PBM Contract Audit Findings of Benecard for Commonwealth of Pennsylvania, Public School Employees' Retirement System

January 2006 – December 2006

1061 Peruque Crossing Court • O'Fallon, Missouri 63366 • (636) 614-1344
Fax (636) 639-8021 • E-Mail: Ken.Anderson@ipc-inc.com • Website: www.ipc-inc.com

The Commonwealth of Pennsylvania, Public School Employees' Retirement System (PSERS) has retained Independent Pharmaceutical Consultants, Inc. (IPC) to assist in the management of the prescription drug vendor which includes periodic electronic audits of the claims administered under their contract with Benecard. This audit report reflects the claims incurred from January 1, 2006 to December 31, 2006. An electronic audit was performed against 100% of the 1,263,902 prescription drug claims during the period. These claims accounted for total costs of $77,769,801.96. These claims were subjected to various electronic audit queries to identify claims that appeared to vary from the established contractual obligations for PSERS being administered by Benecard. This report has been sent to Benecard for their review and response. IPC has retained the detailed claim file and all related analytical work used to perform the audit, and this detail file will be made available to Benecard to assist in their review and resolution of issues if they arise.

Contracted Discounts

PSERS contracted with Benecard to provide a discounted network of pharmacies through a subcontractor, Express Scripts, Inc. (ESI), who offers a contracted network of retail pharmacies and an exclusive mail order pharmacy. On January 1, 2006, the "Consent to Renew Agreement for Prescription Drug Benefits Administrative Services" was implemented. This agreement amended the existing contract between Benecard and PSERS to include services required to service PSERS' members enrolled in the Heath Options Program (HOP) Medicare Part D programs. The agreement changed the contract from an annual guarantee pricing agreement to a "pass-through" pricing agreement. Therefore, PSERS is to receive from Benecard the same claim discount arrangements it receives from ESI, which includes 100% of the rebates Benecard receives on behalf of PSERS. Although changes were required to handle the services needed for Medicare Part D, the basic financial arrangement for 2006 was understood to be at least as good as the 2005 arrangement.

Retail Pharmacies

PSERS was contracted with Benecard to receive a guaranteed average discount of Average Wholesale Price (AWP) less 15% on Single Source Brand Drugs, and 94% of Health Care Finance Administration – Federal Upper Limit (HCFA-FUL) or 33% off AWP for both Tier One and Tier Two Formulary Drugs through the pharmacy network arrangement. The contracted pricing arrangement also included a $1.45 dispensing fee per claim. IPC reviewed all of the claims incurred during the 2006 audit period to determine whether or not Benecard's claims administration process met these established network pricing thresholds. IPC's analysis of the claims indicates Benecard did not meet the established pricing thresholds.

See the chart below for details:

DRUG TYPE	SS BRAND	TIER 1	TIER 2	TOTAL
AWP COST	$32,015,441.09	$3,013,465.89	$8,034,738.13	$43,063,645.11
HCFA-FUL	$0.00	$8,279,836.90	$0.00	$8,279,836.90
INGREDIENT COST	$26,750,470.73	$4,431,889.74	$6,922,624.19	$38,104,984.66
DISPENSING FEE	$558,014.86	$870,865.10	$348,015.42	$1,776,895.38
CLAIM COUNT	276,176	415,624	168,342	860,142
CALCULATED INGRED COST	$27,213,124.93	$7,783,046.69	$7,056,162.22	$42,052,333.84
CALCULATED DISP FEE	$400,455.20	$602,654.80	$244,095.90	$1,247,205.90
CLAIM INGREDIENT COST OVER CALCULATED THRESHOLD	$0.00	$0.00	$0.00	$0.00
CLAIM DISPENSING FEE OVER CALCULATED THRESHOLD	$157,559.66	$268,210.30	$103,919.52	$529,689.48
TOTAL CLAIM AMOUNT OVER CALCULATED THRESHOLD	**$157,559.66**	**$268,210.30**	**$103,919.52**	**$529,689.48**

Benecard's Initial Response: Pending Response from ESI

IPC's Conclusion – 11/12/2007: PSERS contracted with Benecard for the administration of the prescription drug program. If Benecard subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard had the initial audit report since August 23, 2007 and been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $529,689.48 for this error.

Benecard's Response 4/14/2008: See attached chart (2006 Discount Guarantees). Per spreadsheet there is a surplus for retail claims of $4,141,973.78, contract obligations have been met, no payment owed. Per response ingredient cost and dispensing fees for claims paid at retail or mail have been met, no errors identified. Per contract (Appendix C Prescription pricing schedule) "Any excess in a single component may be used to make up for a shortfall in another component".

IPC's Conclusion: IPC has verified Benecard's statement that the last sentence of Appendix C of the contract states, ""Any excess in a single component may be used to make up for a shortfall in another component." Given the context of the contract, IPC agrees with Benecard's response. Therefore, IPC no longer considers these claims in error.

Mail Order Pharmacy

PSERS was contracted with Benecard to receive a guaranteed average discount of AWP (Average Wholesale Price) less 22% on Single Source Brand Drugs, and 94% of HCFA-FUL (Health Care Finance Administration – Federal Upper Limit) or 33% off AWP for both Tier One and Tier Two Drugs for the mail order pharmacy arrangement. The contracted pricing arrangement also included a $0.00 dispensing fee per claim. IPC reviewed all of the claims incurred during the 2006 audit period to determine whether or not Benecard's claims administration process met these established mail order pricing thresholds. IPC's analysis of the claims indicates that Benecard has not met the established pricing thresholds.

See the chart below for details:

DRUG TYPE	SS BRAND	TIER 1	TIER 2	TOTAL
AWP COST	$29,197,780.24	$12,812,054.61	$8,034,738.13	$50,044,572.98
HCFAFUL	$0.00	$6,497,745.09	$0.00	$6,497,745.09
INGREDIENT COST	$23,063,623.45	$3,013,465.89	$5,105,271.58	$31,182,360.92
DISPENSING FEE	$54,896.25	$50,520.40	$22,855.45	$128,272.10
RXCNT	109,663	116,786	47,488	273,937
CALCULATED INGRED COST	$21,898,335.18	$6,107,880.38	$5,383,274.55	$33,389,490.11
CALCULATED DISP FEE	$0.00	$0.00	$244,095.90	$244,095.90
CLAIM INGREDIENT COST OVER CALCULATED THRESHOLD	$1,165,288.27	$0.00	$0.00	$1,165,288.27
CLAIM DISPENSING FEE OVER CALCULATED THRESHOLD	$54,896.25	$50,520.40	$22,855.45	$128,272.10
TOTAL CLAIM AMOUNT OVER CALCULATED THRESHOLD	**$1,220,184.52**	**$50,520.40**	**$22,855.45**	**$1,293,560.37**

Benecard's Initial Response: Pending response from ESI

IPC's Conclusion – 11/12/2007: PSERS has contracted with Benecard for the administration of the prescription drug program. If Benecard has subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard has had the initial audit report since August 23, 2007 and has been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $1,293,560.37 for this error.

