



The State of Delaware

Pharmacy Benefit Manager (PBM) Overview

State Employee Benefits Committee

March 21, 2025

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What is a PBM?

A Pharmacy Benefit Manager (PBM) works with health insurers, employers, and other payors to manage prescription drug benefits.

PBMs act as intermediaries between health insurance providers and drug manufacturers, negotiating pricing and payments between pharmacies, drug manufacturers, and insurance companies.

PBM activities may include all or some of the following:

- Benefit plan design
- Claims processing (aka claims adjudication)
- Creation and administration of retail/mail networks
- Drug utilization review
- Formulary management
- Prior authorization
- Disease and health management
- Drug safety and monitoring programs

*CMS = Centers for Medicare and Medicaid.

What are top priorities for the State?

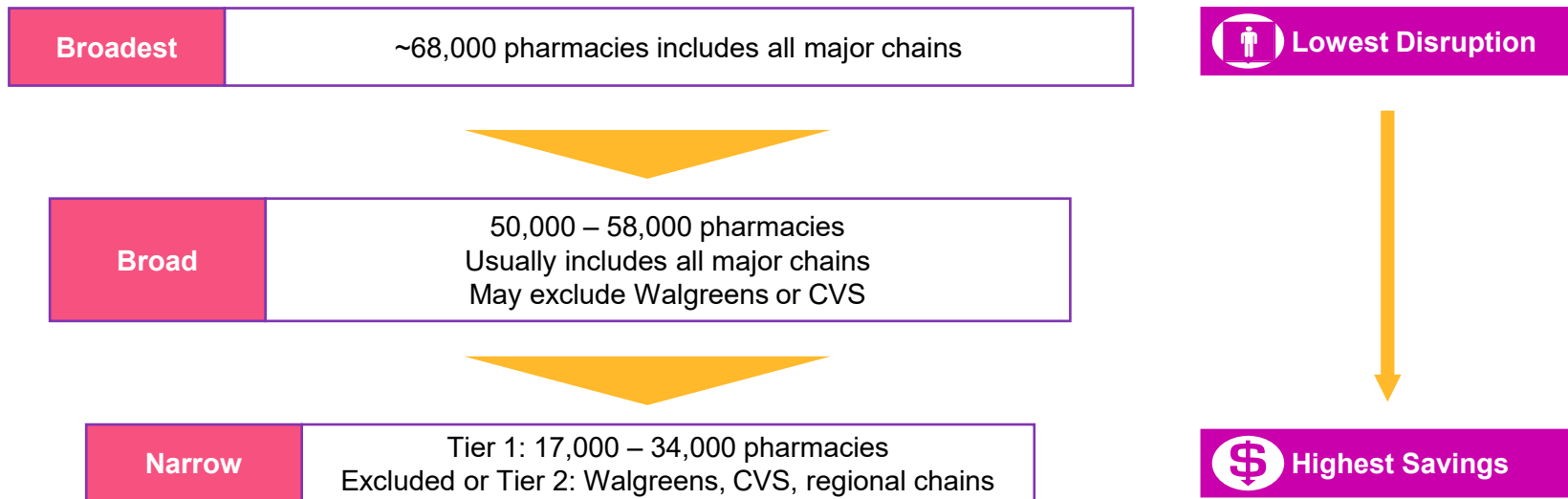
- Greater opportunity for transparency
- Financial arrangements backed by guarantees
- Retail pharmacy network options
- Formulary options that drive to lowest net cost while providing members with the medications they need
- Deliver dedicated member support to simplify their pharmacy benefit experience and mitigate member disruption
- Communication support
- Experienced in administering CMS*-compliant Employer Group Waiver Plan (EGWP)
- Strong account management team that includes clinical pharmacist support
- Strong reporting, including online access and web-enabled capabilities

Pharmacy networks

- The standard (broad) networks are generally very similar between PBMs and include all of the major pharmacy chains
- Options for Retail-30 (30 days supply) and Retail-90 Maintenance (90 days supply) networks

