supplemental rebates. The federal rebate rate per drug will be the same under both the mandate and no mandate scenarios. However, total federal rebates will decrease under the no mandate scenario as a result of increased generic utilization. Federal rebates are not available under the CHIP program.

Formulary. A formulary is a list of drugs. Texas Medicaid/CHIP utilizes a closed formulary where drugs included on the formulary are covered by the program and those drugs not on the formulary are not covered.

Gross Pharmacy Cost. Gross pharmacy cost is equal to the total amount paid to the pharmacy. It includes ingredient cost and dispensing fee. The gross pharmacy cost is also referred to as the "gross cost" throughout this report.

Mandate Scenario. The current scenario where HHSC controls the formulary, preferred drug list (PDL) and prior authorization (PA) requirements.

National Drug Code (NDC). A universal product identifier used to uniquely identify drugs.

Net Pharmacy Cost. Net pharmacy cost is equal to gross pharmacy cost less federal and supplemental rebates. The net pharmacy cost is also referred to as "net cost" throughout this report.

No Mandate Scenario. The scenario where each MCO controls the formulary, preferred drug list (PDL) and prior authorization (PA) requirements for its plan participants.

Preferred Drug List (PDL). The PDL is a list of formulary (covered) drugs separated into preferred and non-preferred categories. Preferred drugs are generally more cost effective than non-preferred drugs. Preferred drugs are available to eligible participants without prior authorization while non-preferred drugs require prior authorization.

Prior Authorization (PA). PA is required for non-preferred drugs and drugs subject to clinical PA edits. The goal of the PA program is to ensure that the client receives treatment that is both appropriate and cost-effective. If a client presents the pharmacy with a prescription for a non-preferred drug, the pharmacy will require additional information in order for the drug to be covered. There are various levels of PA requirements depending on the drug.

Protected Drug Classes. The protected drug classes were identified in a study performed by the University of Texas at Austin and are classes used for chronic or life-threatening diseases. These drug classes include anticonvulsants, blood factors, HIV, multiple sclerosis and cancer.

Rebates. There are two types of rebates in the Medicaid pharmacy program – federal and

supplemental.

Supplemental Rebates. Supplemental rebates are obtained through direct contracts with drug manufacturers and are in addition to federal rebates. HHSC contracts with the drug manufacturer under the current mandate scenario while the MCOs will contract with the drug manufacturer under the no mandate scenario for supplemental rebates.

IV. Advantages of Mandate and No Mandate Scenarios

Advantages of Mandate Scenario – State Control Formulary

- Consistent Protocols – Administering a single formulary will result in a consistent PDL and PA requirements across all Medicaid MCOs.

- Consistent Access – Members will have consistent access to the same drugs regardless of which plan the member is in.

- Minimize Net Cost – Federal rebates are confidential information and only available to the state. As a result, the state can determine the lowest net cost drugs.

- Increased Access to Drugs – State has the flexibility to require MCOs to cover certain drugs by their inclusion on the PDL.

Advantages of No Mandate Scenario – MCO Control Formulary

- Align PDL with Member's Needs – Allow the MCOs to align the PDL to their member's population.

- MCO Flexibility – Allow the MCOs the flexibility to design their own PDL that is similar to their other lines of business.

- Increase Generic Dispensing Rate (GDR) – MCOs would shift utilization to generic drugs resulting in a reduction to gross pharmacy spend. As a result, the capitation payments to the MCOs would also be reduced compared to the current mandate scenario. However, increasing GDR doesn't necessarily result in lower net cost because rebates collected by HHSC would also be reduced.

V. Overview of Methodology and Results

This report details the methodology and assumptions used to compare the gross and net pharmacy cost between the mandate and no mandate scenarios for control over the formulary and PDL used for Medicaid. In addition, other expense items such as administrative expense, risk margin, premium tax and ACA Health Insurance Providers Fee were recognized in estimating the overall financial impact to HHSC. In performing the analysis, Rudd and Wisdom has relied on the following data sources:

- Federal and supplemental rebates by NDC provided by HHSC.
- Summary federal and supplemental rebates by NDC invoiced for the period July 1, 2015 through June 30, 2016, provided by HHSC.
- Drug therapeutic class for each NDC provided by HHSC.
- CMS State Drug Utilization Data for the period July 1, 2015 through June 30, 2016. CMS publishes this data quarterly separately for each state. This data includes utilization and cost data by NDC and by managed care vs. FFS for every Medicaid prescription filled.
- MCO responses to a HHSC request for information regarding i) list of all states where the MCOs do business with majority of claims carved into managed care and the MCOs have flexibility to control the PDL, ii) the MCOs expected amount of supplemental rebates as a percent of total gross pharmacy reimbursement for these states and iii) the anticipated impact on overall pharmacy utilization from the propose change in PDL management.

Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

Our pharmacy claims cost analysis modeled Texas utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid drug utilization by therapeutic category to utilization experience from other states that operate pharmacy carve-in programs using a no mandate model. The MCOs provided a list of states where they do business that operate pharmacy carve-in programs using a no mandate approach. The states used in our analysis were California, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Jersey, New York, Ohio, Virginia and Washington. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2015 through June 30, 2016. Utilization data for these states was collected from the CMS State Drug Utilization Data. The data for both Texas and the other states included managed care claims experience for the period July 1, 2015 through June 30, 2016. This was the most recent utilization data available from CMS at the time of the study.

We have assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The difference in the utilization assumptions will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total

scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on utilization data from the other states.

To each of these two utilization distributions, we then applied the net cost (gross pharmacy cost less federal and supplemental rebates) per script for each of the drugs. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the overall impact on net pharmacy cost.

A critical component of this study is having actual federal and supplemental rebates at the NDC level. Rebates vary significantly by drug. As a result, applying average rebate levels across the board could lead to the wrong conclusion. For example, some brand name drugs can have federal and supplemental rebates as a percentage of gross cost in excess of 95%, resulting in a lower net cost than its generic equivalent. However, if average federal and supplemental rebate levels were assumed, then the generic equivalent may incorrectly appear to have a lower net cost than the brand name drug.

Attachment 1 presents a summary of our pharmacy claims cost analysis. The total pharmacy claims net cost under the no mandate scenario is 1.8% less costly than that under the current mandate scenario.

In addition to the pharmacy claims cost, other expense items such as administrative expense, risk margin, premium tax and ACA Health Insurance Providers Fee were considered in order to estimate the overall financial impact to HHSC. Attachment 7 presents an estimate of the overall Texas Medicaid managed care pharmacy cost for the mandate and no mandate scenarios for the period FY2019 through FY2021. The overall cost to HHSC under the no mandate scenario would be approximately $40 million (General Revenue) less per year than that under the current mandate scenario after considering the impact of all expense items for the FY2019 through FY2021 period. Please note this estimate does not include the cost impact of premium tax revenue to the state.

VI. Pharmacy Claims Cost Impact Analysis - Mandate vs. No Mandate

Assumptions

The following assumptions were made for this analysis:

- The Texas no mandate scenario was estimated based on the average managed care utilization experience from California, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Jersey, New York, Ohio, Virginia and Washington. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2015 through June 30, 2016. In order to reduce the impact of state carve-outs and data anomalies, utilization for states with the two highest and two lowest net cost by therapeutic category were excluded.

- We have assumed that the drug utilization shift would occur immediately. Any transition period may impact the results of this study.

- The utilization for drug classes with fewer than 500 prescriptions in each state were excluded from the study. For example, Michigan doesn't have managed care utilization data for the antipsychotic drug class because it is carved out of managed care. As a result, the no mandate scenario utilization for the antipsychotic drug class was estimated based on the average utilization experience from the other states.

- Protected drug classes were assumed to have no cost impact. These drug class were identified in a study by the University of Texas at Austin and are classes used for chronic or life-threatening diseases. These drug classes include anticonvulsants, blood factors, HIV, multiple sclerosis and cancer. Under the current mandate scenario, protected drug classes are required to have open access, i.e., all protected class drugs are available without prior authorization. We have assumed that under the no mandate scenario, HHSC will require the MCOs to provide open access to the protected drug classes as is the case under the current mandate scenario due to the life-threatening nature of these drugs. The utilization, gross cost and net cost for these drug classes were assumed to be the same for the mandate and no mandate scenarios.

- The aggregate utilization (number of prescriptions) within a therapeutic category is assumed to be the same under the mandate and no mandate scenarios. The difference in the utilization will be in the distribution of drugs within a therapeutic category.

- For each NDC, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.

- This analysis assumes that the state would not impose additional restrictions, other than the Protected Drug Class, that would limit the MCOs ability to control the PDL.

- Utilization of drugs currently carved out of the Texas Medicaid program, such as Hepatitis C drugs and Orkambi, were assumed to be unchanged under the no mandate scenario.

- CHIP and the Medicaid Dual Eligible Demonstration (Dual Demo) programs were excluded from the analysis. The CHIP program was excluded from this analysis because i) federal rebates are not available under CHIP and ii) the MCOs are currently allowed PDL flexibility in the CHIP program. Dual Demo was excluded from this analysis because Medicaid is the secondary payer.

Utilization

Our pharmacy claims cost analysis modeled Texas utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid drug utilization by therapeutic category to utilization experience from other states that operate pharmacy carve-in programs using a no mandate model. The MCOs provided a list of states where they do business that operate pharmacy carve-in programs using a no mandate approached. The states used in our analysis were California, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Jersey, New York, Ohio, Virginia and Washington. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2015 through June 30, 2016. Utilization data for these states was collected from the CMS State Drug Utilization Data. The data for both Texas and the other states included managed care claims experience for the period July 1, 2015 through June 30, 2016. This was the most recent utilization data available from CMS at the time of the study.

