BEFORE THE IOWA INSURANCE COMMISSIONER

IN THE MATTER OF THE EXAMINATION OF CAREMARK LLC, CAREMARK PCS, HEALTH, LLC, AND CAREMARK PhC, LLC	)))))	ORDER ADOPTING EXAMINATION REPORT

On May 10, 2024, the Iowa Insurance Division opened an examination pursuant to Iowa Code chapter 507 of Caremark LLC, Caremark PCS Health, LLC, and Caremark PhC, LLC ("Caremark") to determine if Caremark's policies, procedures, and contractual obligations comply with Iowa's statutes and regulations. The period of review is January 1, 2023, to December 31, 2023, including subsequent events through the date of the report. On March 17, 2025, Chief Examiner Daniel Mathis issued an examination report. Caremark reviewed this report and provided a response on April 13, 2025. Based on the response provided, Chief Examiner Mathis modified the examination report. The final examination report has been provided for adoption on April 17, 2025.

The commissioner has reviewed the draft report, Caremark's response, and the relevant workpapers and has concluded that the amended report accurately reflects the policies and procedures as provided by Caremark.

The amended examination report is hereby ADOPTED pursuant to Iowa Code section 507.10(3)(a). This order is final agency action and may be appealed pursuant to Iowa Code chapter 17A.

Please be advised that pursuant to Iowa Code section 507.10(4)(a), each member of the Caremark board of directors shall timely review the adopted report and the minutes of the board meeting at which the adopted report is considered shall reflect that each member of the board has reviewed the adopted report.

Examiner Attestation

I hereby attest that the examination report findings and conclusions is an accurate reflection of Caremark policies and procedures as provided by Caremark.

DANIEL MATHIS
Chief Examiner

IT IS SO ORDERED.

Dated this 17th day of April, 2025.

DOUG OMMEN
Commissioner of Insurance

IOWA INSURANCE DIVISION

EXAMINATION OF

Caremark, LLC, CaremarkPCS Health, LLC & Caremark PhC, LLC

EXAMINATION REPORT

Des Moines, Iowa
March 17, 2025

HONORABLE DOUG OMMEN
Commissioner of Insurance
State of Iowa
Des Moines, Iowa

Commissioner:

In accordance with your authorization and pursuant to Iowa statutory provisions, an examination has been made of the records, business affairs and practices of

CAREMARK, L.L.C., CAREMARKPCS HEALTH, L.L.C. & CAREMARK PHC, L.L.C.

SCOTTSDALE, ARIZONA

AS OF DECEMBER 31, 2023.

INTRODUCTION

This examination report, containing applicable comments, explanations and findings, is presented herein. In general, this is a report by exception. Comments regarding practices and procedures reviewed during the examination have been omitted from the report if no improprieties were found. All unacceptable or non-complying practices may not have been identified. The failure to identify specific company practices does not constitute acceptance of these practices.

SCOPE OF EXAMINATION

This examination of Caremark, L.L.C., CaremarkPCS Health, L.L.C., & Caremark PhC, L.L.C. ("Caremark" or the Caremark Companies) was conducted pursuant the Iowa Insurance Division's authority in Iowa Code section 510B.10. The Caremark companies are registered in Iowa as Pharmacy Benefit Managers (PBMs). A pharmacy benefits manager means a person who, pursuant to a contract or other relationship with a third-party payor, either directly or through an intermediary, manages a prescription drug benefit provided by the third-party payor. A pharmacy benefits manager doing business in Iowa must also obtain a certificate as a third-party administrator (TPA) under Iowa Code Chapter 510. This examination covers the period from January 1, 2023, through December 31, 2023.

The examination reviews the Caremark companies' policies, procedures, and contractual obligations relating to its business in Iowa in the following areas:

1. Contracts with insurers, pharmacies, and other entities.
2. Claims payment methodologies and criteria, including 'real time' processes for determining claims payment amounts.
3. Pharmacy dispute resolution processes including complaints, appeals and audit appeals and independent third-party reviews.

CAREMARK AND PHARMACY CONTRACTING PROCESS

The Division reviewed the Caremark's policies and procedures related to the contract negotiation and renewal processes for pharmacies and pharmacy service administrative organizations (PSAOs). Caremark's procedures allow providers [meaning pharmacies and PSAOs] to engage with [Caremark] to negotiate terms of the (initial) contract. This process may occur through the pharmacy portal. Providers often engage with [Caremark] to negotiate terms via email or fax. The Caremark Network Development team would review any proposed modifications and determine the Caremark's response.

The Division reviewed seven provider contracts. Caremark was not able to produce any communications, inquiries, and/or complaints submitted to the Companies related to the Provider Agreement or any part thereof, reimbursement methodologies, and/or pricing changes for any of the seven entities. Caremark did provide one pharmacy network amendment showing that Caremark amended its network reimbursement when requested by a client not included in the sample.

