DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION

AUDIT AND MONITORING REPORT

CONTRACT COMPLIANCE FOR CVS CAREMARK PURSUANT TO PUBLIC ACT 408 OF THE 108TH GENERAL ASSEMBLY

AUDIT AND MONITORING REPORT

TCA §4-3-1021(a) STATUTORY REQUIREMENT

The Department of Finance and Administration, Division of Benefits Administration, has generated this report pursuant to Public Act 408 of the 108th General Assembly. Public Act 408 of the 108th General Assembly requires the Department of Finance and Administration to monitor, and cause to be audited, the state-sponsored public sector health plans' Pharmacy Benefit Manager's compliance with the Pharmacy Benefits Manager contract. This report represents the results of the state's audit and monitoring plan. For this reporting period, the state's qualified independent auditor is Aon and the state's contracted Pharmacy Benefits Manager is CVS Caremark. Public Act 408 of the 108th General Assembly requires this report be delivered annually on or before July 1st to the Lieutenant Governor, the Speaker of the House of Representatives, and the Fiscal Review Committee.

TCA §4-3-1021(b) FIRST YEAR RISK ASSESSMENT

Public Act 408 of the 108th General Assembly subsection 1(b) requires the Department of Finance and Administration to conduct a risk assessment within one year of entering into a Pharmacy Benefits Management contract. The current Pharmacy Benefits Management contract was entered into on January 1, 2021 (benefits go-live date). The Division of Benefits Administration, part of the Department of Finance & Administration, however, completes a PBM risk assessment each calendar year and the 2022 risk assessment was completed in March 2023. The assessment found that material areas of risk were already mitigated or monitored in the current monitoring plan. A copy of the pharmacy risk assessment was provided to the Comptroller's Office.

TCA §4-3-1021(c)(1) REPRICING OF PHARMACY CLAIMS AT THE DRUG LEVEL

Aon audited CVS Caremark's compliance with this requirement and presented their findings in a report entitled *2021 Prescription Drug (Rx) Audit Findings-2021 Financial Guarantees* dated May 2023. Aon presented this audit's results to the state in May 2023. The purpose of this audit was to evaluate CVS Caremark's accuracy of adjudication processes for the State's financial guarantees and to validate CVS Caremark's performance of financial guarantees for the period of January 1, 2021 - December 31, 2021.

Auditors used the following technique to test CVS Caremark's performance:

- **Financial Review** - 100% of paid claims were re-adjudicated (by complete file load and re-priced against independent data source) electronically to determine aggregate ingredient cost discounts and average dispensing fees. Specialty drug products were re-priced using drug specific discount guarantees. This process included validation of CVS Caremark's average wholesale prices (AWP) used in financial reconciliation.

- **Invoice Reconciliation Review—**100% of paid claim costs less member out-of-pocket costs were aggregated by auditors and compared to amounts invoiced to the State.

For the period of January 1, 2021-December 31, 2021, CVS Caremark reported to the state that they had missed their 30 day brand and generic drug dispensing fee guarantees, retail 90 day brand drug discount guarantee, retail 30 day generic drugs discount guarantee, and their specialty drug discount guarantees contracted with the State of Tennessee. CVS Caremark reimbursed the State $7,909,147.15 via check on August 9, 2022 as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees. Auditors found two pricing errors:

- Auditors observed that CVS Caremark applied the incorrect Mail Brand Discount Rate. Per the Fees & Guarantees 2010-2024 Document , the 1/1/2021-12/31/2021 Mail Brand Guarantee is quoted as AWP minus 26.50%. CVS Caremark used a prior discount rate of 26.37%. CVS Caremark agrees that the correct Mail Brand rate is 26.50%. A revised Performance Guarantee was sent reflecting a shortfall of $21,810.03 that is due to the State of Tennessee. Auditors confirmed the revised PBM's self-reported results. Per CVS Caremark, the additional amount due to the State of Tennessee will be paid to the State of Tennessee at the close of the audit.
- Auditors observed that CVS Caremark excluded Generic Specialty Pharmacy claims from all guarantees. Per the 2021-2024 contract, page 61, "Brand drugs not on the PBM's Specialty Drug List will be included in non-specialty guarantees, and the channel of distribution dictates the pricing guarantees for any drug moving off the specialty drug list. Any Generic Specialty Pharmacy claims will fall into the retail generic category." Auditors included the Generic Specialty Pharmacy claims in the Retail Generic guarantee. Not including the 5,788 Generic Specialty Pharmacy Multisource Drugs in their Retail Generic Guarantee reduced the PBM reported shortfall by $6,109,869.30. CVS Caremark agreed that the Generic Specialty Pharmacy claims should be included in the Retail Generic Guarantee. A revised performance guarantee report will be run at the conclusion of the audit to determine the final impact to performance and any additional payment will be owed to the State of Tennessee.