At issue is whether HHSC or the MCOs should manage the formulary and the preferred drug list (PDL). Under either scenario, the same physicians will be writing prescriptions for the same patients treating the same conditions. What will potentially change is the drug that the physician prescribes depending on the PDL. As a result, we have assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The difference in the utilization assumption will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on the utilization data from the no mandate states. In order to reduce the impact of state carve-outs and data anomalies, utilization for states with the two highest and two lowest net cost for each therapeutic category were excluded.

Attachment 2 presents how the no mandate utilization was derived for a sample therapeutic category. This analysis was performed for each therapeutic category.

Net Pharmacy Cost Comparison

To each of the mandate and hypothetical no mandate distributions, we applied the net cost (gross cost less federal and supplemental rebates) per script for each drug. For each individual drug, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. The net cost per script for the mandate scenario is determined by dividing the Texas managed care net pharmacy cost by the number of scripts for each drug. The net cost per script for the no mandate scenario assumed the same gross cost per script and federal rebate per script for each NDC as the mandate scenario. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the financial impact.

Attachment 3 presents the calculation of net cost for the mandate and no mandate scenarios for a sample therapeutic category. This analysis was done for every therapeutic category.

Pharmacy Cost Impact Analysis

Attachment 1 presents a summary of our pharmacy cost analysis. The total net pharmacy cost under the no mandate scenario is 1.8% less costly than that under the current mandate scenario.

Attachment 4 presents a summary of the analysis by therapeutic category for the top net cost categories.

VII. Overall Cost Impact Analysis - Mandate vs. No Mandate

In addition to the pharmacy claims cost, other expense items such as administrative expense, risk margin, premium tax and ACA Health Insurance Providers Fee were considered in order to estimate the overall financial impact to HHSC.

Attachment 7 presents an estimate of the overall cost of the Texas Medicaid program for the mandate and no mandate scenarios for the period FY2019 through FY2021. The overall cost to HHSC under the no mandate scenario would be approximately $40 million (General Revenue) less per year than that under the current mandate scenario after considering the impact of all expense items. This estimate does not include the cost impact of premium tax revenue to the state.

Please note that projections in this report are presented to compare the overall cost between the mandate and no mandate scenarios. They should not be used for any other purpose.

VIII. Key Findings

Under the no mandate scenario, the MCOs will develop a PDL that minimizes the MCO's cost. Since federal rebates are collected by the states, the MCO's cost is the gross pharmacy cost less supplemental rebates. This strategy will increase the generic dispensing rate and reduce the gross pharmacy cost. We estimated that, as a result, the capitation rates paid to the MCOs will be reduced by approximately 22.7%. The cost impact to HHSC, on the other hand, must also consider other factors outside of the capitation rates such as rebates. Increasing the GDR will reduce total federal and supplemental rebates because the rebate per unit is higher for brand drugs than generic drugs. The reduction in gross pharmacy cost is slightly more than the reduction in total federal and supplemental rebates which results in a total net pharmacy claims cost under the no mandate scenario that is 1.8% less costly than that under the current mandate scenario.

Attachment 5 presents the top therapeutic classes in which the total net cost is less under the current mandate scenario. The current mandate scenario uses a brand name drug much more than the generic in each of the therapeutic classes listed. The rebates collected for these brand drugs makes it a lower net cost option than the generic drug. This may be a surprise to many. The magnitude of the federal rebate is significantly greater than rebates in the commercial sector. As a result, the current mandate scenario has these brand name drugs on the PDL rather than their generic equivalents.

Attachment 6 presents the top therapeutic classes where the net cost is more under the current mandate scenario. The current mandate scenario's PDL management is sometimes more relaxed than that of the no mandate scenario for the therapeutic classes listed. As a result, the current mandate scenario covers more drugs and/or dispenses higher net cost drugs than that under the no mandate scenario for these therapeutic drug classes.

The current mandate scenario requires each participating MCO to use a single PDL. HHSC could, theoretically, operate exactly the same PDL, the same PA requirements and in the same manner as the MCOs. Even though there are therapeutic classes where the pharmacy net cost is lower under the no mandate scenario, HHSC could achieve the same level of savings by modifying the existing program to produce a utilization pattern more similar to that of the no mandate scenario for these therapeutic classes. The MCOs have argued that while HHSC could implement more aggressive PDL management tools, HHSC has been hesitant to do so in the past.

IX. Summary

At issue is whether HHSC or the MCOs will be responsible for the development and management of the formulary, preferred drug list and prior authorization requirements under the Medicaid pharmacy carve-in program. We prepared an analysis which compared actual Texas pharmacy experience to experience from other states which currently utilize a no mandate approach.

