Pharmacy Benefit Manager (PBM) Request for Proposals (RFP) – Scope of Work

State Employee Benefits Committee Meeting

March 7, 2025

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Background

- Pharmacy benefit manager (PBM) services are provided by CVS Health to State Employee Group Health Insurance Plan (GHIP) enrollees in the following groups:
  - Commercial population: Active State employees, including school districts, charter schools and higher education instruction employees, and non-State groups that are allowed to participate in the GHIP according to Delaware Code (e.g., municipalities, local fire departments)
  - Employer Group Waiver Plan (EGWP) population: Medicare pensioners

Additional context: GHIP EGWP

- The Standard Medicare Part D Benefit is the leanest plan design that a Part D plan can offer in order to meet Medicare Part D (prescription drug) requirements
- Standard Part D Benefit plans are commonly found in the individual marketplace and only cover Medicare Part D medications
- Medicare allows employer plan sponsors to offer their Medicare-eligible retirees the same or better Rx benefits than the Standard Medicare Part D benefit
- The GHIP's EGWP provides much richer benefits than the Standard Medicare Part D benefit, including:
  - No deductible for GHIP participants (vs. Standard Part D Benefit deductible of $590)
  - Flat dollar copays for GHIP participants (vs. Standard Part D Benefit coinsurance of 25% member cost share)
  - GHIP EGWP covers additional "non-Part D" drugs, such as diabetic supplies and cough & cold medications
- For the CY2025 plan year, the Inflation Reduction Act (IRA) reduced the Standard Part D Benefit True Out of Pocket (TrOOP) to $2,000 (from $8,000 in 2024), and the GHIP EGWP also reduced its TrOOP to $2,000 (from $2,100 in 2024) to match the Standard Part D Benefit

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Background (continued)

- The State's current contract with CVS Health expires on June 30, 2026 for the Commercial population and on December 31, 2026 for the EGWP population
- Following the customary timeline for GHIP vendor contracts, work on the next Request For Proposals (RFP) for PBM services must begin now to allow for sufficient time to conduct the procurement (9-10 months) and contracting and implementation activities (6 months) ahead of the next contract effective date, which is July 1, 2026 for Commercial and January 1, 2027 for EGWP
- Today's discussion will focus on the scope of services that will be incorporated into the next PBM RFP, with additional context provided through an update on the CVS market check along with some perspectives from the broader marketplace on pharmacy benefits delivery models

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Update on the CVS market check

- As permitted by the State's contract with CVS Health (CVS), the State retained WTW to conduct a market check to ensure that CVS pricing guarantees for the GHIP remain competitive with the pharmacy benefit marketplace
  - This year's market check is for the contract term effective July 1, 2025, through June 30, 2026 for the Commercial plan and calendar year 2026 for the EGWP plan
- Per the market check contractual provision, the aggregate value of the current arrangement will be compared to the marketplace (i.e., retail, home delivery, specialty, rebates and administration fees)
  - Should market conditions result in a 1% or greater savings of gross plan (plan and member cost share combined) costs, the State — or its representative — will provide a report of the market check findings to CVS
- WTW requested a proactive market check offer from CVS to be submitted by the week of January 13th
  - CVS responded on January 17 and indicated that there is no opportunity for improvements; therefore, they did not provide an offer
- WTW made an additional request for improvements from CVS to be submitted by the week of February 24th
  - CVS has stated they are unable to make improvements due to being underwater on the rebate guarantees, but is working to provide an option to further re-balance pricing between brand and generic specialty drugs to better align the plan costs with the market price of the drug