TCA §4-3-1021(c)(2) VALIDATION OF THE NATIONAL DRUG CODE (NDC) USAGE

Aon monitored CVS Caremark's compliance with this requirement in an audit entitled *2021 Prescription Drug (Rx) Audit Findings-2021 Financial Guarantees* dated May 2023. Aon presented this audit's results to the state in May 2023. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2021 through December 31, 2021.

Auditors reviewed the National Drug Codes (NDC) received and matched them with their internal data (purchased from MediSpan) to ensure that CVS Caremark used valid NDCs for claims adjudication. Auditors then used the NDCs to verify that the Average Wholesale Prices (AWP) that CVS Caremark used were correct as a basis of the pricing for each claim (based on the date the claim was processed). According to the analysis performed "*…auditors did not find any issues related to the usage of the NDCs*, *and no material issues were noted in the auditors' review of AWP*." No duplicate payments were noted, no issues were noted with compounds or

paper claims, and no issues were noted with the retail pricing algorithm, where auditors confirmed that lower of Usual and Customary (U&C) applied as expected.

TCA §4-3-1021(c)(3) APPROPRIATENESS OF THE NATIONALLY RECOGNIZED REFERENCE PRICES, OR AVERAGE WHOLESALE PRICE (AWP) IN ACCORDANCE WITH TCA §56-7-3104

TCA §56-7-3104 reads as follows:

> ***56-7-3104. Calculation of reimbursement of pharmacy benefits manager.***
>
> ***(a)*** *Reimbursement by a pharmacy benefits manager under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefits manager or its agent.*
>
> ***(b)*** *For purposes of compliance with this section, pharmacy benefits managers shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.*

Aon audited CVS Caremark's compliance with this requirement in an audit entitled *2021 Prescription Drug (Rx) Audit Findings- 2021 Financial Guarantees* and presented this audit's results to the state in May 2023.

CVS Caremark has contractual guarantees with the state to achieve prescription discounts (compounds excluded) from the AWP. The amount of the discount is dependent upon whether the prescription is brand or generic and the distribution type (retail, retail 90, mail order or specialty). The discounts are also dependent upon the calendar year, per the contract between CVS Caremark and the Insurance Committees (State, Local Education and Local Government).

Auditors compared the AWP used by CVS Caremark to process and reprice the State claims to an industry standard benchmark housed in a database maintained independently by auditors for this price, specifically MediSpan. Claims were parsed out into over 100 sub-categories based on attributes including claim channel (mail versus retail), drug type (brand versus generic), basis of cost (AWP, MAC, ZBL, etc.) and other claim indicators (compounds, specialty claims, etc.). According to auditors' analysis, the AWP used by CVS Caremark in re-pricing the State claims accurately reflects industry AWP data sources.

The Department of Finance and Administration, Division of Benefits Administration agrees that the AWP is appropriate in accordance with TCA §56-7-3104.

TCA §4-3-1021(c)(4) ELIGIBILITY OF BENEFICIARIES FOR PHARMACY CLAIMS PAID

The state monitored CVS Caremark's compliance with this requirement in-house in May 2022-April 2023.