Our analysis compares the overall cost impact between the mandate and no mandate scenarios taking into consideration all expense related items such as pharmacy claims cost, administrative expense, risk margin, premium tax and ACA Health Insurance Providers Fee. Based on our assumptions, the no mandate scenario overall cost to HHSC would be approximately $40 million (General Revenue) less per year than that under the current mandate scenario after considering the impact of all expense items for the FY2019 through FY2021 period. This estimate does not include the cost impact of premium tax revenue to the state. Our analysis also indicates that there are modifications HHSC could make to the existing mandate arrangement which might achieve higher savings by reviewing therapeutic classes where the no mandate scenario has a lower pharmacy net cost.

X. Attachments

Health and Human Services Commission
Medicaid Managed Care Prescription Drug Experience
Mandate vs. No Mandate Study
Summary of Analysis to Pharmacy Cost (1)
CY2015Q3-CY2016Q2 Experience - July 1, 2015 through June 30, 2016

	Mandate Scenario (2)	No Mandate Scenario (3)	Cost Difference (4)	Percentage Difference
Number of Prescriptions (5)				
Brand Drugs	7,299,201	4,704,554		
Generic Drugs	24,825,210	27,419,857		
Total	32,124,411	32,124,411		
Generic Dispensing Rate	77.3%	85.4%		
Gross Pharmacy Cost	2,657,537,401	2,127,496,266	-530,041,135	-19.9 %
Rebates				
Federal (less offsets)	1,453,546,315	1,001,713,554		
% Total	54.7%	47.1%		
Supplemental (6)	143,748,377	85,099,851		
% Total	5.4%	4.0%		
Total Rebates	1,597,294,692	1,086,813,405	-510,481,287	
% Total	60.1%	51.1%		
Net Pharmacy Cost	1,060,242,709	1,040,682,862	-19,559,847	**-1.8 %**

Footnotes:
(1) The analysis is described in the attached report. All Amounts are on an All Funds basis.
(2) The current pharmacy carve-in arrangement whereby HHSC dictates the formulary, PDL and PA requirements.
(3) An alternative arrangement where the MCOs develop and use their own formulary, PDL and PA requirements.
(4) Equals values for the No Mandate Scenario less values for the Mandate Scenario.
(5) Overall utilization by therapeutic class assumed to be the same under both scenarios. The difference is the distribution of drugs within a therapeutic class.
(6) Supplemental rebate assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.

Health and Human Services Commission
Mandate vs. No Mandate Study
Sample Analysis - Utilization by Therapeutic Category

Drug Class	Drug Name	Mandate (TX) Scripts	No Mandate Utilization by Drug Class												
			CA	IL	IN	KY	LA	MD	MI	MN	NJ	NY	OH	VA	WA
A1A	A	-	32.9%	30.5%	29.5%	26.9%	28.9%	25.9%	31.9%	34.9%	27.5%	22.9%	23.9%	29.9%	32.9%
A1A	B	-	34.6%	32.0%	31.0%	26.1%	28.1%	25.1%	31.1%	36.6%	29.0%	22.1%	23.1%	29.1%	34.6%
A1A	C	3,272	7.4%	4.7%	3.7%	18.4%	18.4%	15.4%	13.4%	9.4%	1.7%	14.4%	13.4%	11.4%	7.4%
A1A	D	2,070	5.3%	4.8%	3.8%	11.0%	13.0%	13.0%	6.0%	7.3%	7.8%	7.0%	11.0%	4.0%	5.3%
A1A	E	1,002	5.4%	5.1%	4.1%	5.0%	5.0%	5.0%	5.0%	7.4%	8.1%	7.0%	3.0%	3.0%	5.4%
A1A	F	585	5.0%	5.1%	6.1%	5.0%	3.0%	3.0%	5.0%	1.0%	8.1%	7.0%	5.0%	7.0%	3.0%
A1A	G	3,604	4.1%	15.0%	16.0%	0.7%	0.7%	3.7%	0.7%	0.1%	15.0%	2.7%	5.7%	2.7%	2.1%
A1A	H	2,173	0.0%	0.0%	1.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	2.0%	5.0%	2.0%	2.0%
A1A	I	506	4.9%	2.7%	3.7%	4.3%	0.0%	3.0%	4.3%	2.9%	0.0%	6.3%	5.0%	6.3%	4.9%
A1A	J	-	0.1%	0.0%	1.0%	2.5%	0.0%	0.0%	2.5%	0.1%	0.0%	4.5%	2.0%	4.5%	2.1%
A1A	K	117	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	2.0%	0.0%	0.0%	0.1%
A1A	L	576	0.0%	0.0%	0.0%	0.0%	2.3%	2.3%	0.0%	0.0%	0.0%	2.0%	2.3%	0.0%	0.0%
A1A	M	41	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%
A1A	N	-	0.0%	0.0%	0.0%	0.0%	0.5%	0.5%	0.0%	0.0%	2.7%	0.0%	0.5%	0.0%	0.0%
Total		13,946	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Drug Class	Drug Name	Mandate (TX) Scripts	No Mandate Projected Number of Scripts by Drug Class												
			CA	IL	IN	KY	LA	MD	MI	MN	NJ	NY	OH	VA	WA
A1A	A	-	4,583	4,260	4,120	3,750	4,029	3,611	4,447	4,862	3,841	3,192	3,332	4,169	4,583
A1A	B	-	4,830	4,463	4,323	3,636	3,915	3,496	4,333	5,109	4,044	3,078	3,218	4,054	4,830
A1A	C	3,272	1,037	656	517	2,567	2,567	2,148	1,869	1,316	238	2,009	1,869	1,590	1,037
A1A	D	2,070	738	675	536	1,535	1,814	1,814	838	1,017	1,093	977	1,535	559	738
A1A	E	1,002	753	714	575	697	697	697	697	1,032	1,133	976	418	418	753
A1A	F	585	701	711	851	697	418	418	697	143	1,130	976	697	976	422
A1A	G	3,604	572	2,091	2,230	97	97	515	97	14	2,091	376	794	376	293
A1A	H	2,173	-	-	139	-	-	418	-	-	-	279	697	279	279
A1A	I	506	686	376	515	601	-	418	601	407	-	880	697	880	686
A1A	J	-	8	-	139	352	-	-	352	8	-	630	279	630	287
A1A	K	117	20	-	-	-	-	-	-	20	-	279	-	-	20
A1A	L	576	-	-	-	-	322	322	-	-	-	279	322	-	-
A1A	M	41	12	-	-	15	15	15	15	12	-	15	15	15	12
A1A	N	-	5	-	-	-	73	73	-	5	376	-	73	-	5
Total		13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946
Net Cost		452,676	438,705	433,735	431,696	436,340	453,501	449,147	438,128	441,374	446,265	441,728	445,070	434,051	437,297
Net Cost Rank			7	2	1	4	13	12	6	8	11	9	10	3	5
				Low 2	Low 1		High 1	High 2							