Benecard's Response 4/14/2008: See attached chart, (2006 Discount Guarantees) Per spreadsheet there is a surplus for mail claims of $2,883,659.49, contract obligations have been met, no payment owed. Per response ingredient cost and dispensing fees for claims paid at retail or mail have been met, no errors identified. Per contract (Appendix C Prescription pricing schedule) "Any excess in a single component may be used to make up for a shortfall in another component".

IPC's Conclusion: IPC has verified Benecard's statement that the last sentence of Appendix C of the contract states, ""Any excess in a single component may be used to make up for a shortfall in another component." Given the context of the contract, IPC agrees with Benecard's statement that they have met the guarantee. Therefore, IPC no longer considers these claims in error.

Rebates

PSERS was contracted with Benecard to receive a minimum established rebate threshold of $1.75 per retail claim and $4.50 per Mail Order claim. IPC reviewed all of the claims incurred through fourth quarter 2006 and compared them to the rebates received by PSERS for the claims incurred through fourth quarter 2006 to determine whether or not Benecard met this minimum threshold of the agreement. IPC has determined that Benecard has not met this minimum threshold in regards to rebates paid through 4th quarter 2006.

See the chart below for details, by calendar quarter:

PERIOD	# OF MAIL CLAIMS	# OF RETAIL CLAIMS	CALCULATED MAIL REBATES	CALCULATED RETAIL REBATES	TOTAL CALCULATED REBATES	TOTAL RECEIVED	VARIANCE
1st qtr	68,443	296,773	$307,993.50	$519,352.75	$827,346.25	$365,851.62	$461,494.63
2nd qtr	72,219	304,676	$324,985.50	$533,183.00	$858,168.50	$838,843.86	$19,324.64
3rd qtr	68,352	315,696	$307,584.00	$552,468.00	$860,052.00	$715,414.07	$144,637.93
4th qtr	63,416	259,780	$285,372.00	$454,615.00	$739,987.00	$0.00	$739,987.00
TOTAL					**$3,285,553.75**	**$1,920,109.55**	**$1,365,444.20**

In summary, it appears that Benecard has not met their contractual obligation in regards to the minimum thresholds for retail and mail ingredient cost discounts, dispensing fee discounts and rebates for 2006. It should be noted that these findings are a result of the 2006 agreement being no worse than the 2005 agreement in these cost areas. Since the intent of a "pass-through" arrangement is for PSERS to receive 100% pass-through of all network and mail provider and rebate contracts, IPC recommends that PSERS audit the ESI/Benecard's retail and mail pharmacy contracts and the contracts related to manufacturer rebates in order to assign a true value to the 2006 pass-through pricing and rebate arrangement.

Benecard's Initial Response: Rebates received in a given calendar quarters are not necessarily indicative of rebates to be paid by manufacturers on claims incurred during that calendar quarter. Pending review by ESI ending response from ESI

IPC's Response: On November 7, 2007, PSERS received a rebate reimbursement check for $845,136.37 for 2006 rebates. The rebate reimbursement was delinquent according to the contract, which states, "pursuant to the terms of this Agreement shall be paid on a quarterly basis approximately 150 days following the end of each quarterly period." IPC has factored this reimbursement into the rebate calculation and still finds that Benecard owes PSERS $520,307.83 in rebates based on the contracted minimum guarantees for a previously contracted arrangement. The 2006 contract states PSERS will receive 100% of the rebates received by Express Scripts and paid to Benecard. IPC is currently in the process of confirming 100% of the rebates paid by manufacturers have been received by PSERS.

PERIOD	# OF MAIL CLAIMS	# OF RETAIL CLAIMS	CALCULATED MAIL REBATES	CALCULATED RETAIL REBATES	TOTAL CALCULATED REBATES	TOTAL RECEIVED - PREVIOUS	TOTAL RECEIVED - 11/7/2007	TOTAL RECEIVED	VARIANCE
1st qtr	68,443	296,773	$307,993.50	$519,352.75	$827,346.25	$365,851.62	$0.00	$365,851.62	$461,494.63
2nd qtr	72,219	304,676	$324,985.50	$533,183.00	$858,168.50	$838,843.86	$0.00	$838,843.86	$19,324.64
3rd qtr	68,352	315,696	$307,584.00	$552,468.00	$860,052.00	$715,414.07	$0.00	$715,414.07	$144,637.93
4th qtr	63,416	259,780	$285,372.00	$454,615.00	$739,987.00	$0.00	$845,136.37	$845,136.37	-$105,149.37
TOTAL					**$3,285,553.75**	**$1,920,109.55**	**$845,136.37**	**$2,765,245.92**	**$520,307.83**

Benecard's Response 4/14/2008: In 2006 PSERS was under the Preferred Savings Grid (PSG) and Medicare (SCH) rebate programs.

For the PSG rebate program Traditional PSERS was paid the greater of 100% of rebates invoiced and reconciled from manufacturers, or the per script rebate amount of $1.75 at retail and $4.50 at mail, excluding specialty injectable claims. There were 11,136 retail claims and 2,702 mail claims, the calculated rebate would be $19,488 retail and $12,159 mail for a total of $31,647. The spreadsheet titled "YC7 Feb 08 PVR" shows PSERS was credited $32,920.21 in rebates for 2006 under the PSG program.

For the SCH rebate program PSERS was paid 100% of rebates invoiced and reconciled from manufacturers. Any attempt to use a per script rebate amount to recalculate the amount paid under the SCH rebate program would not be applicable. Please see the attached PDF file called "Feb 2008 Allocation" that shows the total rebates paid to PSERS under the SCH rebate program for 2006 was $2,765,312.79. Therefore, total rebates paid to PSERS for the PSG and SCH rebate programs in 2006 were $2,798,233.00.

Contract obligations have been met, no payment owed.

IPC's Conclusion: IPC has reviewed Benecard's response and compared it to the rebate payments PSERS has received to date. The following chart is a summary of the rebate payments received, IPC's calculations and Benecard's response:

Per PSERS' finance department, PSERS has received a total of $2,765,245.92 in rebate payments. IPC calculates that PSERS should have received $2,800,691.17. The rebate payments received vary $35,445.25 from IPC's calculations. In addition, Benecard states they have paid PSERS $2,798,233.00 in rebates. Benecard's calculation varies by $32,987.08 from what PSERS has actually received. Therefore, IPC concludes that Benecard has an outstanding rebate payment owed PSERS of $35,445.25.

2006 Rebate Summary	Traditional	Medicare	Total
IPC's Calculation	$35,445.25	$2,765,245.92	$2,800,691.17
Total Received	$21,800.71	$2,743,445.21	$2,765,245.92
Variance (Received v. IPC)	**$13,644.54**	**$21,800.71**	**$35,445.25**
Benecard's Response	$32,920.21	$2,765,312.79	$2,798,233.00
Variance (Received v. Benecard)	**$11,119.50**	**$21,867.58**	**$32,987.08**

Plan Design Administrative Accuracy

IPC reviewed PSERS plan design administrative accuracy and compared the claims paid to PSERS' 2006 SPDs.