The Department of Finance and Administration, Division of Benefits Administration's Program Integrity Group performed a review to determine whether the members for whom claims were paid each month from May 2022-April 2023 were in fact eligible for the benefit. The Program Integrity Group obtained an extract from CVS Caremark's data warehouse of all pharmacy claims paid during this time period. There were 4,605,923 pharmacy claims paid during May 2022-April 2023. The Program Integrity Group obtained an eligibility extract from Edison for the beginning of each month reviewed. The Program Integrity Group performed a data match against the pharmacy claims file and the state's own eligibility file. From the data match and subsequent research, the Program Integrity Group did not note any material, consistent findings. The Program Integrity Group continues to monitor pharmacy claims monthly for member eligibility.

TCA §4-3-1021(c)(5) FOR PHARMACY BENEFITS CONTRACTS ENTERED INTO OR RENEWED ON OR AFTER JULY 1, 2013, RECONCILIATION OF THE PHARMACY BENEFITS MANAGER'S PAYMENTS TO PHARMACIES WITH THE STATE'S REIMBURSEMENT TO THE PHARMACY BENEFIT MANAGER

The state's current PBM contract with CVS Caremark runs from January 1, 2021 through December 31, 2024 (with a six month runout for claims runout). Aon audited CVS Caremark's compliance with this requirement and presented their findings in a report entitled *2022 Prescription Drug (Rx) Audit Findings Retail Transparency Review*. Aon presented this audit's results to the state on May 12, 2023. The audit time period included 100% of claims paid from January 1, 2022 through December 31, 2022 for the retail transparency review. The audit evaluated CVS Caremark's accuracy of adjudication processes for the State's financial guarantees related to retail transparency and the invoiced amounts billed to the State.

The Retail Transparency review was conducted using 100% of all claims. From 100% of claims, there were 4,486,541 claims eligible for testing (non-adjusted retail claims). These eligible claims were further split between generic and brands to compare the costs invoiced to the State versus the amounts paid by the PBM to the pharmacies. According to Aon's analysis, CVS has met their obligation to bill the State for brand and generic drug products under the State's Pass-Through Transparent Pricing terms. Based on an extensive review of all non-adjusted claims, no discrepancies were noted between claim costs charged to the State and retail pharmacy reimbursement documentation.

TCA §4-3-1021(c)(6) CONFIRMATION THAT THE PHARMACY BENEFITS MANAGER'S PAYMENTS TO PHARMACIES DO NOT REFLECT DISPARITY AMONG NETWORK PHARMACIES ATTRIBUTABLE TO PREFERENTIAL TREATMENT OF ONE (1) OR MORE PHARMACIES

Aon audited CVS Caremark's compliance with this requirement for calendar year 2021 and presented findings in a report entitled *2021 Prescription Drug (Rx) Audit Findings - Retail Pharmacy Pricing Comparison*. Aon presented this audit's results to the state in May 2023.

Using 100% of claims data from calendar year 2021 broken up into 6-month periods, Aon calculated the price (discounted ingredient cost) per unit for all eligible retail claims. In this audit, Aon validated 100% of claims. Aon first notes that the negotiated pricing for retail 90 claims (greater than 83 days' supply) is discounted more in the State's advantage than for retail claims (less than or equal to 83 days) due to improved rates (i.e., better pricing, or lower cost) for retail 90 claims. Pricing for brands has been negotiated as a fixed discount from a pricing benchmark, AWP (Average Wholesale Price), while pricing for most generics is based on the PBM's proprietary pricing algorithm, called MAC (maximum acquisition cost). Aon notes that pricing based on these algorithms and benchmarks is in line with what Aon observes generally in the industry.

For purposes of the pricing comparison to validate relative economic equivalency, Aon assessed the pricing of claims segmented into the following four different subgroups:

1. Retail Brand claims (claims for brand drugs with less than or equal to 83 days' supply)
2. Retail Generic claims (claims for generic drugs with less than or equal to 83 days' supply)
3. Retail 90 Brand claims (claims for brand drugs with greater than 83 days' supply)
4. Retail 90 Generic claims (claims for generic drugs with greater than 83 days' supply)

Aon compared the ingredient cost per unit (e.g., cost per unit dose) for all eligible drugs for each of the above four drug types. These above four drug types were separated by year, and further separated into six-month reconciliation periods for a more granular view of the data. The data evaluated were claims incurred and paid during calendar year 2021. Brand claims without brand pricing based on an AWP discount (e.g., Usual and Customary (U&C) claims) were excluded from the analysis. Similarly, generic claims without MAC pricing were excluded. Comparison for all generic claims was reported by month to more accurately portray pricing but aggregated on a 6-month basis. Each drug has a unique identifier called NDC that is provided by the manufacturer. The 11-digit NDC is specific for that drug, strength, dosage form, package size and manufacturer. Brands were compared at the 9-digit NDC level, which is unique for drug, strength, dosage form and manufacturer, but not package size. This was performed at this level to eliminate the effects of package size in the comparison.