Health and Human Services Commission
Mandate vs. No Mandate Study
Sample Analysis - Utilization by Therapeutic Category

Attachment 2

Drug Class	Drug Name	Mandate (TX) Scripts	No Mandate Utilization by Drug Class												Selected	
			CA	IL	IN	KY	LA	MD	MI	MN	NJ	NY	OH	VA	WA	Distribution	Scripts
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15) = Avg (2) - (14)	(16) = Total (1) * (15)
A1A	A	-	32.9%	Excluded	Excluded	26.9%	Excluded	Excluded	31.9%	34.9%	27.5%	22.9%	23.9%	29.9%	32.9%	29.3%	4,084
A1A	B	-	34.6%	Excluded	Excluded	26.1%	Excluded	Excluded	31.1%	36.6%	29.0%	22.1%	23.1%	29.1%	34.6%	29.6%	4,126
A1A	C	3,272	7.4%	Excluded	Excluded	18.4%	Excluded	Excluded	13.4%	9.4%	1.7%	14.4%	13.4%	11.4%	7.4%	10.8%	1,504
A1A	D	2,070	5.3%	Excluded	Excluded	11.0%	Excluded	Excluded	6.0%	7.3%	7.8%	7.0%	11.0%	4.0%	5.3%	7.2%	1,004
A1A	E	1,002	5.4%	Excluded	Excluded	5.0%	Excluded	Excluded	5.0%	7.4%	8.1%	7.0%	3.0%	3.0%	5.4%	5.5%	764
A1A	F	585	5.0%	Excluded	Excluded	5.0%	Excluded	Excluded	5.0%	1.0%	8.1%	7.0%	5.0%	7.0%	3.0%	5.1%	715
A1A	G	3,604	4.1%	Excluded	Excluded	0.7%	Excluded	Excluded	0.7%	0.1%	15.0%	2.7%	5.7%	2.7%	2.1%	3.8%	523
A1A	H	2,173	0.0%	Excluded	Excluded	0.0%	Excluded	Excluded	0.0%	0.0%	0.0%	2.0%	5.0%	2.0%	2.0%	1.2%	170
A1A	I	506	4.9%	Excluded	Excluded	4.3%	Excluded	Excluded	4.3%	2.9%	0.0%	6.3%	5.0%	6.3%	4.9%	4.3%	604
A1A	J	-	0.1%	Excluded	Excluded	2.5%	Excluded	Excluded	2.5%	0.1%	0.0%	4.5%	2.0%	4.5%	2.1%	2.0%	283
A1A	K	117	0.1%	Excluded	Excluded	0.0%	Excluded	Excluded	0.0%	0.1%	0.0%	2.0%	0.0%	0.0%	0.1%	0.3%	38
A1A	L	576	0.0%	Excluded	Excluded	0.0%	Excluded	Excluded	0.0%	0.0%	0.0%	2.0%	2.3%	0.0%	0.0%	0.5%	67
A1A	M	41	0.1%	Excluded	Excluded	0.1%	Excluded	Excluded	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	12
A1A	N	-	0.0%	Excluded	Excluded	0.0%	Excluded	Excluded	0.0%	0.0%	2.7%	0.0%	0.5%	0.0%	0.0%	0.4%	52
Total		13,946	100.0%	Excluded	Excluded	100.0%	Excluded	Excluded	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	13,946

