ILLINOIS MEDICAID MANAGED CARE PHARMACY ANALYSIS
EXECUTIVE SUMMARY

In 2018 Illinois expanded managed care to all counties in the state

Concern expressed by community pharmacies that Medicaid managed care reimbursements are not covering pharmacy cost to dispense

This study was commissioned by the Illinois Pharmacists Association to analyze change in reimbursements and state costs as a result of the 2018 Illinois Medicaid managed care expansion

Key findings of the study are:

- Average pharmacy margins* fell from just over $6 per prescription in 2017 (before managed care expansion), to under $2 per prescription in July 2017 (after managed care expansion)
- Pharmacies lost money (before operating expenses) on 26% of claims in Q3 2018, up from 5% of claims in Q1 2017
- Despite pharmacy reimbursement pressure, managed care does not appear to be bringing down drug costs when compared to fee for service
- In Q2 2018, we estimate that Illinois paid $3.82 per prescription above pharmacy acquisition cost** for generic drugs
  - $1.39 per prescription went to the pharmacy and $2.43 per prescription of pricing spread was retained by the PBM/plan
  - Q2 2018 pricing spread was 23% of overall generic cost
- Illinois Medicaid fee for service program is not in compliance with the Centers for Medicare and Medicaid Services (CMS) pharmacy reimbursement requirements

We conclude that the managed care expansion has materially pressured pharmacy margins without generating corresponding savings on drug costs***

We recommend that the state conduct a full audit to assess cost savings and pricing spread, including the long-term impact of under-reimbursement of pharmacies on patient access and Medicaid medical expenses

* Total amount reimbursed less CMS’ National Average Drug Acquisition Cost (NADAC)
** NADAC is used as a proxy for pharmacy acquisition cost to normalize for differences in purchasing between pharmacies
*** Based on publicly available information
MANAGED CARE EXPANDED TO ALL COUNTIES IN ILLINOIS IN 2018

Effective April 2018, Illinois Medicaid managed care (HealthChoice Illinois) was expanded to every county in the state.

Seven health plans in 2018:

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>PBM</th>
<th>Dec 1, 18 Enrollment</th>
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</thead>
<tbody>
<tr>
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<td>Prime</td>
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<tr>
<td>NextLevel Health</td>
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On May 29, 2018, WellCare (owner of Harmony Health Plan) entered into a definitive agreement to acquire Meridian Health Plan of Illinois:
- The transaction closed on September 4, 2018
- As of January 1, 2019 Harmony members were transitioned to Meridian, unless they selected a different health plan

Sources:
- https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn171027b.aspx
- https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn180328a.aspx
- https://www.illinois.gov/hfs/SiteCollectionDocuments/201812MCOEnrollmentReportforWebsite.pdf
MUCH SPECULATION ON HOW THE 2018 MEDICAID REBOOT IMPACTED ILLINOIS PHARMACIES
PURPOSE OF THIS STUDY

3 Axis Advisors was commissioned by the Illinois Pharmacists Association to analyze the change in pharmacy reimbursements and state costs resulting from Illinois’ 2018 managed care expansion.

The goal was to develop fact-based insight into the following three questions:

1. Did pharmacies experience meaningful generic drug reimbursement pressure due to managed care expansion?

2. How much did the state save on generic drug costs in managed care, relative to fee-for-service?

3. In Q2 2018*, what was the difference between what Illinois paid for generic drugs and what pharmacies received (i.e. the pricing “spread”)?

This study focused on generic drug reimbursements and costs

- Ohio’s state auditor found that the preponderance of Ohio’s Medicaid managed care spread was extracted from generic drugs ($208 of $225 million over 12 months)
- Relative to brand-name drugs, generic drug pricing is much more opaque and allows for supply chain arbitrage of different pricing benchmarks. Spread results from the difference between what the payer pays (based on one benchmark) and the provider receives (based on a different benchmark) – See slide 22 in the Appendix for an illustration of how pricing spread works on a generic transaction

* Q2 2018 was the focus of spread pricing analysis because 1) it reflects state costs for generic drugs after full transition of the Illinois Medicaid program to managed care and 2) it was the most recent quarter of State Drug Utilization Data available from the Center for Medicare and Medicaid Services (CMS) when this study was conducted.