Aon stated that with the knowledge obtained during this pricing review, limited to the parameters of the audit, they (Aon) did not observe broad instances where Caremark, the PBM for the State, paid retail network pharmacies at a rate less than the rate CVS reimbursed its own pharmacies. Based on the claims review, Aon determined that "*Caremark paid CVS stores, other chains, and independent pharmacies equally at retail. In aggregate, it does not appear that Caremark is paying CVS stores a higher amount*."

TCA §4-3-1021(c)(7) RECALCULATION OF DISCOUNT AND DISPENSING FEE GUARANTEES

Aon audited CVS Caremark's compliance with this requirement and presented their findings in a report entitled *2021 Prescription Drug (Rx) Audit Findings- 2021Financial Guarantees* dated May 2023. Aon presented this audit's results to the state in May 2023. The purpose of this audit was to perform a review of CVS Caremark's administration of the state's Pharmacy Benefits Management program and to validate CVS Caremark's performance of financial guarantees for the period of January 1, 2021 - December 31, 2021.

Auditors used the following technique to test CVS Caremark's performance:

- **Financial Review** - 100% of paid claims were re-adjudicated (by complete file load and re-priced against independent data source) electronically to determine aggregate ingredient cost discounts and average dispensing fees. Specialty drug products were re-priced using drug specific discount guarantees. This process included validation of CVS Caremark's average wholesale prices (AWP) used in the financial reconciliation.
- **Invoice Reconciliation Review—**100% of paid claim costs less member out-of-pocket costs were aggregated by auditors and compared to amounts invoiced to the State.

For the period of January 1, 2021-December 31, 2021, CVS Caremark reported to the state that they had missed their 30 day brand and generic drug dispensing fee guarantees, retail 90 day brand drug discount guarantee, retail 30 day generic drugs discount guarantees, and their specialty drug discount guarantees contracted with the State of Tennessee. CVS Caremark reimbursed the State $7,909,147.15 via check on August 9, 2022 as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees. As mentioned in section one on page three of this report, Aon auditors calculated approximately $6,131,679.33 due to the State of Tennessee as a result of an incorrect Mail Brand Discount Rate being used (totaling $21,810.03) as well as an incorrect exclusion of Generic Specialty Pharmacy claims (totaling $6,109,869.30). A revised performance guarantee report will be run at the conclusion of the audit to determine the final impact to performance and any additional payment will be owed to the State of Tennessee. Where there were differences in the dispensing fee calculations by CVS Caremark and the Aon auditors, all differences noted were within auditors' tolerance (0.15%).

TCA §4-3-1021(c)(8) REVIEW OF THE STATE'S CLAIM UTILIZATION TO ENSURE THAT PER CLAIM REBATE GUARANTEES WERE ACCURATELY CALCULATED BY THE PHARMACY BENEFIT MANAGER

Aon audited CVS Caremark's compliance with this requirement in an audit entitled *2021 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 2023.

Auditors reviewed 4,406,027 pharmacy claims processed for the State of Tennessee from January 1, 2021 through December 31, 2021 to validate Per Rx Minimum Rebate Amounts. Auditors' aggregate calculated minimum rebate was 3.63% higher than the minimum rebate amount determined by CVS Caremark for claims paid during the audit scope period of January 1, 2021 through December 31, 2021. In other words, Aon calculated $6,234,069.61 more in minimum

rebates than CVS Caremark**.** This variance is outside auditor's tolerance of 2%. However, this is considered by auditors as financially immaterial for the time period under scope because the actual pass-through rebates paid to the State significantly exceeded the minimum guarantees. CVS Caremark complies with this requirement.