Health and Human Services Commission
Mandate vs. No Mandate Study
Net Cost by Therapeutic Category
Sample Analysis - Therapeutic Drug Class : A1A

Drug Type	Drug Name	Gross Cost per Script		Federal Rebate per Script		Supplemental Rebate per Script	
		Mandate	No-Mandate	Mandate	No-Mandate	Mandate	No-Mandate
		(1)	(2) = (1)	(3)	(4) = (3)	(5)	(6)
Generic	A	39.06	39.06	7.81	7.81	-	-
Generic	B	41.25	41.25	8.25	8.25	-	-
Brand	C	58.00	58.00	6.09	6.09	17.00	17.76
Brand	D	35.00	35.00	7.00	7.00	-	0.46
Brand	E	98.10	98.10	68.67	68.67	-	1.29
Brand	F	96.09	96.09	67.27	67.27	-	1.26
Brand	G	101.67	101.67	71.17	71.17	-	1.34
Brand	H	96.83	96.83	67.78	67.78	-	1.27
Brand	I	108.25	108.25	75.78	75.78	-	1.42
Brand	J	83.33	83.33	58.33	58.33	-	1.10
Brand	K	140.12	140.12	98.08	98.08	-	1.84
Brand	L	221.03	221.03	154.72	154.72	-	2.91
Brand	M	125.51	125.51	87.85	87.85	-	1.65
Brand	N	283.33	283.33	198.33	198.33	-	3.73
Total		1,197,195	790,636	688,894	319,127	55,624	31,625
					No Mandate Sup Rebate % Gross		4.0%

Drug Name	Drug Name	Net Cost per Script		Number of Scripts		Net Cost	
		Mandate	No-Mandate	Mandate	No-Mandate	Mandate	No-Mandate
		(7) = (1) - (3) - (5)	(8) = (2) - (4) - (6)	(9)	(10)	(11) = (9) * (7)	(12) = (10) * (8)
Generic	A	31.25	31.25	-	4,084	-	127,633
Generic	B	33.00	33.00	-	4,126	-	136,155
Brand	C	34.91	34.15	3,272	1,504	114,226	52,490
Brand	D	28.00	27.54	2,070	1,004	57,960	28,100
Brand	E	29.43	28.14	1,002	764	29,489	22,494
Brand	F	28.83	27.56	585	715	16,865	20,626
Brand	G	30.50	29.16	3,604	523	109,922	15,956
Brand	H	29.05	27.78	2,173	170	63,126	4,952
Brand	I	32.48	31.05	506	604	16,433	19,619
Brand	J	25.00	23.90	-	283	-	7,076
Brand	K	42.04	40.19	117	38	4,918	1,588
Brand	L	66.31	63.40	576	67	38,195	4,425
Brand	M	37.65	36.00	41	12	1,544	455
Brand	N	85.00	81.27	-	52	-	4,379
Total				13,946	13,946	452,676	445,949
						Net Cost Difference	**-1.5%**

Notes:
Cost for the mandate scenario is the average Texas managed care net cost per script.
Gross cost per script and federal rebate per script assumed to be the same for each drug under both scenarios.
Supplemental rebate assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.
Utilization by therapeutic class assumed to be the same under both scenarios.
The utilization difference is the distribution of drugs within a therapeutic class.

Health and Human Services Commission
Medicaid Managed Care Prescription Drug Experience
Mandate vs. No Mandate Study
Summary of Analysis by Therapeutic Drug Class
CY2015Q3-CY2016Q2 Experience - July 1, 2015 through June 30, 2016