Examiners requested information relating to the negotiations, including requests to negotiate, between Caremark and several other entities including affiliated and unaffiliated pharmacies. Caremark was unable to produce the communications, track change versions, emails and faxes, or any documentation related to this request.

Examiners reviewed documentation related to reimbursement rates for all network pharmacies in the scope of the exam. Caremark negotiated reimbursement rates for every pharmacy chain and PSAO. Of the over 160 independent pharmacies not associated with a PSAO, with only 25 pharmacies (fifteen percent) successfully negotiated reimbursement terms with Caremark.

REIMBURSEMENT PROCESS TO PHARMACIES

Examiners reviewed the Caremark companies' reimbursement policies and procedures. Providers are reimbursed according to the most recent Provider Manual (which may be updated more frequently than a provider's contract). Caremark reviews several sources to determine the lowest identified drug cost. Providers will be reimbursed at a rate based on the lowest of the following less the applicable Patient Pay Amount:

- Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon an alternate Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type plus the applicable Dispensing Fee); or
- Maximum Allowable Cost (MAC) plus the applicable Dispensing Fee; or
- Ingredient cost submitted by Provider plus the applicable Dispensing Fee; or
- Provider's U&C Price; or
- Provider's submitted "gross amount due" (as defined by NCPDP).

Caremark utilizes the 'Price Type' reimbursement method when paying pharmacies through network contracts called Network Enrollment Forms. This method is largely used to reimburse brand and non-MAC generic drugs. Caremark utilizes the MAC reimbursement method when paying pharmacies for most generic drugs dispensed. Caremark uses a proprietary method to estimate discounts pharmacies receive when purchasing drugs from wholesalers. Caremark reduces the amount reimbursed to pharmacies by their current estimate. The amount of the reduction may be changed at any time, without notice to the pharmacy, based on Caremark's sole discretion.

Contracts reviewed during the exam had provisions limiting the maximum discounts that would be applied for brand and non-MAC generic drugs. From the information provided by Caremark, the 'discounts' for its various networks range between 20-25% for brand drugs and are up to 42% for non-MAC generics.

The MAC drug source price reduction is not described in any documentation to pharmacies or in any documentation provided by Caremark during the examination. Based on how Caremark applies the effective rate reconciliation process for generic drugs, the MAC drug price source reduces each MAC paid claim by up to 90 percent. Caremark publishes a MAC price list in the provider portal that lists MAC reimbursement rates. Pharmacies are not affirmatively notified of updates to the list.

Certain contracts had additional provisions, effective rate reconciliation (ERR) and AWP Normalization, where the discounts applied in aggregate would not exceed specified minimums or maximums. The ERR process is performed at an aggregate level across all non-Medicare lines of business and across all pharmacies across the entire country with a PSAO or chain pharmacies within a chain. Pharmacies that are part of a chain or PSAO (including affiliated pharmacies) may have an ERR contract with Caremark; independent pharmacies may not. No independent pharmacies have contract provisions that include AWP Normalization. The ERR process results in retroactive payment adjustments in aggregate.

Pharmacies with ERR provisions are provided an annual report. Examiners reviewed a sample of the annual reports. The annual report is a one-page document assessing all claims reconciled during the ERR process. The reports detail the number of claims included and excluded from the ERR process. Reimbursement documentation provided to pharmacies includes the amount reimbursed and may provide the amount discounted in aggregate. Annual reports provided to pharmacies with ERR provisions do not provide claims level detail. The report does not provide adequate detail to determine if fully and self-insured claims from Iowa pharmacies were included in the reconciliation process.

During the period under examination Caremark excluded certain commercial claims from the ERR process. Caremark did not provide any notice to the PSAOs or pharmacy chains that relied on Caremark's contract requiring commercial claims be part of the ERR process. This exclusion resulted in Iowa pharmacies having 6.2 million claims excluded from the reconciliation process in 2023. Caremark submitted a plan to address the excluded claims.

The documentation provided to pharmacies documenting reimbursement is opaque relating to the source or amount of initial price used. There is no plain language description of the amount an individual claim was reduced, or of the reconciliation calculation when allowed for by one or more contractual provisions.

UNAFFILITED THIRD-PARTY AGREEMENTS

Caremark entered into a contract with an unaffiliated third-party, called the Program Services Agreement, to administer Caremark's Cost Saver Program. The unaffiliated third-party is not a registered PBM in Iowa. The program performs a price comparison between the unaffiliated third-party's Network Rate and the payment a pharmacy would receive based on the consumer's healthcare plan administered by Caremark. If the assessment shows the unaffiliated third-party's Network Rate cost is lower than the consumer's cost sharing obligation under the consumer's healthcare plan, Caremark requires that pharmacy submit the claim to the unaffiliated third-party. Per the terms of the contract, when the unaffiliated third-party processes the claim, the pharmacy collects the unaffiliated third-party's Network Rate from the consumer (in lieu of the consumer's cost-sharing obligation under the healthcare plan). Caremark's contract permits the unaffiliated third-party to reimburse the pharmacy any dispensing fee and may charge the pharmacy an administrative fee. Caremark then ensures the amount the consumer paid is applied the out-of-pocket costs under the consumer's healthcare plan.