THE PHARMACY’S COST TO FILL A PRESCRIPTION

Effective April 1, 2016, the Covered Outpatient Drug rule sets a standard methodology for pharmacy reimbursement in Medicaid fee for service

- Pharmacies to be paid based on actual acquisition cost (NADAC and/or AAC) plus a professional dispensing fee that “reflects the pharmacist’s professional services and costs” – see slide 23 in Appendix for more detail

Some states have set a flat professional dispensing fee while others have set a tiered dispensing fee

- Tiers are usually set based on the size of the pharmacy, to ensure that smaller / rural pharmacies with higher per unit costs can remain viable

As of September 2018, 42 states had a professional dispensing fee in place within their Medicaid fee for service programs

- National average dispensing fee is $11.30 per prescription for multi-source generic drugs

Despite CMS’ requirement to have an AAC plus professional dispensing fee model in place by April 2017, Illinois has still not set a professional dispensing fee

- Illinois pays a dispensing fee of $5.50 per prescription for multi-source generics

ILLINOIS PHARMACY GROSS MARGIN* FELL TO UNDER $2 IN MID-2018

To provide insight into the change in pharmacy reimbursements over 2018, we collected de-identified claim information from a geographically diverse sample of Illinois pharmacies:

- 21 pharmacies included in study
- 280,236 generic drug Medicaid claims dispensed between January 1, 2017 and September 30, 2018

Pharmacy claim information was joined with CMS’ National Average Drug Acquisition Cost (NADAC)

- NADAC measures the national average retail pharmacy invoice cost for drugs. It is based on a national survey conducted by Myers and Stauffer on behalf of the Centers for Medicare and Medicaid Services (CMS)
- We used NADAC as a proxy for acquisition cost to normalize for differences in purchasing across pharmacies
- Gross margin is pharmacy revenue less NADAC

In 2017, pharmacy gross margin on generic drugs was in the low-to-mid $6 range, and relatively stable

- Managed care comprises only 14-22% of claims

Margin stepped down to the mid-$4 range in January 2018, to below $3 in April 2018, and bottomed at under $2 in July 2018

- Percent managed care claims of total Medicaid claims jumps to 83% in April 2018 – rises to 88% by September 2018
- Illinois pharmacies received only 18% of U.S. average cost to dispense in July 2018

* Relative to NADAC – not inclusive of pharmacy rebates from wholesalers. See Slide 24 in Appendix for more detail.

DRILLING DOWN TO MANAGED CARE VS. FEE-FOR-SERVICE

Managed care pharmacy reimbursements / margins lagged those in fee for service in 2017, but impact was not widely felt by pharmacies since managed care was a smaller portion of their payer “mix”

- First half 2017 fee for service margins were in the low-$7 range
- First half 2017 managed care pharmacy margins were in the low-$3 range

Managed care margins started experiencing heavy pressure in Second half 2017, bottoming at $0.40 per prescription in January 2018

Fee for service margins also stepped down in early 2018 to below $6 per prescription

Major shift in payer “mix” from fee for service to managed care experienced in April 2018 is responsible for the reduction in overall Illinois Medicaid pharmacy margin

- Thickness of line corresponds to number of claims in the sample within managed care and fee for service
EVALUATING THE CHANGE IN “UNDERWATER CLAIMS”

We also evaluated the number of claims that paid below acquisition cost (a.k.a. “underwater claims”)

- Calculated the NADAC acquisition cost by multiplying the NADAC per unit by the dispensed quantity
- Subtracted the NADAC per prescription from the total reimbursement for both fee for service and managed care prescriptions

Underwater claims in fee for service increased from 2% in Q1 2017 to 9% in Q3 2018

Underwater claims in managed care increase from 14% to 38% in Q1 2018, before dropping to 29% in Q3 2018

Overall Medicaid underwater claims up from 5% in Q1 2017 to 26% in Q3 2018, driven by mix shift from fee for service to managed care
Q2/Q3 2018 pharmacy gross margins varied widely by MCO**, but all were lower than fee-for-service and cost to dispense

Illinois lists Envolve Pharmacy Solutions as the PBM for both IlliniCare and NextLevel. However, both plans are utilizing a CVS/Caremark BIN (004336)

- We suspect both PBMs are somehow participating in the management of the prescription benefit for these two plans – a similar arrangement to what was found in Ohio with Buckeye Health Plan
- Ohio found “what essentially was a second middleman, given $20 million annually to perform services seemingly already provided by the existing middleman. And in a possible conflict of interest, the second, possibly redundant middleman and the managed-care organization that hired it are owned by the same multibillion-dollar corporation (Centene)”

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* See Slide 25 in Appendix for a more in-depth discussion on Chicago
** See Slide 26 in Appendix for BIN/PCN/Group definitions of managed care plans

Sources: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/full-nadac-downloads/nadacmethodology.pdf
HOW MUCH MONEY IS MANAGED CARE SAVING ILLINOIS ON GENERIC DRUGS?

With pharmacy margins down considerably, the next logical question is how much money the state is saving on drug costs in Medicaid managed care.