		Gross Pharmacy Cost			Net Pharmacy Cost		
Class	Therapeutic Class Name	Mandate	No Mandate	Difference	Mandate	No Mandate	Difference
	Protected Drug Class	392,158,293	392,158,293	0	211,800,914	211,800,914	0
	Carve-out (Hep C Drugs & Orkambi)	79,670,171	79,670,171	0	27,823,047	27,823,047	0
H7X	Antipsychotics, Atyp, D2 Partial Agonist/5Ht Mixed	128,377,028	77,407,548	(50,969,481)	39,657,731	68,378,134	28,720,403
H7T	Antipsychotic,Atypical,Dopamine,Serotonin Antagns	148,780,566	94,861,030	(53,919,536)	58,748,987	37,475,604	(21,273,382)
Z2P	Antihistamines - 1St Generation	20,973,939	5,946,147	(15,027,792)	19,011,438	5,694,757	(13,316,681)
L5H	Acne Agents,Topical	29,763,183	18,432,331	(11,330,853)	1,112,407	12,438,740	11,326,334
W5A	Antivirals, General	35,381,504	13,120,119	(22,261,385)	17,254,027	8,529,332	(8,724,695)
W1Y	Cephalosporins - 3Rd Generation	40,237,439	15,280,561	(24,956,878)	22,873,088	14,695,524	(8,177,564)
Q5P	Topical Anti-Inflammatory Steroidal	15,182,774	23,163,064	7,980,290	13,793,430	21,518,011	7,724,581
Q5W	Topical Antibiotics	5,853,714	14,069,911	8,216,197	5,145,894	12,730,182	7,584,288
Q7P	Nasal Anti-Inflammatory Steroids	56,975,362	9,091,277	(47,884,085)	14,168,171	7,114,479	(7,053,693)
J5B	Adrenergics, Aromatic, Non-Catecholamine	72,754,621	45,166,330	(27,588,292)	19,236,391	25,648,388	6,411,998
B3R	Non-Narc Antituss-1St Gen. Antihistamine-Deconge:	19,409,551	16,341,616	(3,067,936)	8,045,170	14,343,728	6,298,558
C4G	Insulins	155,315,091	149,598,553	(5,716,538)	7,667,165	1,425,902	(6,241,263)
C6H	Pediatric Vitamin Preparations	7,428,163	1,050,262	(6,377,901)	6,665,184	1,000,753	(5,664,431)
Q5R	Topical Antiparasitics	44,243,191	20,632,304	(23,610,887)	12,536,877	17,752,535	5,215,658
Q5N	Topical Antineoplastic Premalignant Lesion Agents	10,555,338	5,821,638	(4,733,700)	9,439,505	4,781,965	(4,657,539)
B6M	Glucocorticoids, Orally Inhaled	59,286,002	59,688,598	402,596	10,438,577	14,964,172	4,525,595
H3A	Analgesics, Narcotics	19,386,044	19,499,100	113,056	10,045,933	14,272,954	4,227,021
D6S	Laxatives And Cathartics	10,129,685	5,320,780	(4,808,905)	7,824,648	3,602,860	(4,221,789)
H3U	Narcotic Analgesic And Non-Salicylate Analgesic	14,088,406	18,410,520	4,322,114	13,429,259	17,586,550	4,157,291
H2V	Tx For Attention Deficit-Hyperact(Adhd)/Narcolepsy	80,784,090	61,645,602	(19,138,488)	29,863,222	33,888,422	4,025,200
Q5F	Topical Antifungals	8,056,145	11,620,384	3,564,239	7,006,209	10,752,703	3,746,495
C3B	Iron Replacement	5,049,523	5,306,834	257,312	955,932	4,067,545	3,111,613
B63	Beta-Adrenergic And Glucocorticoid Combo, Inhalec	75,100,539	74,637,025	(463,515)	8,645,003	6,026,584	(2,618,419)
D4J	Proton-Pump Inhibitors	91,583,701	9,983,695	(81,600,006)	4,790,425	7,278,673	2,488,249
	All Others	1,031,013,337	879,572,574	(151,440,762)	472,264,077	435,090,403	(37,173,674)
	Total	2,657,537,401	2,127,496,266	(530,041,135)	1,060,242,709	1,040,682,862	(19,559,847)
						Net Cost Difference	**-1.8%**

Health and Human Services Commission
Mandate vs. No Mandate Study
Summary of Results - Top Drug Class Where Mandate Scenario More Cost Efficient

Top Drug Classes Where Mandate Scenario is More Cost Efficient

HIC3	Therapeutic Class	Higher Net Cost Drugs Utilized More Under No Mandate	Lower Net Cost Drugs Utilized More Under Mandate
H7X	Antipsychotics, Atyp, D2 Partial Agonist/5Ht Mixed	Aripiprazole	Abilify
L5H	Acne Agents,Topical	Clindamycin-Benzoyl	Benzaclin
J5B	Adrenergics, Aromatic, Non-Catecholamine	Dextroamp-Amphetamine	Vyvanse, Adderall
Q5P	Topical Anti-Inflammatory Steroidal	Clobetasol	Triamcinolone, Hydrocortisone
B3R	Non-Narc Antituss-1St Gen. Antihistamine-Decongest	Bromphenir-Pseudoephed-Dm	Bromfed, Vanacof
D4J	Proton-Pump Inhibitors	Omeprazole	Nexium
Q5W	Topical Antibiotics	Clindamycin	Mupirocin

Health and Human Services Commission
Mandate vs. No Mandate Study
Summary of Results - Top Drug Class Where No Mandate Scenario More Cost Efficient