Provider contracts have provisions that state the provider acknowledges and agrees that Caremark may elect to partner with third parties for the administration of consumer card programs. Caremark may forward any claim submitted to Caremark to a third party for the purposes of processing a consumer card claim under a contract between Provider and the third-party and return the third-party's claim response to Provider. To the extent Provider is contracted with that third party, Provider agrees that such claims will be reimbursed pursuant to the Provider's contract with the third party, and not the Caremark Provider Agreement.

Caremark applies the Cost Saver Program to all pharmacies that are part of the networks of its third-party payor clients that have opted to implement the Cost Saver Program. Caremark does not have a process or perform any detailed testing to confirm pharmacies reimbursed under this method have a contract in place with the unaffiliated third-party. Pharmacies may contact [Caremark] to opt-out of the program if they do not have a contract with the unaffiliated third-party.

PHARMACY CONTRACT NETWORKS

Examiners requested information about each pharmacy network used by Caremark during the examination. Caremark identified five (5) pharmacy networks.

A review of Caremark's contract with an affiliated pharmacy showed several different networks that were not disclosed in Caremark's response. Independent pharmacies are not included in either of the two additional networks identified.

One of the additional networks identified, consisting of only affiliated pharmacies, is available to clients that are not subject to 'Any Willing Provider' laws and are very narrow networks focused only locations with affiliated pharmacies. Members who live within a set distance from one of their affiliated pharmacies are required to use the affiliate, while other members without nearby affiliated pharmacy would have access to another network.

The second additional network identified, consisting of affiliated and un-affiliated pharmacies, allows reduced copays for covered individuals. Claims filled through this network are excluded for the purpose of ERR.

DRUG SUBSTITUTION PROCESS & FORMULARY CREATION

Examiners reviewed the Caremark companies' policies and procedures related to substitutions of prescribed drugs. Caremark's policies and procedures were consistent with Iowa Code requirements when a prescription drug order prohibits a substitution. Iowa Code allows a PBMs to request the substitution of a lower priced generic and therapeutically equivalent prescription drug for a higher priced prescription drug. The Caremark companies rely on the professional standards of pharmacists to confirm the substitution was made only for medical reasons that benefit the covered person.

The Caremark companies may also require pharmacists dispense brand-name drugs rather than generic drugs. In instances where the generic is not the most cost-effective for the plan, Caremark may exclude the generic from the formulary. Caremark was not able to provide any documentation demonstrating their calculation of net cost to the plan for these substitutions.

CAREMARK'S DISPUTE RESOLUTION PROCESS

Inquiry and Complaint Process

Examiners reviewed Caremark's inquiry and complaint process. Caremark's Provider Manual requires pharmacies to contact Caremark via postal mail addresses for numerous processes. Caremark provided information to the examiners showing that pharmacies are able to contact Caremark via email or phone for inquiries and complaints. Caremark asserted that phone, email and website contact information described in the Provider Manual that appeared to be available only for certain processes was not limited to those processes. The Examiners found that Caremark has reasonable procedures for pharmacies to submit complaints.

MAC Appeals

Examiners reviewed the Caremark companies' policies and procedures related to MAC appeals. It is Caremark's policy that if an appeal includes documentation of the pharmacies' actual cost of a drug as a part of its appeal, Caremark will reimburse the pharmacy at its cost. Fewer than one percent of appeals include this documentation. Communication of denied appeals does not contain detailed information related to the price or discount used by Caremark in the appeal process. When Caremark determines an update to reimbursement rates is warranted based on an appeal, their system reflects the new rate for all claims going forward. Caremark does not identify and adjust any claims that were paid based on the inaccurate rate. Pharmacies are not proactively notified of these rate changes. Pharmacies are required to identify any claim that may be eligible for adjustment and submit it as an appeal.

Independent Third-Party Reviews

PBMs are required to provide pharmacies access to an independent third-party review of final audit findings and of decisions to terminate or suspend the pharmacy. The regulations require a PBM to establish of process to notify the pharmacy of its right to request an independent third-party review. All contracts have provisions for an independent third-party review to be conducted through an arbitration process. To request an arbitration, however, a pharmacy must place no less than $50,000 into an escrow account. Caremark did not receive any requests for third-party reviews during the period under examination.

CONCLUSION

In addition to the undersigned Risk & Regulatory Consulting, LLC, participated in the examination and preparation of this report.

Respectfully submitted,

/s/ Daniel Mathis
Daniel Mathis, CFE
Chief Examiner
Iowa Insurance Division