To answer this question, we compared the weighted average cost per prescription in Illinois Medicaid fee for service and managed care:

- The analysis was performed for all generic drugs dispensed in both FFS and MCO within the same quarter.
- To normalize for drug mix, we modeled the average cost per prescription if all dispensing had been performed in one program or the other—in other words, the chart shows an estimate of the cost per prescription if all drugs were “carved out” (fee for service) or all drugs were “carved in” (managed care).
- Costs per unit for both programs in each quarter were derived from CMS’ State Drug Utilization Database.

After normalizing the data for drug mix, we found that over the last six quarters, managed care and fee for service have averaged almost the exact same cost per prescription:

- FFS = $16.01; MCO = $16.03

As such, it does not appear that managed care is generating any meaningful savings in generic drug cost, despite pressure to pharmacy reimbursements.

MANAGED CARE IS NOT PRODUCING SAVINGS ON BRAND DRUGS EITHER*

We then performed the same analysis for brand name drugs dispensed in both Illinois fee for service and managed care.

Over six quarters, we found fee for service to be, on average, 2% cheaper than managed care for the same brand drug mix.

- FFS = $435.61; MCO = $444.86

Managed care PBMs do not appear to be producing drug cost savings for Illinois on generic or brand drugs.

* Based on gross unit costs reported into CMS’ State Utilization Database - excludes rebates
ASSESSING SPREAD IN Q2 2018

Our analysis of pharmacy reimbursements and margin identified considerable pressure in Q2 2018 in absolute and relative to fee for service.

Our analysis of state costs did not identify any savings relative to fee for service.

The gap is likely “pricing spread”

To estimate spread, we compiled a list of all generic oral solid drugs dispensed in managed care in Q2 2018 where we had per unit state cost, pharmacy revenue, and NADAC.

- Sample includes all generic oral solid drugs for which we had a pharmacy revenue per unit (393 different generic drugs)*. This was 21% of the 1,846 different generic drugs dispensed in IL managed care in Q2 2018.

Total markup (state cost less NADAC) on this basket of drugs was $3.82

- Pharmacy received $1.39 - 36% of markup – 13% of state cost
- Pricing spread was $2.43 – 64% of markup – 23% of state cost

Due to limitations of CMS’ state utilization data, this analysis was performed in aggregate for all of managed care.

- Not all of Illinois’ plans are in spread contracts – as such, we believe some plans could be realizing spread that is higher than $2.43 while others will be lower, or even zero.
- See Slide 26 in the Appendix for a comparison of this study’s Q2 2018 managed care claim mix with May 2018 Illinois managed care enrollment

We recommend a state audit to understand the differences in drug prices and spread pricing by plan.

* Only included drugs for which there were 11 or more records available (derived from CMS data set restrictions). Used managed care drug mix to aggregate data and calculate cost share.
IS ILLINOIS ALSO LEAVING REBATE DOLLARS ON THE TABLE?

While drug-level rebate information are not publicly available, MACPAC publishes total gross and net spending by state in fee-for-service and managed care.

In Fiscal 2017, Illinois’ managed care program returned rebates equaling 51% of gross spending while its fee for service program returned rebates equaling 63% of gross spending.

Misaligned incentives in managed care could lead to premature brand-to-generic switching, potentially resulting in higher net costs.

Higher rebates in fee-for-service could be worth over $170 million to the state:

- Based on gross Illinois managed care drug spending of $1.44 billion in FY17
- Assumes equal drug mix

HOW MANAGED CARE HELPS STATES SIDE-STEP CMS-MANDATED PHARMACY REIMBURSEMENTS

Another possible reason the state switched has to do with CMS’ Covered Outpatient Drug Rule

As mentioned earlier, Illinois is one of the last “hold-out” states to have not moved to an AAC plus professional dispensing fee in its fee for service program

Our analysis of pharmacy data suggests that IL is paying below its SMAC plus $5.50 for generic drugs

- Grey line is modeled payments based on SMAC + $5.50 while Pink line is the actual pharmacy margin over NADAC for oral solid generic drugs
- State MAC appears to be at a $1-2 per prescription premium to NADAC (Purple line) – it resembles more of an AAC (acquisition cost) than a MAC (maximum allowable cost)

Compliance with the Covered Outpatient Drug Rule will add ~$5 per prescription to the cost of generic drugs in Illinois fee for service

- IL pharmacies may be entitled to recoupment of fee-for-service underpayments going back to April 1, 2017

The switch to managed care could have been a proactive move to preserve the state’s drug costs at a level below the pharmacy’s cost to dispense