Narrow Networks	
Description	<ul style="list-style-type: none"> • A smaller network of retail pharmacies that generally will include at least one major pharmacy chain (i.e., CVS, Walgreens)
Advantages	<ul style="list-style-type: none"> • Deeper discounts on retail claims • Modeling is available to ensure that members have adequate access to the pharmacies within the narrow network
Considerations	<ul style="list-style-type: none"> • Narrows member choice to select pharmacies, typically leads to some disruption • Possible State level regulatory concerns with excluding pharmacies

GHIP
current
network



Formularies

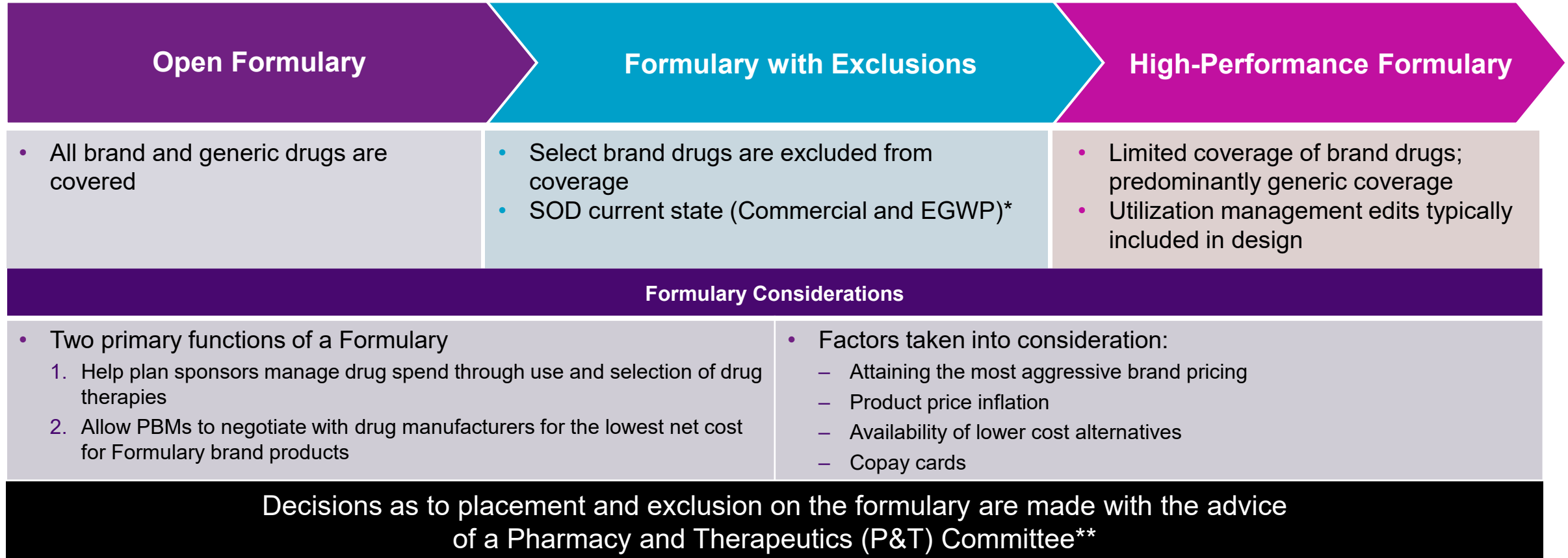
What is a formulary?