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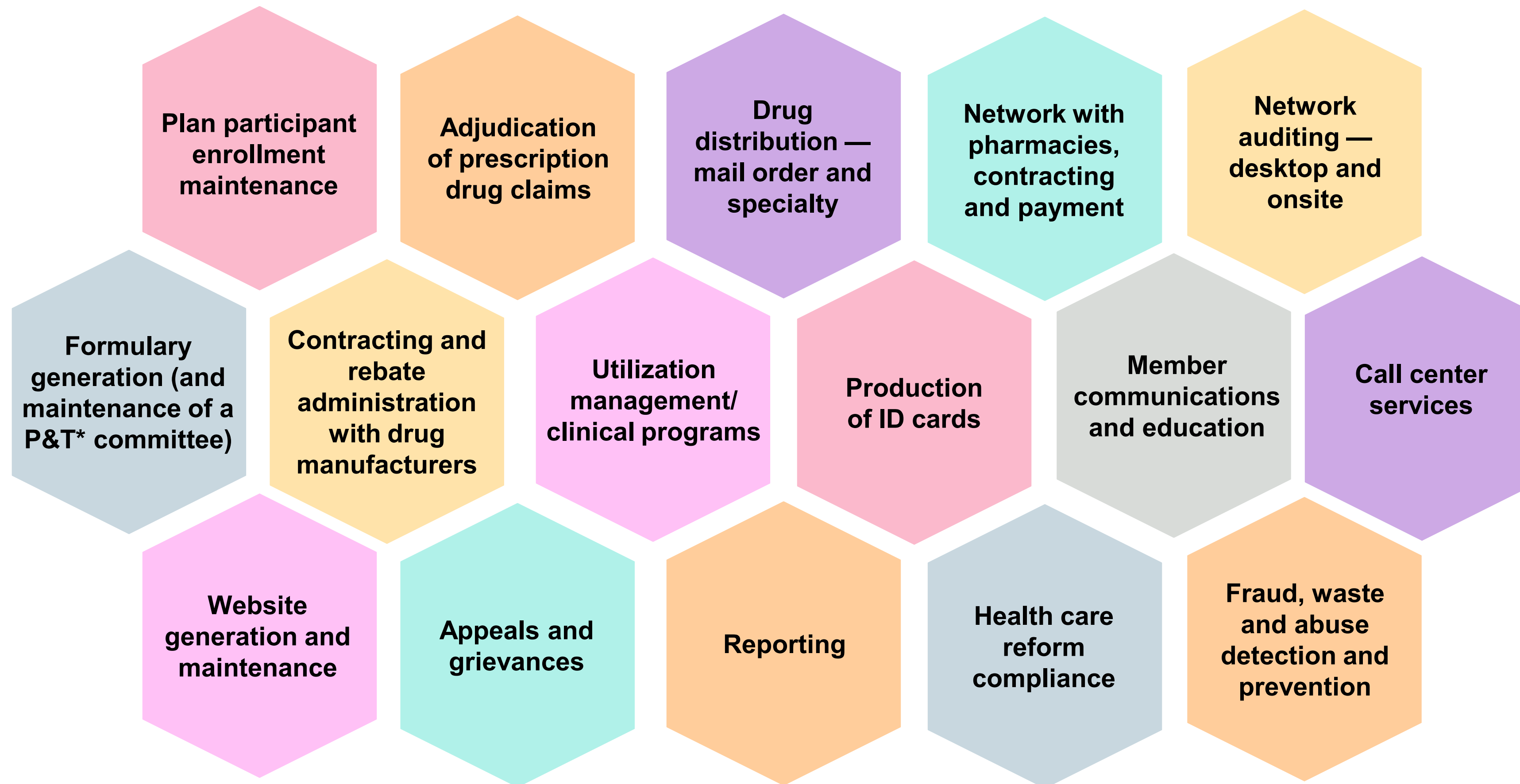
Marketplace perspective

What do PBMs do?