LIMITATIONS TO THIS ANALYSIS

The following are limitations to this analysis:

1. Does not capture chain pharmacy reimbursements, which may be different from independent pharmacy reimbursements

2. We do not have per unit pharmacy reimbursements for all generic drugs dispensed in Illinois managed care
   - Spread analysis captures 21% of generic drugs dispensed managed care in Q2 2018

3. Drug spending by MCO is not publicly available. Only have access to overall MCO costs per quarter.
   - Introduces MCO-mix error when estimating spread for Q2 2018

4. Does not include any additional revenue sources to the state such as additional tax revenue or administrative fee savings

5. Does not include Medicaid-Medicare Alignment Initiative

We recommend the state conduct a full audit to understand the differences in drug prices and spread pricing by plan
CONCLUSIONS AND RECOMMENDATIONS

Key findings of the study are:

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*** Based on publicly available information
ABOUT 3 AXIS ADVISORS

3 Axis Advisors is an elite, highly-specialized consultancy that partners with private and government sector organizations to solve complex, systemic problems and propel industry reform through data-driven advocacy. With a primary focus on identifying and analyzing U.S. drug supply chain inefficiencies and cost drivers, we offer unparalleled expertise in project design, data aggregation and analysis, government affairs and media relations.

3 Axis Advisors arms clients with independent data analysis needed to spur change and innovation within their respective industries. Our team was instrumental in exposing the drug pricing distortions and supply chain inefficiencies embedded in Ohio’s Medicaid managed care program. We are also the co-founders of 46brooklyn Research, a non-profit organization dedicated to improving the transparency and accessibility of drug pricing data for the American public.
GLOSSARY OF TERMS

**Actual Acquisition Cost (AAC)** - AAC is defined as the CMS' determination of the pharmacy providers' actual prices paid to acquire drugs marketed or sold by specific manufacturers. [https://www.medicaid.gov/federal-policy-guidance/downloads/smd16001.pdf](https://www.medicaid.gov/federal-policy-guidance/downloads/smd16001.pdf)

**Fee for service (FFS)** - Fee-for-service is health care's most traditional payment model where physicians and healthcare providers are paid by government agencies and insurance companies (third-party payers), or individuals, based on the number of services provided, or the number of procedures ordered. [http://www.insight-txcin.org/post/what-is-fee-for-service](http://www.insight-txcin.org/post/what-is-fee-for-service)

**Managed care** - Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. [https://www.medicaid.gov/medicaid/managed-care/index.html](https://www.medicaid.gov/medicaid/managed-care/index.html)

**Managed care organization (MCO)** - A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans. [https://definitions.uslegal.com/m/managed-care-organization-mco/](https://definitions.uslegal.com/m/managed-care-organization-mco/)


**National Average Drug Acquisition Cost (NADAC)** - The NADAC is designed by CMS to create a national benchmark that is reflective of the prices paid by retail community pharmacies to acquire prescription and over-the-counter covered outpatient drugs. [https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/full-nadac-downloads/nadacmethodology.pdf](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/full-nadac-downloads/nadacmethodology.pdf)
GLOSSARY OF TERMS

National Drug Code (NDC) - The NDC, or National Drug Code, is a unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs in the United States. [https://www.drugs.com/ndc.html](https://www.drugs.com/ndc.html)

Pharmacy benefit manager (PBM) - PBMs are companies that deliver prescription benefits. PBMs are hired by corporate employers, health plans, labor unions, and other organizations to interface with drug manufacturers and process prescription-related claims. [https://www.truveris.com/resources/what-is-a-pbm-and-how-does-a-pbm-impact-the-pharmacy-benefits-ecosystem](https://www.truveris.com/resources/what-is-a-pbm-and-how-does-a-pbm-impact-the-pharmacy-benefits-ecosystem)

Professional Dispensing Fee - A professional dispensing fee is defined in federal regulations (42 CFR 447.502) as the professional fee that pays for costs in excess of the ingredient cost of an outpatient prescription drug each time a drug is dispensed. The dispensing fee covers the pharmacy’s costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. [https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf](https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf)


Spread - Spread pricing refers to the difference between what the PBM charges a patient or patient’s health insurance and what the PBM pays the pharmacy for dispensing the medication. [https://www.uspharmacist.com/article/understanding-drug-pricing](https://www.uspharmacist.com/article/understanding-drug-pricing)

State Utilization Data - Drug utilization data are reported by states for covered outpatient drugs that are paid for by state Medicaid agencies since the start of the Medicaid Drug Rebate Program. The data includes state, drug name, National Drug Code, number of prescriptions and dollars reimbursed. [https://healthdata.gov/dataset/state-drug-utilization-data-2018](https://healthdata.gov/dataset/state-drug-utilization-data-2018)
HOW A SPREAD PRICING GENERIC TRANSACTION WORKS

Spread Pricing in a Generic Drug Transaction

Typically based on a discount to Average Wholesale Price (AWP)

Price 1
- Transparent? ✗
- Market-based? ✗

Buyer

Price 1
- $71.88

Intermediary

Price 2
- $50.21

Price 2
- Transparent? ✗
- Market-based? ?