Copayments

PSERS' Medicare Basic Option co-payments are as follows:

- $250 deductible per calendar year per person (applies to both retail and mail order pharmacies combined),
- After deductible is met:
    - 25% co-insurance for all Medicare covered drugs up to $2,250
- After $2,250 is met (Coverage Gap):
    - 100% co-insurance for all Medicare covered drugs up to $3,600 in TrOOP
- After $3,600 TrOOP is met (Catastrophic Coverage):
    - 5% co-insurance for all Medicare covered drugs

PSERS' Medicare Enhanced Option co-payments are as follows:

- $250 deductible per calendar year per person (applies to both retail and mail order pharmacies combined),
- After deductible is met:
    - 25% co-insurance for all Medicare covered drugs up to $2,250
- After $2,250 is met (Coverage Gap):
    - 50% co-insurance for all Medicare covered drugs up to $3,600 in TrOOP
- After $3,600 TrOOP is met (Catastrophic Coverage):
    - 5% co-insurance for all Medicare covered drugs

PSERS' Medicare Low Income Subsidy (LIS) co-payments are as follows:

- Co-payment Category 1:
    - No deductible
    - $2.00 Generic or Multisource Brand; $5.00 Single Source Brand
- Co-payment Category 2:
    - No deductible
    - $1.00 Generic or Multisource Brand; $3.00 Single Source Brand

- Co-payment Category 3:
    - No deductible
    - $0.00 Generic, Multisource Brand, or Single Source Brand
- Co-payment Category 4:
    - $50 deductible per calendar year per person (applies to both retail and mail order pharmacies combined),
    - After deductible is met:
        - 15% co-insurance

PSERS' Traditional co-payments are as follows:

- $250 deductible per calendar year per person (applies to both retail and mail order pharmacies combined),
- After deductible is met:
    - 50% co-insurance for generic medications and non "Critical Care" brand drugs
- $3,000 maximum benefit per calendar year per person
    - Generic drugs and "Critical Care" brand drugs are still covered as stated above beyond the $3,000 maximum benefit.

IPC Findings: Since PSERS separates their benefit offerings into three distinct plans, IPC segregated the claim benefit design audit into three separate sections: Medicare – Enhanced Option, Medicare – Basic Option and Traditional Plan (as described above). Also, since the detail of these errors, to account for accumulators and threshold amounts, must be reviewed on an annuitant by annuitant basis.

Benecard's Initial Response: Pending response from ESI

IPC's Conclusion – 11/12/2007: On November 14, 2007, IPC had discussions with Benecard regarding their claim copayment calculations on qualifying claims. Following that discussion, IPC revised the method used to calculate the Medicare eligible claim copayments resulting in a reduction in this error. IPC has since sent the revised findings to Benecard for their review. Until IPC receives a response from Benecard, IPC still considers these claims in error, and the plan is owed $1,378,612.55 for this error.

PLAN OPTION	ERROR TYPE	# OF CLAIMS	ERROR AMOUNT
MEDICARE – BASIC	MEMBER OVERPAYMENT	855	$38,783.70
	PLAN OVERPAYMENT	1,610	$49,764.80
MEDICARE – ENHANCED	MEMBER OVERPAYMENT	23,265	$487,109.98
	PLAN OVERPAYMENT	35,437	$441,995.72
MEDICARE – LIS	MEMBER OVERPAYMENT	3,318	$58,164.93
	PLAN OVERPAYMENT	379	$443.15
TRADITIONAL	MEMBER OVERPAYMENT	453	$17,796.07
	PLAN OVERPAYMENT	12,497	$284,554.20
TOTAL ANNUITANT OVERPAYMENT		**27,891**	**$601,854.68**
TOTAL PLAN OVERPAYMENT		**49,923**	**$776,757.86**
TOTAL OVERPAYMENT		**77,814**	**$1,378,612.55**

Benecard's Response 4/14/2008: IPC presented 77,814 claims totaling $1,378,612.55 (per adjusted files from Erin) as having an incorrect copayment assessed, resulting in an overcharge to either the member or the client. The claims were separated by Medicare and Traditional claims. The traditional response is below, Medicare response pending ESI.

Traditional
IPC presented 12,950 commercial (non-Medicare) claims that IPC indicated processed in error with an incorrect copayment assessed, resulting in either an overcharge to the member or to PSERS.

There were 2,246 claims for which the difference between IPC and ESI's calculations of the correct copay were due to IPC's copay logic. For all of these claims IPC indicates the copay should have been equivalent to the Total Cost field in the data, presumably indicating that 100% copay should have been applied and was not. The following claim, taken from the data submitted by IPC, will be used to illustrate this issue:

Audit #	Date Filled	Ingredient Cost	Copay	Dispensing Fee	Amount Paid	Total Cost	Final Copay WCC
82604271	12/20/2006	$173.54	$175.54	$2.00	$0.50	$178.04	$178.04

Per IPC's submitted spreadsheet the TOTAL COST field is calculated as follows:

Dispensing Fee	$2.00
Add:	
Copay	$175.54
Add:	
Amount Paid (Admin Fee)	$0.50
Total Cost	$178.04

As stated IPC indicates that the FINAL COPAY amount should be equivalent to the TOTAL COST field. This logic is incorrect since the copay amount for each claim already includes the dispensing fee:

Ingredient Cost	$173.54
Add:	
Dispensing Fee	$2.00
=	
Copay	$175.54

The result of using this logic would be to charge the dispensing fee twice for each claim. This represents a potential overcharge of $3,363.85 to PSERS and its' members if this logic had been applied. These claims adjudicated correctly and therefore no reimbursement is due PSERS for this issue.

ESI is unable to determine what IPC's logic was for identifying the remaining 10,704 claims as discrepant. In order to facilitate the closure of this issue ESI researched 6 randomly generated member numbers. All claims for these members adjudicated similarly. The data for the sampled members has been included with this response (PSERS traditional copay 5 members), and includes each member's claims detail for 2006 and the rationale for the copay that applied to the claim. Member number 171321131 will be used to demonstrate that the copay logic was applied correctly. See the following example below:

The member met the $250.00 deductible on 01/07/2006, which included the following claims:

Audit Number	Amount	Transaction Date	Copay	Final Copay WCC	Ingredient Cost	Dispensing Fee	Amount Paid	Total Cost
71828684	$53.83	1/7/2006	$73.11	$94.33	$90.93	$1.45	$19.77	$94.33
71782684	$9.43	1/7/2006	$9.43	$11.38	$7.98	$1.45	$0.50	$11.38
71268684	$34.67	1/7/2006	$34.67	$36.62	$33.22	$1.45	$0.50	$36.62
71825684	$72.14	1/7/2006	$72.14	$74.09	$70.69	$1.45	$0.50	$74.09
71924657	$79.93	1/6/2006	$79.93	$81.88	$78.48	$1.45	$0.50	$81.88
Total:	$250.00							

IPC incorrectly calculated 100% copay as detailed above for audit #'s 71924657, 71825684, 71268684, and 71782684, which would have resulted in the dispensing fee being assessed twice for each claim. The member met the deductible limit on 01/07/2006, and paid the remaining $53.83 of the balance. This left $38.55 in remaining costs that are subject to the plan copay structure. The product dispensed is generic, and the plan parameters indicate a 50% copay is applied to all generic medications. The calculation of the copay is detailed below:

Ingredient Cost	$90.93
Add:	
Dispensing Fee	$1.45
Total:	$92.38
Less:	
Remaining Deductible	$53.83
Total:	$38.55
Multiply: 50%	50%
Copay	$19.28
Add:	
Remaining Deductible	$53.83
Total Copay Passed:	$73.11

IPC does not account for the deductible, and indicates a 100% copay should have been applied totaling $94.33, which would have resulted in an overcharge to the member of $21.22.