- List of prescription drugs that a PBM offers to its members covered under a health plan
- Drugs not on the list are excluded from coverage under the plan
- Different drugs are placed on various tiers, for example:
 - Tier 1: Generic Medications
 - Tier 2: Preferred Brand
 - Tier 3: Non-Preferred Brand
- Each tier typically has a different member cost share (copay or coinsurance) amount
- The member cost share is typically lowest for generic/low-cost drugs, and higher for brand/more expensive drugs to incentivize members to select lower cost drugs; for example, the GHIP member cost share for a 1-month* supply at an in-network, retail pharmacy:
 - Tier 1: Generic Medications = \$10 copay
 - Tier 2: Preferred Brand = \$32 copay
 - Tier 3: Non-preferred Brand = \$60 copay
- Drug manufacturers negotiate drug placement and tiering placement on the formulary with PBMs in exchange for rebate payments
- PBMs make formulary lists based on drug safety, effectiveness, and cost
- Employer Group Waiver Plan (EGWP) formularies are regulated by CMS and have specific requirements to stay in compliance
 - Ex. Certain classes of medications must be covered

*Up to a 30-day supply for non-Medicare prescription plans, and up to a 31-day supply for the EGWP.

Formularies (continued)

Types of formularies



*If a member is prescribed a medication that is not on the formulary or covered under the plan, the member, their doctor or a pharmacist can initiate a coverage review in which CVS Caremark will review additional information from the member's doctor before they can fill the prescription under the member's plan.

**The SEBC is also able to determine whether certain classes of drugs are covered under the GHIP, such as weight loss drugs (covered for Commercial only) and erectile dysfunction agents (not covered for Commercial or EGWP).

Utilization Management (UM)

Standard UM strategies

Quantity Limits

- Ensures quantities are considered safe by the Food and Drug Administration (FDA) and medical studies
 - Members can get quantities up to the limit at the regular cost share
 - Prescriptions for a larger amount may be changed to a higher strength (i.e., Crestor 10 mg twice per day to Crestor 20 mg once per day)
 - Can help prevent stockpiling
 - A prior authorization can be requested for higher quantities when needed

Step Therapy

- Requires trial of a lower-cost (usually generic) alternative as a front-line option before a more expensive brand drug is covered
 - Members will need a new prescription for the generic product
 - Pharmacies can assist in requesting a new prescription from the physician

Prior Authorization

- Confirms the member meets pre-specified criteria to ensure safe and effective use of the target drug
 - The physician will need to complete a prior authorization form
 - If the request is denied, an alternative medication may be more appropriate
 - Applies to both non-specialty and specialty drugs

Typical Rx pricing arrangements

	Traditional (GHIP* prior to FY2022)	Transparent/Pass-Through (GHIP* Current State)	Cost Plus
Retail Network	PBM retains any spread on what they pay the retail pharmacy and their negotiated price with the network pharmacy	100% pass-through of all retail network discounts and dispensing fees (plan sponsor pays the same amount that PBM pays pharmacy)	Pharmacy pricing is aligned with acquisition cost of the drug plus a higher dispensing fee. PBM does not retain any spread.
Mail Order & Specialty	Flat discounts vary by drug (typically not acquisition cost**). Specialty/Mail order spread retained by pharmacy (which may also be the PBM).	Flat discounts vary by drug (typically not acquisition cost**). Specialty/Mail order spread retained by pharmacy (which may also be the PBM).	Pharmacy pricing is aligned with acquisition cost** of the drug plus a higher dispensing fee. PBM does not retain any spread.
Rebates	100% pass-through of all pharmaceutical manufacturer revenue and other monies	100% pass-through of all pharmaceutical manufacturer revenue and other monies	100% pass-through of all pharmaceutical manufacturer revenue and other monies
Administrative Fees	No administrative fees	Administrative fees	Higher administrative fees may apply

*Applicable to both Commercial and EGWP populations for the GHIP.