TCA §4-3-1021(c)(9) REVIEW OF REBATE CONTRACTS BETWEEN THE PHARMACY BENEFIT MANAGER AND FIVE (5) DRUG MANUFACTURERS, TO BE SELECTED BY THE BENEFTS ADMINISTRATION DIVISION OF THE DEPARTMENT, AND THE CONTRACTED AUDITOR TO ENSURE THAT ELIGIBLE REBATE UTILIZATION WAS ACCURATELY INVOICED ON BEHALF OF THE STATE

Aon audited CVS Caremark's compliance with this requirement in an audit entitled *2021 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 2023.

The ten manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were AbbVie Inc., Allergan, Amgen, AstraZeneca, Boehringer Ingelheim, Eli Lilly & Co., Johnson & Johnson, Merck & Co., Inc., Novo Nordisk, and Takeda. Aon auditors reviewed 294,888 claims associated with these ten manufacturers. Those claims are included in the over four million total claims processed in 2021 to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

Auditors' aggregate base rebates were within 0.24% of CVS Caremark's calculations for the in-scope manufacturers and quarters.

- Auditors identified two (2) findings with the estimated total impact of $27,361.28 as follows:
  - The estimated impact for claims invoiced at an incorrect rate for one drug for one drug manufacturer is $7,982.97.
  - The estimated impact for claims that were originally omitted during rebate invoicing for two drugs for two manufacturers is $19,378.31.
  - CVS Caremark has agreed to submit a service warranty in the total amount of $27,361.28 at the close of this audit to cover these two findings.

- Auditors found 17 scenarios where rebates were reinvoiced:
  - The estimated amount for claims that were originally invoiced at an incorrect rate for seven drugs for four manufacturers is $32,176.06. According to CVS Caremark, these claims were subsequently billed for the correct amount; therefore, there is no need for Service Warranties as the payments (when collected) will flow-through to the State of Tennessee as 2021 rebates on future invoices.
  - The estimated amount for claims that were originally omitted during rebate invoicing for 10 drugs for six manufacturers is $362,957.77. According to CVS Carmark, these claims were subsequently billed for the correct amount; therefore, there is no need for Service Warranties as the payments (when collected) will flow-through to the State of Tennessee as 2021 rebates on future invoices.

- Auditors identified one finding with an estimated impact of (-9,734.49) for claims invoiced with an incorrect price protection rate. Although CVS Caremark invoiced these claims incorrectly, the manufacturer adjusted their payment to the correct rebate.
- Value Based Arrangement (VBA) rebate eligibility and payments are determined by the drug manufacturer. Auditors note that the State of Tennessee is eligible for VBA rebates for the in-scope period for one drug for one manufacturer. According to CVS Caremark, the State of Tennessee is eligible for the estimated amount of $288,220.17. Once finalized, CVS Caremark will invoice and distribute to the State through the usual rebate process.
- Additional rebate amounts are due to the State related to Rebate Adjustments based on the reconciliation report CVS Caremark provided to auditors for the in-scope manufacturers. According to this report, $4,684,941.36 in Rebate Adjustments were collected. As of 12/31/2022, $4,048,746.64 has been passed through to the State, with $636,194.72 still owed to the State of Tennessee. The remainder due will be distributed to the State through the usual rebate process.
- Auditors validated a sample of WAC (Wholesale Acquisition Cost) unit costs reported by CVS Caremark and used to calculate final client rebates. This sample included one drug from each manufacturer and each quarter reviewed. No discrepancies were noted.

TCA §4-3-1021(c)(10) COMPARISON OF TOTAL REBATES COLLECTED BY THE PBM (PASS-THROUGH REBATES) TO THE MINIMUM REBATE GUARANTEES (PER CLAIM REBATES) TO ENSURE ANNUAL RECONCILIATION OF REBATE PAYMENTS TO THE STATE REPRESENTED THE GREATER OF THE TWO (2) AMOUNTS

Aon audited CVS Caremark's compliance with this requirement in an audit entitled *2021 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 2023.