For claims that occurred after the deductible was met, the member should have incurred the following copay structure, as outlined by IPC:

- After deductible is met:
    - 50% co-insurance for generic medications and non “Critical Care” brand drugs
- $3,000 maximum benefit per calendar year per person
    - Generic drugs and “Critical Care” brand drugs are still covered as stated above beyond the $3,000 maximum benefit.

Per IPC’s data files for the remainder of the year, the member received only generic and brand medications (no critical care), and the plan’s total drug spend for this member did not equal or exceed $3,000.00. Consequently the members’ copayments subsequent to meeting the $250.00 deductible should have been 50%.

For 111 of the remaining 112 prescriptions for this member IPC incorrectly calculated the copayment at 100%, similar to the deductible claims detailed above. The 1 remaining claim presented by IPC for this member contains the following information:

Audit #	Date Filled	Copay ESI	Final Copay IPC	Ingredient Cost	Dispensing Fee	Drug Type
78209220	8/2/2006	$47.74	$65.75	$94.02	$1.45	BRAND

ESI correctly calculates the copay as 50% of the ingredient cost plus the dispensing fee:

Ingredient Cost	$94.02
Add:	
Dispensing Fee	$1.45
Total	$95.47
Multiply: 50%	50%
Total	$47.74
Copay ESI	$47.74

ESI is unsure as to how IPC arrived at the $65.75 copay indicated for this claim. Using this copay amount would have resulted in an overcharge to the member totaling $18.01. It appears that IPC used incorrect copay logic and also did not take into account the members’ deductible contribution. Therefore, it is apparent that IPC calculated the copays incorrectly, and that these claims did adjudicate with the correct copay. No reimbursement is due PSERS for this issue.

Medicare

ESI researched a randomly generated sample of 6 members from the data provided by IPC and in each case the copayment IPC indicates should have applied is incorrect, thus adjudicated claims are correct. The claims data for each member has been included with this response in document labeled PSERS Medicare copay 5 members, and contains the claims presented as discrepant by IPC and a comparative analysis of each claim and the corresponding level of coverage that applied as of the fill date. To facilitate the closure of the Medicare copay issue ESI will demonstrate how to correctly apply the 3 copay levels for Medicare. The following example will utilize the claims history for member # 170303781, taken from the claims files presented by IPC as discrepant. The full claims history for this member for 2006 has also been attached to this response for comparison to the results below.

PSERS Medicare copay structure for calendar 2006 was:

Level 1	Deductible	Member Obligation	Client Obligation
	$0.00 - $250.00	100%	0
Level 2	Total Drug Spend	Member Obligation	Client Obligation
	$250.00 - $2,250.00	25%	75%
Level 3	Maximum Out of Pocket (TrOOP)	Member Obligation	Client Obligation
	$2,250.00 - $3,600.00	100%	0
Remainder	Per Claim		
	5%, with a $5.00 brand minimum and a $2.00 generic minimum		

The member is responsible for the first $250.00 in total eligible prescription drug costs. Once the deductible is met the member pays 25% and the plan 75% of the ingredient costs and dispensing fees until a Total Drug Spend (TDS) of $2,250.00 has been reached. TDS is measured as the amount paid by both the beneficiary and the plan for each claim (i.e. the ingredient cost + dispensing fee). Once the $2,250.00 in TDS has been paid the coverage gap begins, and the member is responsible for 100% of the eligible prescription drug costs until the member has paid $3,600.00 for prescriptions in out-of-pocket costs. These payments are measured as True Out Of Pocket (TrOOP) costs paid by the member, and include all dollars paid for prescription drug products. After the member has reached $3,600.00 in TrOOP expenses the member is charged a flat 5% rate for all prescription drug costs for the remainder of the year, subject to a $5.00 minimum for branded medications and a $2.00 minimum for generic medications.

Member # 170303781 met each level of payment on the following dates:

		Total	Date Total Reached
Level 1	Deductible	$250.00	**01/06/2006**
Level 2	TDS	$2,250.00	**03/28/2006**
Level 3	TrOOP	$3,600.00	**08/01/2006**

Deductible

The deductible was met on 01/06/2006, when the member received a prescription totaling $534.21 in ingredient cost and dispensing fees:

Audit #	Ingredient Cost	Dispensing Fee	Deductible	Remainder	25% of remainder	Copay	Admin Fee	AMT PD
71944365	$532.21	$2.00	$250.00	$284.21	$71.05	$71.05	$1.28	$214.44

The member is initially charged the full deductible of $250.00, leaving $284.21 in remaining ingredient cost and dispensing fees due. The copay logic is then moved to level 2, where the member is responsible for 25% and the client 75% in TDS until $2,250.00 is reached. The 25% copay is applied to the $284.21 remaining, generating a copay of $71.05. The total remaining is the clients' responsibility, which is $213.16 in ingredient cost and dispensing fees and $1.28 in administrative fees. This calculation is summarized below:

Ingredient Cost	$532.21
Add: Dispensing Fee	$2.00
Total	$534.21
Less: Deductible	$250.00
Remainder	$284.21
Less: 25% copay	$71.05
Remainder	$213.16
Add: Administrative Fee	$1.28
Amount Billed to Client	$214.44
Amount Paid by Member	$321.05

For this claim IPC indicated a copay of $133.55 should have been applied, and that this claim has resulted in a member overcharge:

COPAY	TOTAL COST	FINAL CALCED COPAY	VARIANCE	Audit #	Eessn	Dtfilled
$321.05	534.21	$133.55	$187.50	71944365	170303781	1/6/2006

It appears IPC is calculating that the level 2 copay of 25% should have been applied to the entire cost of the claim and no deductible charged the member, based on the $133.55 copayment IPC has indicated:

TOTAL COST	$534.21
FINAL CALCED COPAY	$133.55
FINAL CALCED COPAY / TOTAL COST	25%

This copay is incorrect as detailed above, and if applied without being reduced by the deductible would have resulted in an overcharge to PSERS totaling $151.94.