** Acquisition cost is the cost paid by the pharmacy to acquire the drug from their supplier.

GHIP-specific programs and services provided by the State's PBM

- Programs that have been exclusively developed and/or customized for the GHIP:
 - **Spousal Coordination of Benefits (SCOB) Policy** – determines a spouse's eligibility for primary coverage under the GHIP
 - **Diabetic Medication Savings Program** – allows member to pay for multiple diabetic medications with just one copay when filled at the same time at a 90-day participating pharmacy or the CVS Caremark® Mail Service Pharmacy
 - **Maintenance Medication Program** – provides prescription cost savings by allowing members to fill 90-day prescriptions for non-specialty maintenance medications at reduced copays at any participating retail pharmacy or through CVS Caremark® Mail Service Pharmacy. Assesses a copay penalty beginning with the fourth 30-day fill on eligible maintenance medications that are not filled for a 90-day supply; penalty is equal to the 90-day supply copay for filling a 30-day supply.
 - **Choice Program (Generic vs. Brand Medications)** – allows member to purchase a brand medication when a generic equivalent is available; however, the member will pay the generic copay plus the Plan's cost difference between the generic and the brand medication.*
- Ongoing monitoring** of Delaware legislation to ensure the GHIP's compliance. Several important and recent include:
 - HB 359 with HA 2 and SA 2 (152nd GA) – Pharmacy Access Act
 - HB 219 (151st GA) – National Average Drug Acquisition Cost (NADAC) Pricing
 - SB 316 with SA 1 (151st GA) – Insurance Coverage of Diabetes Equipment and Supplies
 - SB 232 (152nd GA) – Over-The-Counter Non-Emergency Contraceptive Pills

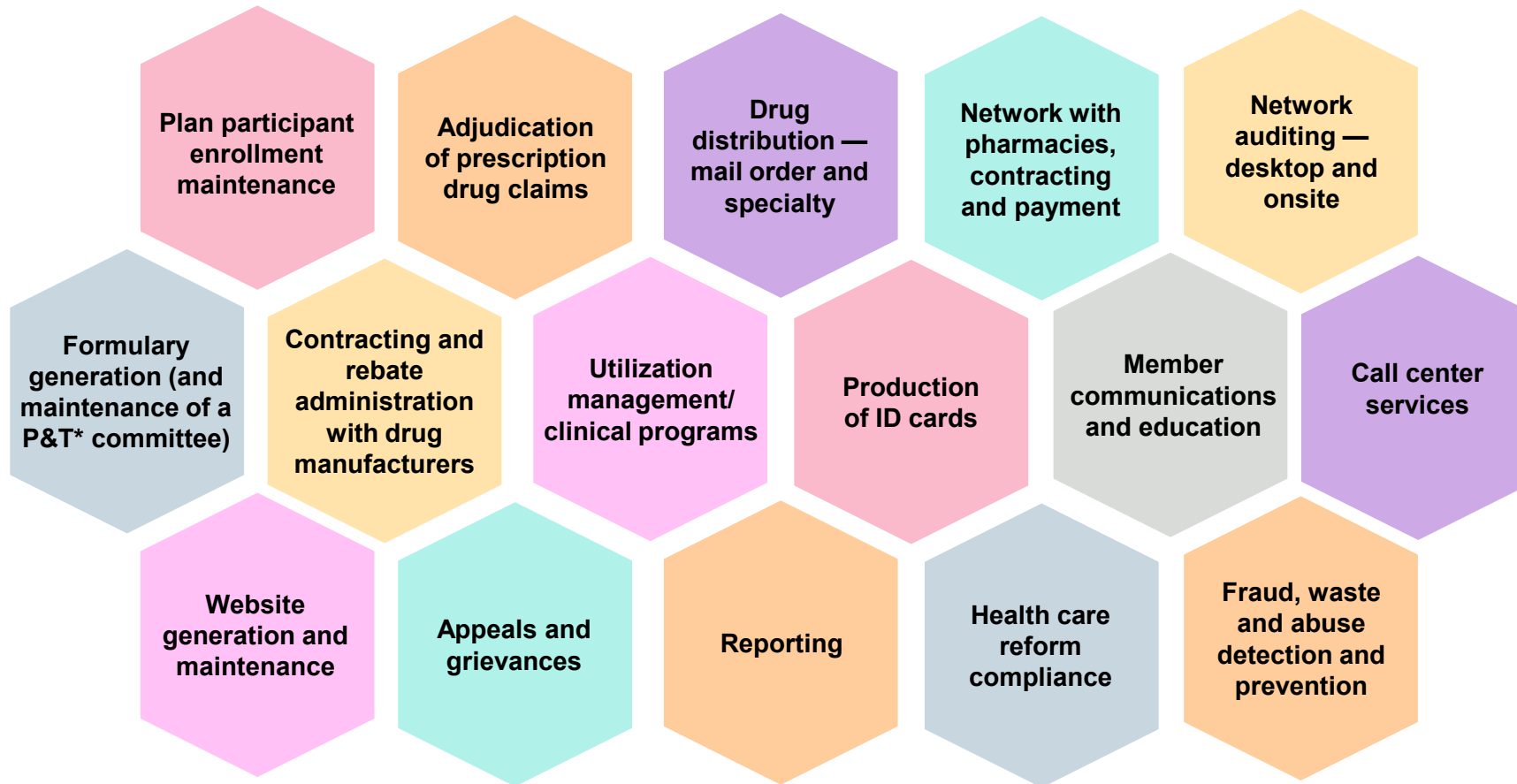
*If there is a medical reason why a member cannot take the generic equivalent, the member, their doctor or their pharmacist may initiate a coverage review to allow the member to obtain the brand name drug at the non-preferred copay.