CVS Caremark is contractually obligated to pay to the state the greater of the guaranteed minimum average rebate Per Claim or 100% of the rebates collected from manufacturers. For the audit period Aon indicated in their report to the State: *"…For the audit scope of plan year 2021, auditors confirmed CVS's reconciliation where Formulary Pass Through rebates paid to the client during the time period exceeded the Per Rx Minimum Rebate Guarantees. As of 10/20/2022, the State has collected 94.24% of the rebates invoiced for 2021 utilization. CVS indicated that these dollars could take up to four years to fully collect."* Benefits Administration agrees with this based on our internal rebate tracking documents, and auditors note that this is within the range PBMs generally cite for the rebate collection cycle. CVS Caremark complies with this requirement.

TCA §4-3-1021(c)(11) MONITOR THE ACTIVITIES OF THE PHARMACY BENEFITS MANAGER TO ENSURE THAT THE CONTRACTOR IS CONDUCTING AUDITS AND OTHER REVIEWS OF PHARMACIES AS PROVIDED IN THE CONTRACTOR'S SCOPE OF SERVICES

The Pharmacy Benefits Manager contract requires CVS Caremark to conduct annual audits of network pharmacies, including a certain percentage of field audits. CVS Caremark currently delivers quarterly reports, called "Quarterly Field Audit/Daily Review Discrepant Amount Recovery," to meet the annual obligation. The state considers these contractually required reports

as sufficient monitoring of CVS Caremark's obligation to conduct audits and other reviews of pharmacies as provided in their contracted scope of services. During the quarterly desk and field audits of network pharmacies, CVS Caremark staff audit for such things as: different drugs billed or filled than what was written on the prescription, missing prescriptions, over billed quantities, early refills, insufficient directions for use, wrong patient or plan member, or a denied patient or a denied prescriber. The PBM's reports to the Division of Benefits Administration detail the number of new audits performed, the number of audits still open from the prior reporting period and the number of audits closed.

TCA §4-3-1021(c)(12) CONSIDERATION OF OTHER INDUSTRY RELATED RISKS TO REDUCE THE RISK OF FINANCIAL LOSSES DUE TO FRAUD, WASTE AND ABUSE

The Division of Benefits Administration has identified a potential industry risk associated with individuals abusing prescription narcotics or pain medications, commonly referred to as "doctor shopping." CVS Caremark has protocols in place for flagging an individual's record for further review by one of CVS Caremark's clinical pharmacists. If the CVS Caremark clinical pharmacist suspects abuse, the individual's pharmaceutical record is referred to the Director of Clinical Services within the Division of Benefits Administration who works with the Division's Director of Pharmacy Services to determine if an individual's history warrants locking that individual into one (1) single pharmacy. Locking the member into a single pharmacy causes all prescriptions to be filled at just one pharmacy. That single pharmacy and their associated pharmacists will see in real time if a member is trying to fill more than a normal quantity of a particular type of medication or is having multiple narcotics and/or pain medications prescribed by several different physicians. In 2021 and 2022, a total of four members in the state group insurance program were locked into a single pharmacy for suspected doctor shopping and/or pharmacy shopping.

The Division of Benefits Administration has identified a potential industry risk of abuse of certain drug classes used to treat narcolepsy. The drugs *Provigil*, *Nuvigil*, *Xyrem and Sunosi* which are used for narcolepsy or to improve the wakefulness in patients diagnosed as having Shift Work Disorder, are increasingly abused nationwide. Members who wish to fill one of these medications must receive a prior authorization from the Pharmacy Benefits Manager (via their doctor providing to the Pharmacy Benefits Manager various medical records for review). Without a prior authorization, the Pharmacy Benefits Manager will not allow a fill of this type of prescription and the state plans would not pay for it. The state Division of Benefits Administration has a prior authorization requirement in place for any compound drug with a cost over $300, and also has excluded coverage of certain topical agents, bulk powders and creams and pain patches that are not FDA-approved due to an increase nationwide in fraudulent billing of these types of medications by some pharmacies. This is something that has affected not just the state-sponsored plans, but other employer groups and health plans nationwide. Benefits Administration has implemented these and other responsible utilization management programs with our pharmacy benefits manager in order to be a responsible steward of taxpayer and other employer groups' dollars.