Level 2

Once the deductible is met the members' responsibility is reduced to 25% of the total ingredient cost and dispensing fees assessed per claim, until a TDS of $2,250.00 is reached. The member correctly paid this copay for pharmaceutical products dispensed after the deductible was met on 01/06/2006 until 03/20/2006, when the TDS reached $2,250.00. For the majority of these claims IPC indicated that a 100% copay should have been applied, which would have been incorrect until 08/01/2006, when the member had paid a total of $3,600.00 in TrOOP costs. The copayments indicated by IPC are summarized below, with the correct 25% copay cost included for comparison:

Audit #	Date Filled	Ingredient Cost	Dispensing Fee	Total	25% Copy	Copay Assessed	Copay per IPC	Copay % IPC	Difference
72227452	2/2/2006	$532.21	$2.00	$534.21	$133.55	$133.55	$249.41	47%	$115.86
72375274	1/30/2006	$8.03	$2.00	$10.03	$2.51	$2.51	$10.03	100%	$7.52
72097440	1/30/2006	$27.56	$2.00	$29.56	$7.39	$7.39	$29.56	100%	$22.17
72373638	1/29/2006	$4.41	$2.00	$6.41	$1.60	$1.60	$6.41	100%	$4.81
72814836	1/28/2006	$16.91	$2.00	$18.91	$4.73	$4.73	$18.91	100%	$14.18
72171270	1/25/2006	$1.92	$2.00	$3.92	$0.98	$0.98	$3.92	100%	$2.94
72924026	1/25/2006	$24.69	$2.00	$26.69	$6.67	$6.67	$26.69	100%	$20.02

If the copays calculated by IPC had been applied the member would have been overcharged in total $187.50 for the claims that IPC has indicated are discrepant.

Level 3

As indicated above once the total TrOOP cost incurred by the member for eligible prescription drug costs has reached $3,600.00, the members copayments are reduced to a flat 5% rate for all prescription drug costs for the remainder of the year, subject to a $5.00 minimum for branded medications and a $2.00 minimum for generic medications. This total was reached by the member on 08/01/2006, after which the member was correctly charged the greater of 5% of the ingredient cost and dispensing fees, or the $5.00 and $2.00 brand and generic minimums, respectively. For all claims IPC presented as discrepant they indicate either a 5% copay should have applied when the $5.00 or $2.00 minimum correctly applied, a 60% copay should have applied when the 5% copay was correctly applied, or a 100% copay should have applied when the $5.00 or $2.00 minimum correctly applied. An example of each of these copay amounts is presented below, with the correct copay total included for comparison:

Audit #	Date Filled	Ingredient Cost	Dispensing Fee	Total	5%	Copay Assessed	Copay per IPC	Copay % IPC
82941143	12/30/2006	$36.92	$1.75	$38.67	$1.93	$5.00	$1.93	5%
82909292	12/23/2006	$7.68	$1.75	$9.43	$0.47	$2.00	$0.47	5%
78331466	8/25/2006	$520.04	$2.00	$522.04	$26.10	$26.10	$315.78	60%
78434236	8/15/2006	$24.61	$1.75	$26.36	$1.32	$5.00	$26.36	100%

It appears IPC did not apply the minimum $5.00 brand and $2.00 generic charges when 5% of the combined ingredient cost and dispensing fees were less than the minimum. The claims for which IPC indicated a 100% copay should have been applied were incorrect since the TrOOP cost limitation had been met by the member as of 08/01/2006. The one claim that IPC indicated a 60% copay should have been applied is incorrect and the 5% copay was correctly applied.

Based on the research conducted and illustrated in the examples above, ESI has determined that the Medicare copayments for the claims processed during the audit period were correctly applied. It appears that IPC did not apply this structure correctly when performing their analysis, and therefore no reimbursement is due PSERS for this issue.

IPC's Conclusion: IPC has reviewed Benecard's response in regards to the copayment errors. Overall, IPC has learned from Benecard's response that the administrative fee is included in the plan pay and member share amount field of the claims file. The addition of the administrative fee into the claim calculation is not specified in the file layout and is a practice that is rather unique to Benecard/ESI. Generally, our experience indicates that the administrative fees are invoiced separately from the claims to the client. IPC agrees that we did not take this unique administrative billing into account in our original analysis. Therefore, IPC has since removed the administrative fee from the plan pay amount and has re-run the copay analysis. IPC will also be checking to make sure PSERS was not double billed for these administrative fees.

In regards to the Traditional copayment issues, IPC has reviewed Benecard's response regarding the 100% copay claims. IPC has removed these claims from the analysis, and recalculated the copayments without these claims included.

The following chart represents IPC's conclusion regarding the copayment errors:

PLAN OPTION	ERROR TYPE	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	MEMBER OVERPAYMENT	414	$30,737.25
	PLAN OVERPAYMENT	1,291	$37,106.09
MEDICARE - ENHANCED	MEMBER OVERPAYMENT	9,717	$370,393.62
	PLAN OVERPAYMENT	27,970	$285,738.80
MEDICARE - LIS	MEMBER OVERPAYMENT	3,318	$58,164.93
	PLAN OVERPAYMENT	379	$443.15
TRADITIONAL	MEMBER OVERPAYMENT	315	$19,427.68
	PLAN OVERPAYMENT	67	$18,512.05
TOTAL ANNUITANT OVERPAYMENT		**13,764**	**$478,723.48**
TOTAL PLAN OVERPAYMENT		**29,707**	**$341,800.08**
TOTAL OVERPAYMENT		**43,471**	**$820,523.56**

Brand Penalty

According to Appendix A of the contract:

> When a Generic Drug is available and the prescribing physician has not specified that the Brand Drug must be dispensed as written on the Prescription Order, the Generic Drug will be dispensed and the dispensing pharmacist will be reimbursed based upon the applicable Generic Drug price. Annuitants who decline the Generic Drug under these circumstances will be required to pay the generic co-payment plus the difference in price between the Brand Drug and the equivalent Generic Drug.

IPC Findings: IPC has determined that Benecard assessed the Brand Penalty correctly for the 2006 claims. The brand penalty was appropriately added to the patient pay amount and no errors were noted.

Day Supply Limitation

IPC Findings: PSERS has a 90 days supply limitation on all claims. There were 10 claims that exceeded this day supply limitation totaling $73.75 in overpayments.

Benecard's Initial Response: Pending response from ESI

IPC's Conclusion – 11/12/2007: PSERS has contracted with Benecard for the administration of the prescription drug program. If Benecard has subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard has had the initial audit report since August 23, 2007 and has been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $73.75 for this error.

Benecard's Response 4/14/2008: IPC presented 10 claims totaling $73.75 in discrepant charges as having adjudicated outside of the established 90 day supply plan parameter. ESI researched all claims. In all cases the member received Prior Authorization (PA) to obtain a greater than 90 day supply. No reimbursement is due PSERS for this issue.

IPC's Conclusion: IPC agrees that the 10 claims identified in error did have a prior authorization included on the claim. IPC no longer considers these claims in error.