**While monitoring compliance with state legislation is a typical service provided by PBMs, the degree of plan design customization implemented to ensure ongoing compliance of the GHIP with Delaware state legislation is an enhancement for the GHIP.

Appendix

What do PBMs do?

Anatomy of a PBM



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
- Monitors compliance with ongoing state legislation

*Pharmacy and Therapeutics Committee

PBM terminology

Pricing and contract terms

Acquisition cost

- The cost paid by the pharmacy to acquire the drug from their supplier.

Average Wholesale Price (AWP)

- “List” price for drugs reported by pharmaceutical manufacturers. Each price is specific to the drug, strength, dose form, package size and manufacturer

Dispensing fee

- The charge for the professional services provided by the pharmacist when dispensing a prescription

Formulary

- A list of the PBM’s preferred drugs. The list is determined based on extensive and frequent research and review focused on effectiveness, safety and costs of the medications

Ingredient Cost

- The cost of the prescription after the discount is applied (AWP – XX%)

Maximum Allowable Cost (MAC)

- MAC is the highest unit price that will be paid for a drug and is designed to increase generic dispensing

Rebate/Manufacturer Admin. Fee (MAF)

- Monetary amount (credit) returned to a plan sponsor from a prescription drug manufacturer based on pharmaceutical use by a covered person or purchases by a provider. Rebates and manufacturer administrative fees (MAF) can be considered two separate types of “credit”

Trend

- Pharmacy trend is made up of two components: cost and utilization. Trend is typically measured on a per-member-per-month (PMPM) basis (year over year)

Usual and customary (U&C)

- The price for a given drug that a pharmacy or other provider would charge a cash-paying customer without the benefit of insurance

PBM terminology (continued)

Specialty pharmacy arrangements

Exclusive Specialty

Description	<ul style="list-style-type: none">• An exclusive arrangement with one specialty pharmacy for fulfillment of specialty drugs
Advantages	<ul style="list-style-type: none">• Deeper discounts on specialty drugs• Specialty pharmacy typically provides enhanced member support and clinical services<ul style="list-style-type: none">– Benefits verification– Adherence support and side effect management– Dosing verification based on member's weight– Waste reduction by verifying the supply on-hand for the member
Considerations	<ul style="list-style-type: none">• Members must use the exclusive mail PBM owned specialty pharmacy or incur cost-share penalties

Open Network

Description	<ul style="list-style-type: none">• An arrangement with more than one specialty pharmacy for fulfillment of specialty drugs
Advantages	<ul style="list-style-type: none">• Allows member choice
Considerations	<ul style="list-style-type: none">• Plan pricing will not be as aggressive as an exclusive arrangement• Members can use any in-network retail pharmacy but can only fill mail orders through the PBM-owned specialty pharmacy