Other typical PBM services provided by CVS Health to the GHIP:

- Comprehensive management of Medicare Part D EGWP
- Integration with GHIP medical and wellness programs
- Secure delivery of claims data to the Delaware Health Information Network and the GHIP's health data warehouse

*Pharmacy and Therapeutics Committee

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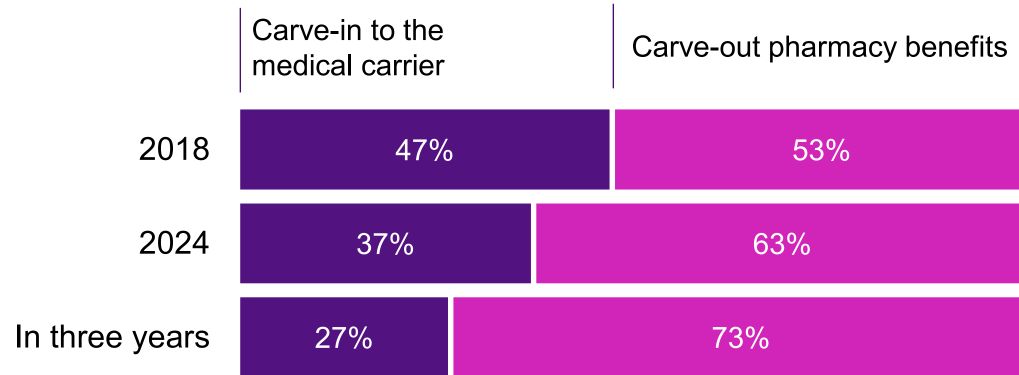
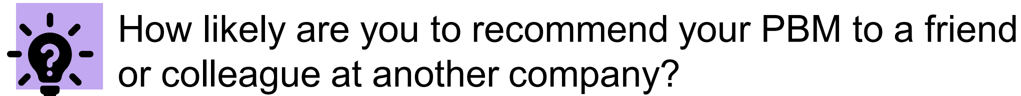
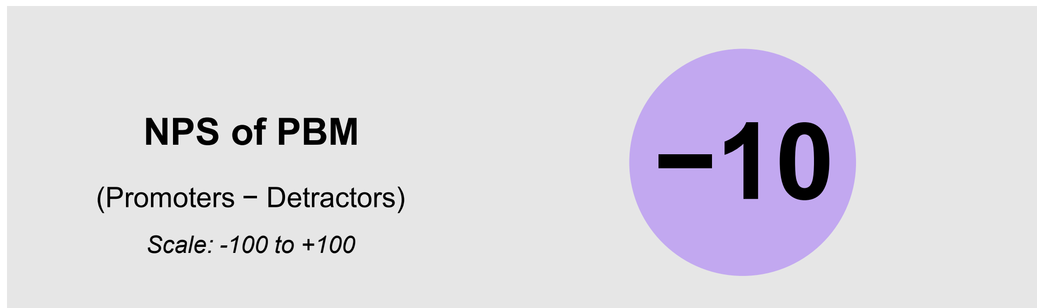
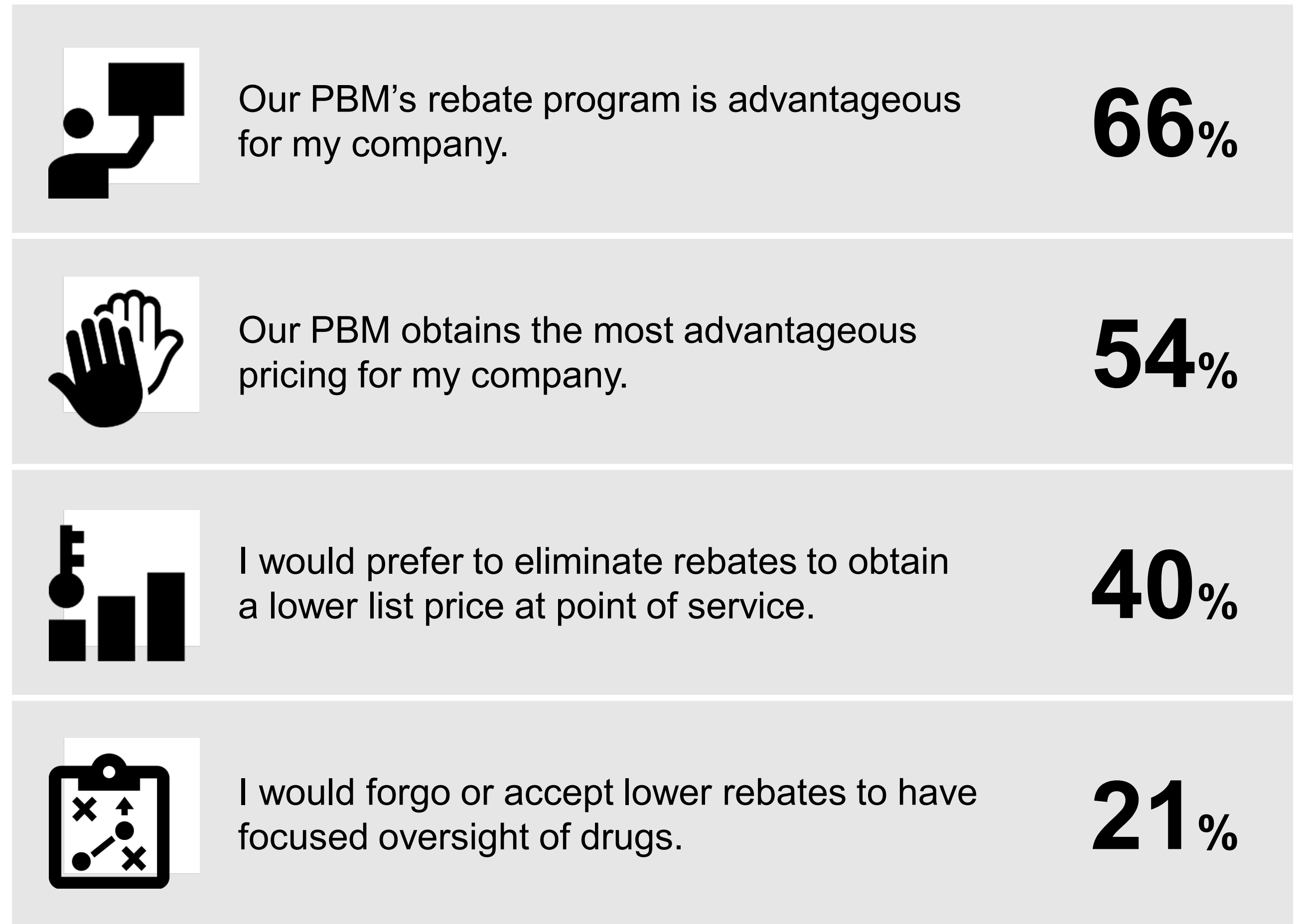
Marketplace perspective (continued)