First Fill Starter Quantity Limitation

IPC Findings: Included in PSERS' plan design is a requirement that prior to an annuitant receiving coverage for a medication in a quantity in excess of 34 days, they must first receive a claim for that medication for a 34 days supply or less. This allows the annuitant to verify the effectiveness in treating their condition without unexpected side effects prior to receiving a covered claim for a larger quantity of medication that may not be consumed. This claim edit was first implemented for PSERS in 2006. Therefore, annuitants that received the medication in 2005 were "grandfathered" into the coverage for that medication. The following chart represents the claims which were filled with a days supply greater than 34 prior to receiving a claim for 34 days or less (it should be noted that if an annuitant received coverage for a claim for more than a 34 days on the initial coverage date, but received coverage for the same medication at a later date, it was assumed that coverage for these medications was for a continuation of treatment and does not appear as an error in the chart below):

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE – BASIC	310	$10,182.76
MEDICARE – ENHANCED	13,057	$444,618.93
TRADITIONAL	214	$8,017.96
TOTAL	**13,581**	**$462,819.65**

Benecard's Initial Response: Pending response from ESI and review by Benecard.

IPC's Conclusion – 11/12/2007: PSERS has contracted with Benecard for the administration of the prescription drug program. If Benecard has subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard has had the initial audit report since August 23, 2007 and has been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $462,819.65 for this error.

Benecard's Response 4/14/2008: IPC presented 13,581 claims totaling $462,819.65 as having adjudicated incorrectly per the First Fill Starter limitation. IPC's audit report contained the following:

> Included in PSERS' plan design is a requirement that prior to an annuitant receiving coverage a medication in a quantity in excess of 34 days, they must first receive a claim for that medication for a 34 days supply or less. This allows the annuitant to verify the effectiveness in treating their condition without unexpected side effects prior to receiving a covered claim for a larger quantity of medication that may not be consumed. This claim edit was first implemented for PSERS in 2006. Therefore, annuitants that received the medication in 2005 were "grandfathered" into the coverage for that medication. The following chart represents the claims which were filled with a days supply greater than 34 prior to receiving a claim for 34 days or less.

To establish a 90% confidence interval ESI researched a randomly generated sample of 352 member numbers totaling 360 claims from the claims presented by IPC. This analysis was performed to determine if any members in the sample received a prescription exceeding a 34 days supply prior to first obtaining a fill for the same medication.

There were 339 claims for which the member received a fill of the same medication in 2005, and therefore was grandfathered into coverage and was allowed to receive a subsequent fill greater than 34 day supply.

There were 10 claims for which the members received a 30 day fill of the same medication in 2006 prior to receiving a greater than 34 day supply for the same product. These claims adjudicated correctly per PSERS intent as documented on the PSERS HOP website:

> The first time that you fill a prescription under the Basic or Enhanced Medicare Rx Option, you are limited to a first fill starter quantity, which cannot exceed a 33-day supply. If you are taking the medication for the first time, this initial supply should be sufficient for you and your doctor to determine if it is having the anticipated results without unintended detrimental side effects.

There were 10 claims for which the member received a PA to allow a greater than 34 day supply prior to previously obtaining a 34 day supply or less.

The remaining claim was for the product ESTRING, an estrogen product that is pre-packaged in quantities of 1 with a 90 day supply. Certain medications have an altered quantity limit since the package cannot be broken due to packaging, which is true for Estring.

All claims adjudicated correctly per the random sample, and therefore no reimbursement is due PSERS for the first fill starter limitation issue.

IPC's Conclusion: IPC has reviewed Benecard's response regarding the first fill starter quantity program. IPC agrees that claims for annuitants that had the same medication filled in 2005 should not be included as in error. In addition, IPC agrees that claims for annuitants that received a prior authorization for the same medication prior to receiving the claim that was counted in error should not be included as an error. IPC has removed the claims with these two types of issues from the claims in error. The following is a summary of IPC's conclusion regarding the first fill starter quantity error claims:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	72	$2,114.12
MEDICARE - ENHANCED	2,471	$82,995.67
TRADITIONAL	109	$4,357.59
TOTAL	**2,652**	**$89,467.38**

Medications with Dispensing Limitations

IPC Findings: According to the Traditional Plan, PSERS' limits its annuitants to 4 dosages of oral male erectile dysfunction medication per month with a prior authorization. There were zero claims identified in the audit that exceeded this limitation. In addition, the Traditional Plan limits its annuitants to a 90-day lifetime maximum of smoking cessation medications. There were no claims identified in the audit that exceeded this limitation.

The Medicare Plan's dispensing limitations were defined for the Basic and Enhanced HOP in the Medicare Formulary as submitted to the Centers for Medicare and Medicaid Services (CMS) with the 2006 PDP application. There were no claims identified in the audit that exceeded the dispensing limitations as defined in the formulary.

Prior Authorized Medications

IPC Findings:

For the Traditional Plan, PSERS requires the following list of medications to be prior authorized:

- Alferon N – interferon alfa N3
- Brethine – terbutiline
- Calcitonin
- Calcitriol
- Caverject – *alprostadil*
- Delatestryl – testosterone ethanthate
- Epipen – epinephrine
- Forteo – teriparatide
- Genotropin – *somatropin*
- Gentamicin
- Glucagon – glucagon
- Heparin – heparin sodium
- Humatrope – *somatropin*
- Hyalgan – hyaluvonate sodium
- Imitrex – sumatriptan
- Methotrexate
- Miacalcin – calcitonin – salmon
- Nebcin – tobramycin
- Norditropin – *somatropin*
- Nutropin – *somatropin*
- Nutropin AQ – *somatropin*
- Protropin – *somatrem*
- Saizen – somatropin
- Solganal – aurothioglucose
- Synarel – nafarelin acetate
- testosterone propionate
- Vitamin B12 – cyanocobalamin
- All Critical Care Medications

Of the medications that are listed above, there were 3 claims for Epipen that were covered without a prior authorization being noted. The amount in error for these claims total $98.98.

Benecard's Initial Response: Please see response from 2004 (Jan-June) audit response: "Epipen (54 claims) paid without a PA because Mr. Sanford Barth gave us direction in September 2003 to cover this self injectable without a PA. Epipen is used in emergencies to prevent anaphylactic allergic reaction and if treatment is delayed because the member is waiting for a PA, adverse reactions and consequences could occur. For the safety of members it was decided that this medication would be covered without a prior authorization."

IPC's Conclusion – 11/12/2007: IPC agrees with Benecard's response regarding the Epipen Claims. IPC no longer considers these claims in error.

The Medicare Plan's prior authorization medications were defined in the Basic and Enhanced HOP in the Medicare Formulary as submitted to CMS with the 2006 PDP application. A summary of the covered claims that were required to have a prior authorization that did not have one is as follows:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE – BASIC	41	$1,617.04
MEDICARE – ENHANCED	1,697	$110,354.95
TOTAL	**1,738**	**$111,971.99**

Benecard's Initial Response: The basic plan had 41 claims in question, for 3 different medications, Lunesta, Topamax and Trentinion. Lunesta does not require a prior authorization, unless it exceeds the quantity per day supply which is 15 for 30 days at retail and 45 per 90 at mail. 36 Lunesta claims processed correctly and 2 are being investigated by ESI, response will follow. There was one claim for Topamax which processed correctly because they previously used another product within this therapeutic class, so they were grandfathered and did not require a prior authorization. There were 2 claims trentinion, which are being investigated further by ESI.