Seller

Price 1 – Price 2 = “Spread”

Typically based on a proprietary PBM benchmark called Maximum Allowable Cost (MAC)
COVERED OUTPATIENT DRUG RULE PHARMACY REIMBURSEMENT REQUIREMENTS

**Pharmacy Reimbursement**
- Actual Acquisition Cost (AAC)
- Professional Dispensing Fee
- Reimbursement for Federal Discount Programs (340B and Federal Supply Schedule (FSS))
- Federal Upper Limits (FULs)

**Actual Acquisition Cost (AAC)**
- Final Rule:
  - Defines AAC ($\$447.502$) to mean the agency’s determination of the pharmacy providers’ actual prices paid to acquire drug products marketed or sold by specific manufacturers.
  - Replaces estimated acquisition cost (EAC) with actual acquisition cost (AAC) in $\$447.512(b)$
  - Explains that the change to AAC was necessary as it represents a more accurate reference price to be used by states to reimburse providers for drugs.

**Professional Dispensing Fee**
- Final Rule:
  - Finalizes replacing “dispensing fee” with “professional dispensing fee” in $\$447.502$ (as applied in $\$447.512(b)$).
  - Reinforces CMS’s position that the fee to dispense the drug to a Medicaid beneficiary reflects the pharmacist’s professional services and costs.

**Reimbursement Requirements**
- $\$447.518(d)$ requires that when states propose changes to either the ingredient cost or professional dispensing fee, states must consider both to ensure that total reimbursement to the pharmacy provider is in accordance with requirements of section 1902(a)(30)(A) of the Social Security Act (the Act).
- When proposing reimbursement changes, states are required to submit a state plan amendment (SPA) to CMS for review which includes a survey or other reliable data to support any proposed changes to either or both of the components of the reimbursement methodology.

A NOTE ON PHARMACY REBATES

NADAC’s main limitation is that it does not include off-invoice rebates that pharmacies may receive from wholesalers. Rebates lower the net cost to the pharmacy for many drugs and tend to be a percent discount off the invoice cost if a pharmacy meets various generic purchasing targets with its primary wholesaler. As such, NADAC should not be viewed as a reflection of pharmacy net costs – these will vary depending on pharmacy size and wholesaler contract terms.

Anecdotally, rebates on generic drug purchases can reach up to 30-40% of invoice cost for larger pharmacies, but this value is partly offset by wholesaler requirements that prevent the pharmacy from shopping with other wholesalers for the best invoice price. In other words, there is nothing preventing the wholesaler from increasing the pharmacy’s invoice cost to partly offset the rebate, resulting in an invoice cost that is above NADAC.

Smaller pharmacies, pharmacies that choose to shop more aggressively for better invoice costs, or pharmacies that are predominantly buying from smaller wholesalers may receive rebates that are considerably lower than 30-40%, or there may be no rebates at all. All told, 3 Axis Advisors’ qualitative research suggests that net average pharmacy acquisition cost is some discount to NADAC, but not as large as 30-40%. We believe that the restrictions placed on pharmacies by wholesalers, combined with above-NADAC invoice costs, are offsetting some portion of the rebate.
CHICAGO PHARMACIES APPEAR TO FACE “IMPERFECT STORM” OF LOW REVENUE AND HIGH COSTS

The three Chicago pharmacies within our sample had a disproportionately high percentage of managed care claims
- 55% of overall claims in Q2/Q3 2018
- Managed care comprised 10% of all claims for sampled pharmacies located outside of Chicago
- Chicago pharmacies have a much heavier mix of low reimbursement claims

Chicago pharmacies also are exposed to Cook County-only plans, which we found to be among the lowest margin Plans in Illinois
- See pharmacy margin comparison on Slide 10

Chicago pharmacies also face higher costs
- City of Chicago minimum wage ordinance raises non-tipped employee minimum wage to $13.00 per hour on July 1, 2019
- Illinois minimum wage = $8.25 per hour

We recommend a more robust study on the impact of the managed care transition on Chicago pharmacies to identify areas that would experience patient access issues if pharmacy closures accelerate

# Managed Care Plan Definitions Used in Study

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<th>Plan</th>
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