WTW national survey finding: Employers are seeking changes to the delivery of pharmacy benefits









Note: Percentages may not sum up to 100% due to rounding.
Source: WTW 2024 Best Practices in Healthcare Survey. Reflects 417 survey respondents representing 6M employees.

(% of "Agree" or "Strongly agree")

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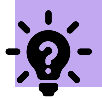
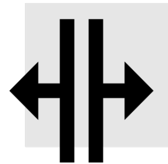
Marketplace perspective (continued)

WTW national survey finding: Heightened employer interest in alternative drug channels and pricing

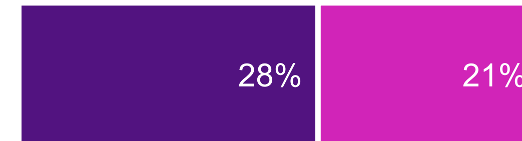


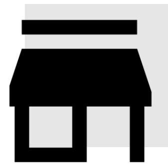
General Rx: Which of the following pharmacy benefit management strategies does your organization have in place or plan to have in place in the next few years?



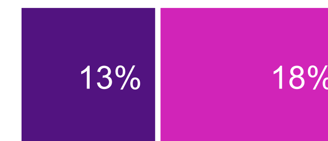
Utilize a transparent and pass-through contract structure for rebates.

Promote drug discount cards or direct-to-consumer Rx delivery to lower out-of-pocket costs for covered populations.