The enhanced claims are still being reviewed by ESI.

IPC's Conclusion – 11/12/2007: IPC agrees with Benecard's response regarding the Lunesta, Topamax and Trentinion claims for the Medicare Basic plan. IPC no longer considers 37 of the original claim errors in error. IPC still considers 2 Lunesta claims and 2 Tretinoin claims in error.

PSERS has contracted with Benecard for the administration of the prescription drug program. If Benecard has subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard has had the initial audit report since August 23, 2007 and has been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $110,526.16 for this error.

A summary of the covered claims that were required to have a prior authorization that did not have one is as follows:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	4	$171.21
MEDICARE - ENHANCED	1,697	$110,354.95
TOTAL	**1,701**	**$110,526.16**

Benecard's Response 4/14/2008:

The Basic claims: The 2 Lunesta being investigated by ESI, response will follow. There were 2 claims trentinion, which are being investigated further by ESI.

The enhanced claims: IPC presented 1,697 claims totaling $110,354.95 in discrepant charges as MEDICARE – ENHANCED Prior Authorization (PA) required claims. For these claims IPC has indicated that a PA should have been obtained prior to the medication being dispensed to the member, and that no PA was issued.

ESI selected a sample of the most commonly occurring member ID numbers and the highest dollar total per discrepant claim. This sample includes 389 claims totaling $38,990.06 in error totals. This sample is representative of over 35% of the claims and 23% of the dollar totals presented for this issue.

There were 254 claims where a PA was issued at the member level. When a PA is issued at the member level it is inclusive of a specific member, for a specific period of time, and for a specified drug or classification of drugs. The PA code appears on only the initial claim, and is not repeated for all claims subsequent to the original fill. (Benecard Included with this response a pdf containing samples. These Samples contained screen prints detailing these PAs.

As indicated in the screen prints provided this member will be able to receive drugs included in generic code number (GCN, listed as GC above) 9268 from 01/01/2006 through 12/31/2006 without requiring a PA to be issued for each dispensed medication within this GCN. See documentation PA documentation 2006 PDF file.

There were 124 claims for the drug Lunesta. Per PSERS Health Options Program (HOP) website Lunesta is a covered medication as of 01/01/2006 with a quantity limit. This is detailed on the 2006 formulary listed within the website: www.hopbenefits.com/pdfs/abFormularyFinal.pdf, all these claims were for quantities that are less than or equal to the quantity limit, therefore no PA is required for these claims to process.

The remaining 11 claims were fills for the same member for the step therapy drug Zonegran. For this drug a PA is required for the initial dispensing; additional PAs are not required for subsequent fills once the step therapy program has begun. The coverage rule contains the following logic:

The UM ST PA TOPAMAX/ZONEGRAN coverage rule applies when ALL of the following occur: 1) the drug is in drug group pal00067 (drug group pal00066 includes generic code 9268 TOPIMIRATE and generic code 9880 ZONISAMIDE . 2) The number of prescriptions in the past 130 days is less than 1 for drugs in drug group: pal00066.

All 11 claims were for the drug Zonegran, which is included in drug group pal00066 within therapy class 54700, OTHER ANTICONVULSANTS. Drug Group pal00066 includes the following pharmaceutical products:

Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54000; ANTICONVULSANT DRUGS
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54100; CARBAMAZEPINES
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54200; ANTICONVULSANT BENZODIAZEPINES
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54300; HYDANTOINS
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54400; VALPROIC ACID AND DERIVATIVES
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54500; SUCCINIMIDES
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54600; ANTICONVULSANT BARBITURATES
Include - Effective: 2003-01-01 Expires: 2003-01-02	Therap. Class Begin: 54700; OTHER ANTICONVULSANTS
Include - Effective: 2003-01-01 Expires: 2049-12-31	Generic Code: 9268; TOPIRAMATE
Include - Effective: 2003-01-01 Expires: 2049-12-31	Generic Code: 9880; ZONISAMIDE
Include - Effective: 2003-01-01 Expires: 2049-12-31	Therap. Class Begin: 54000; ANTICONVULSANT DRUGS

This member received a previous fill of this product on 12/26/2005, therefore did not require a PA in order to receive additional fills of this product.

ESI finds all claims adjudicated correctly and therefore no reimbursement is due PSERS for the PA REQUIRED issue.

Benecard's Response April 25, 2008: The Basic claims: Benecard had questioned why 4 claims were allowed to process for the drugs Lunesta and Tretinoin. The 2 Lunesta claims adjudicated with the following day supply and quantity totals:

Member ID	Quantity	Day Supply	Fill Date
20330068601	45	45	08/02/2006
27830493801	30	60	12/18/2006

Both claims followed the Lunesta Tabs mail order, maintenance network dispensing policy. Per this dispensing policy members are allowed to obtain a quantity of 45 units per 90 days if the product is dispensed through a mail order or maintenance network. Both claims were filled through a maintenance network pharmacy and therefore adjudicated correctly.

For 1 Tretinoin claim the member paid the ingredient cost and the client was billed only the administrative fee of $1.28. The remaining claim adjudicated with the member paying the standard copay, and the client was billed $67.01. Benecard has stated that it was PSERS intention to not cover this product. ESI implemented a coverage rule that rejected Tretinoin claims if the product dispensed was included in a specific drug group. A drug group is a listing of products by NDC, GCN, GPI, or generic name that ESI utilizes for coverage logic. In this case the Tretinoin product that was dispensed was not included in the drug group that was intended to exclude all Tretinoin from coverage. ESI researched all claims that adjudicated for the product Tretinoin for which the client was charge more than the $1.28 administrative fee and a PA was not issued to allow coverage. There were 22 claims that processed for this product that resulted in a total billed amount to PSERS of $739.84. ESI agrees to reimburse PSERS $739.84 for the Tretinoin claims that received coverage during the audit period.

IPC's Conclusion: In regards to the Medicare Basic prior authorization issues, IPC believes that Benecard has been given sufficient time to respond to the outstanding copayment errors. IPC still considers these claims in error.

In response to Benecard's response to the Medicare Enhanced prior authorization issues, IPC has reviewed Benecard's response and process for handling PAs "issued at the member level." Although, IPC agrees with this process from a theoretic perspective, IPC would strongly recommend that Benecard carry the PA numbers for these claims to subsequent claims. IPC no longer considers the claims that had this issue in error.

In addition, IPC has reviewed Benecard's response regarding Lunesta and Zonegran. IPC agrees with their response and no longer considers these claims in error.

IPC agrees that the claims that were charged only an administrative fee are not to be counted in error. IPC has removed these from the analysis.