Top Drug Classes Where No Mandate Scenario is More Cost Efficient

HIC3	Therapeutic Class	Lower Net Cost Drugs Utilized More Under No Mandate	Higher Net Cost Drugs Utilized More Under Mandate
H7T	Antipsychotics,Atypical,Dopamine,& Serotonin Antag	Risperidone, Quetiapine	Invega, Seroquel, Risperdal, Zyprexa
W5A	Antivirals, General	Acyclovir, Valacyclovir	Tamiflu
Z2P	Antihistamines - 1St Generation	Hydroxyzine, Promethazine	Vanahist
W1Y	Cephalosporins - 3Rd Generation	Ceftriaxone	Suprax
Q7P	Nasal Anti-Inflammatory Steroids	Fluticasone	Nasonex

Health and Human Services Commission
Mandate vs. No Mandate Study
Summary of Analysis to Overall Cost
Medicaid Program - STAR, STAR Plus, STAR Health and STAR Kids [1]

	All Funds			General Revenue		
	FY2019 [2] [3]	FY2020 [2] [3]	FY2021 [2] [3]	FY2019 [2] [3]	FY2020 [2] [3]	FY2021 [2] [3]
Member Months	43,468,158	44,410,179	45,374,655			
Current Model - Mandate (in $1,000,000s)						
Pharmacy Gross Cost	3,876.79	4,155.11	4,453.39	1,615.59	1,763.73	1,893.36
Rebates - Federal [4]	2,120.42	2,272.65	2,435.79	883.65	964.68	1,035.58
Rebates - Supplemental [4]	209.70	224.75	240.89	87.39	95.40	102.41
Pharmacy Net Cost	1,546.67	1,657.71	1,776.71	644.55	703.65	755.37
Administrative Expense	78.24	79.94	81.67	31.34	33.33	34.18
Risk Margin	82.18	88.00	94.24	34.22	37.34	40.05
Premium Tax	71.91	77.00	82.46	29.94	32.67	35.05
ACA Health Insurance Providers Fee [6]	96.15	102.96	110.26	40.04	43.69	46.86
MCO Capitation Premiums [7]	4,109.13	4,400.05	4,711.76	1,711.09	1,867.08	2,002.64
Total Overall Cost [9]	1,875.16	2,005.61	2,145.33	780.09	850.69	911.51
Proposed Model - No Mandate (in $1,000,000s)						
Pharmacy Gross Cost [5]	3,103.57	3,326.38	3,565.17	1,293.36	1,411.96	1,515.73
Rebates - Federal [4]	1,461.29	1,566.20	1,678.63	608.97	664.81	713.67
Rebates - Supplemental [4]	124.14	133.06	142.61	51.73	56.48	60.63
Pharmacy Net Cost [5]	1,518.14	1,627.13	1,743.93	632.66	690.67	741.43
Administrative Expense	78.24	79.94	81.67	31.34	33.33	34.18
Risk Margin	63.54	68.02	72.82	26.45	28.86	30.95
Premium Tax	55.59	59.51	63.71	23.14	25.25	27.08
ACA Health Insurance Providers Fee [6]	74.34	79.58	85.19	30.95	33.76	36.21
MCO Capitation Premiums [8]	3,176.80	3,400.79	3,640.77	1,322.56	1,442.92	1,547.31
Total Overall Cost [9]	1,789.85	1,914.17	2,047.33	744.54	811.88	869.85
Comparison - Proposed No Mandate vs. Current Mandate Model (in $1,000,000s)						
Total Overall Cost Impact to HHSC [10]				**(35.55)**	**(38.81)**	**(41.67)**
Total Overall Cost Impact to State [11]				(19.24)	(21.33)	(22.92)
Impact to MCO Capitation Premiums				-22.7%	-22.7%	-22.7%

Notes:
(1) Includes experience for the following programs: STAR, STAR Plus, STAR Health and STAR Kids.
(2) Projections provided by HHSC System Forecasting.
(3) Projections are presented to display overall impact of mandate vs. no mandate scenarios.
They should not be used for any other purpose.
(4) Federal rebates were determined to be 54.7% of gross cost for mandate scenario and 47.1% of gross for no mandate scenario.
Supplemental rebates were determined to be 5.4% of gross cost for mandate scenario and 4.0% of gross for no mandate scenario.
See Attachment 1.
(5) No mandate gross pharmacy cost was determined to be 19.9% less than the current mandate scenario.
No mandate net pharmacy cost was determined to be 1.8% less than the current mandate scenario.
See Attachment 1.
(6) ACA HIP Fee assumed to be 2.34% of capitation for all years.
(7) MCO Capitation Premiums for the mandate scenario includes Pharmacy Gross Cost, Administrative Expense, Risk Margin and Premium Tax.
(8) MCO Capitation Premiums for the no mandate scenario includes Pharmacy Gross Cost less Sup. Rebate, Administrative Expense, Risk Margin and Premium Tax.
(9) Total Overall Cost includes Net Pharmacy Cost, Administrative Expense, Risk Margin, Premium Tax and ACA HIPF Fee.
The no mandate scenario assumes protected drug classes will continue to have open access.
(10) Does not include the cost impact of premium tax revenue to state.
(11) Includes the cost impact of premium tax revenue to state.