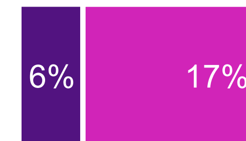




Allow members to purchase drugs through a retail or "cost plus" outlet.



Have an acquisition cost PBM contract structure.



Action taken in 2024 | Planning for 2025 or considering for 2026

Source: WTW 2024 Best Practices in Healthcare Survey. Reflects 417 survey respondents representing 6M employees.

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Marketplace perspective (continued)

PBM adjudication models

- Adjudication refers to how claims are priced at the point of sale.
- There is growing market interest in more cost-plus model approaches to align the price of drugs to a benchmark more closely aligned with the actual cost of the drug.
- Transition to a cost-plus model is not expected to generate savings, but rather rebalance costs for brands and generics to align with actual acquisition costs and could result in both winners and losers from a member perspective.

	AWP/Pass-through	Acquisition cost plus
Pricing basis	• Average wholesale price (AWP)	• Acquisition cost; may be based on NADAC or PBM actual or estimated acquisition cost
Where PBMs make money*	• Administration fees • Spread on PBM owned mail and specialty pharmacies	• Administration fees • Disclosed margin and dispensing fees on PBM owned mail and specialty pharmacies
Where pharmacies make money	• Dispensing fees (minimal) • Variable margin on drugs versus their acquisition cost; higher margins more common on generic drugs	• Dispensing fees (higher) • Possible margin (i.e., in a NADAC pricing arrangement, it’s possible that the pharmacy may acquire the drug for more or less than NADAC)

*In all models, PBMs may also make money on clinical program fees and manufacturer service fees.

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For SEBC discussion and feedback:
Proposed requested scope of services for the 2025 PBM RFP

- **All typical and GHIP-specific PBM functions** noted on slide 3
- **Transparency in contracting terms** with drug manufacturers and pharmacy networks for both traditional and specialty drugs
- **Competitive financial terms** (i.e., drug pricing, fees, credits and performance guarantees)
- **Excellent account management services** to the Statewide Benefits Office (SBO), including superior implementation support and dedicated, expert, and accessible account management staff
- **Meaningful and timely management reporting**
  - To the SEBC and SBO, including detailed reporting of rebate payments by drug, and
  - To other State agencies at the request of the SEBC and SBO, such as the annual completion of the Delaware Department of Insurance Office of Value Based Health Care Delivery's PBM data collection template
- **Responsiveness** to changes in the program and requests of the SEBC and the SBO

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For SEBC discussion and feedback:
Other considerations for the 2025 PBM RFP

- Should the following provisions from the 2020 PBM RFP be updated or changed for the upcoming 2025 PBM RFP?
  - Vendor proposals should duplicate the prescription drug benefit plan designs that will be effective July 1, 2026 for the Commercial (non-Medicare) population and effective January 1, 2027 for the Medicare Part D EGWP
    - *Note: While these final plan designs have yet to be determined by the SEBC, the RFP questionnaire will include questions about the bidding vendors' abilities to duplicate the current plan designs in place at the time the RFP is "live", as well as additional questions about vendor capabilities to administer other types of plan designs that may be under consideration by the SEBC for future plan years (for example: administration of the prescription drug benefits for an IRS-qualified high deductible health plan with a health savings account)*
  - Vendors may submit proposals for pharmacy benefits administration for the Commercial population only, the EGWP population only, or both populations assuming the State may choose to contract for only one population
  - A pharmacy benefits purchasing consortium may submit a proposal, as long as the following conditions are met:
    - The consortium discloses the PBM it works with
    - All responses to RFP questions reflect that PBM's capabilities
    - By contracting with a consortium, the SEBC would not give up any decision-making control over the administrative or clinical management of its pharmacy benefits program
- What pricing models does the SEBC want to receive quotes for?

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Next steps

- SEBC feedback from today's meeting will be incorporated into the next draft of the RFP scope of services, which will be reviewed with this Committee at the March 21, 2025 meeting
- The SEBC will review and vote on the complete RFP document later in Spring 2025 before the formal bid process begins

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