The following is a summary of prior authorization claims IPC still considers in error:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	1	$67.01
MEDICARE - ENHANCED	32	$1,135.04
TOTAL	**33**	**$1,202.05**

Non Covered Medications

IPC Findings:

For the Traditional Plan, PSERS has opted to not cover certain types of medications. Below is a list of these excluded drugs and IPC's review of coverage extended for these medications is as follows:

- Experimental/Investigational Drugs
- Medications for which the cost is recoverable under a program such as Medicare, Veterans' Administration, Workers Compensation, motor vehicle insurance, etc.

- Medications administered by a physician or prescriber, and those not dispensed at a pharmacy such as those you receive at your doctor's office, in a hospital, clinic or other care facility.

- Immunologicals, vaccines, allergy sera or extracts, biological products or treatment, biological or other sera, blood and blood plasma or other derivatives

- Contraceptive drugs, whether oral, injectable, topical or implanted, even when prescribed for other than contraceptive purposes

- Medications prescribed for the treatment of infertility and fertility enhancement drugs.

- Injectable medications and IV infused medications, except those self-administered injectables listed in Exhibit A or "critical care" brand drugs listed in Exhibit B.

- Injectables provided by home care organizations as part of infusion therapy, even if listed in Exhibits A or B, and charges for the administration or injection of drugs

- Prescription drugs utilized for cosmetic purposes such as Retin A and Accutane, and hair re-growth medications such as Rogaine.

- Prenatal vitamins and children's vitamins

In total, there were 87 claims that accounted for $1,224.73 paid by the plan for excluded medications.

Benecard's Initial Response: 25 claims of these claims paid correctly, as they are covered medications that do not fall into any of the excluded categories. These include claims for anti-infective dermatologic products including sodium sulfacetamide/sulfur, finacea, evoclin, metrolotion, brevoxyl, metronidazole cream, and metrogel, acetaminophen poisoning antidote, acetylcysteine an inhaled product, and Epipen. There are then 11 claims that the plan did not pay anything for. The remainder of the claims listed is for non covered medications and discrepancy amount stated on the claim payment file is the ESI portion of the administration fee a $0.50 per retail claim charge. This fee gets added to the overall administrative fee per the contract which is $0.55 per retail claim. Based on this information, there are no miss adjudicated claims and all 87 claims paid correctly.

IPC's Conclusion – 11/12/2007: IPC agrees with Benecard's response regarding the dermatological products, acetaminophen poisoning antidote, and Epipen claims for the Traditional plan. IPC no longer considers these claims in error. IPC also does not consider the claims that only had the administrative fee charged to be in error.

The Basic and Enhanced HOP Medicare Plan's non covered medications were defined in the Medicare Formulary as submitted to CMS with the 2006 PDP application. The Medicare – Basic plan is limited to medications defined by Medicare Part D as "covered drugs"; the Medicare – Enhanced plan covers certain "enhanced" drugs, over and above the Medicare Part D "covered drugs" that were defined at the onset of the plan. A summary of the Basic and Enhanced HOP Medicare claims that were covered by the plan for non-covered drug is as follows:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	246	$5,395.15
MEDICARE - ENHANCED	7,842	$268,084.37
TOTAL	**8,088**	**$273,479.52**

Benecard's Initial Response: Pending response from ESI

IPC's Conclusion – 11/12/2007: PSERS has contracted with Benecard for the administration of the prescription drug program. If Benecard has subcontracted certain services to other vendors, it is Benecard's responsibility to manage their subcontractor arrangement to the requirements defined in the PSERS agreement. Benecard has had the initial audit

report since August 23, 2007 and has been given adequate time to respond to the report. Therefore, IPC still considers these claims in error, and the plan is owed $273,479.52 for this error.

Benecard's Response April 25, 2008:

Non Covered Medications - MEDICARE – ENHANCED IPC presented 8,088 Medicare claims as having adjudicated incorrectly, and for each claim indicates the product dispensed was a non-covered medication as of the fill date. ESI selected a random sample of 10 members from each of the top 5 recurring NDC's within the claims file, which represented 50 claims. There were 49 claims that adjudicated as transition claims; PSERS allows its members to receive a onetime fill of a medication while transitioning from a commercial plan to one of the Medicare plans. These transition claims are restricted to a 34 day supply or less. All 49 claims processed with a days supply of 34 or less, and therefore adjudicated correctly. The 1 remaining claim contained a PA authorizing the fill of a formulary medication. Based on this sample ESI finds all claims adjudicated correctly and no reimbursement is due PSERS for this issue.

Non Covered Medications - MEDICARE – BASIC Medicare NON-Covered BASIC

IPC presented 247 claims as non covered products that incorrectly received coverage. ESI researched all claims. There were 160 claims for which the member paid the cost of the claim and PSERS was charged only the $1.28 administrative fee. There were 2 claims for which an override was issued to allow the claim to process. There were 5 claims for the products Nexium and Aciphex that are listed on the PSERS HOP website as having quantity limitations; none of these claims exceeded 34 units within a 34 day supply. For 1 claim the product NITROSTAT was dispensed; this is not a restricted product. The remaining 79 claims all adjudicated within the 90 day Medicare D transition rule, which allowed a once only fill during the first 90 days Medicare D became an active as of 01/01/2006.

IPC's Conclusion: IPC has reviewed Benecard's response regarding the non-covered drugs. IPC agrees that claims that were charged only an administrative fee are not in error. In addition, IPC agrees that Nexium, Aciphex, and Nitrostat are covered items. Therefore, IPC removed these from the analysis. IPC also removed the claims that satisfied the Medicare transition policy.

The following is a summary of the outstanding non-covered claims that are in error:

PLAN OPTION	# OF CLAIMS	ERROR AMOUNT
MEDICARE - BASIC	3	$172.38
MEDICARE - ENHANCED	3,827	$144,878.93
TOTAL	**3,830**	**$145,051.31**

Audit Conclusion

IPC's audit of ingredient cost, dispensing fee, and benefit design for claims incurred by the PSERS' Plan between January and December 2006 finds a total amount in error listed below. The following chart represents a summary of the errors identified in the audit:

ITEM	DETAILS	# of Claims in Error	$ Amount of Error
Retail Pricing	Ingredient Cost		$0.00
	Dispensing Fee		$0.00
Mail Pricing	Ingredient Cost		$0.00
	Dispensing Fee		$0.00
Rebates			$35,445.25
Plan Design Administrative Accuracy	Copayments	43,471	$820,523.56
	Days Supply	-	$0.00
	First Fill Starter Quantity	2,652	$89,467.38
	Prior Authorization drugs	33	$1,202.05
	Non Covered Drugs	3,830	$145,051.31
Total Errors		**49,986**	**$1,091,689.55**

1061 Peruque Crossing Court • O'Fallon, Missouri 63366 • (636) 614-1344
Fax (636) 639-8021 • E-Mail: Ken.Anderson@ipc-inc.com • Website: www.ipc-inc.com