Pharmacy Benefit Manager (PBM) Report and Analysis

Prepared for the State of Delaware, State Employee Benefits Committee (SEBC)

The State of Delaware provides benefit coverage to over 135,000 state employees, retirees, participating group members, and their families. A primary benefit the state provides is medical and prescription drug coverage. The State of Delaware currently contracts with CVS Caremark for the administration of prescription drug benefits for a non-Medicare prescription drug plan and a Medicare Part D Employer Group Waiver Plan (EGWP) through SilverScript, administered by CVS Caremark.

The Statewide Benefits Office (SBO) is entering into the final year of the contract for both plans with a contract end date of June 30, 2026 for the non-Medicare prescription plan and December 31, 2026 for the EGWP. The initial term of the contract was for three (3) years with two one-year optional renewal years.

The State Employee Benefits Committee (SEBC) is responsible for reviewing and approving a Request for Proposals (RFP) to procure a Pharmacy Benefit Management contract for the non-Medicare prescription plan and the Medicare Part D EGWP. The information in this report is meant to provide background and insight to the Committee to assist in their development of an RFP to procure for PBM services for a contract effective July 1, 2026 for the non-Medicare prescription plan and January 1, 2027 for the EGWP.

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Section 1 – PBM Overview

What is a Pharmacy Benefits Manager (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.

PBMs are contracted by health plans—including commercial insurers, self-insured employers, Medicaid managed care organizations (MCOs), and Medicare Part D plans—to manage prescription drug programs and contain prescription drug spend.

Below are examples of the functions of PBMs and the roles they play in the administration and management of pharmaceuticals for self-insured plans (What PBMs Do, and How They Contribute to Drug Spending | Commonwealth Fund ; Understanding Pharmacy Benefit Managers | Colorado Health Institute).

Roles and Functions of Pharmacy Benefit Managers (PBMs)

1.) **Drug Price Negotiation and Rebates**

PBMs negotiate with pharmaceutical manufacturers to secure rebates and discounts on prescription medications. These negotiations are typically based on the inclusion of a drug on the PBM's formulary, or its placement within preferred tiers. The size and structure of these rebates vary significantly and can impact overall drug pricing.

2.) **Formulary Design and Management**

PBMs are responsible for designing formularies, which are curated lists of prescription drugs covered under a given health plan. The list is determined based on extensive and frequent research and review focused on effectiveness, safety, and costs of the medications. These formularies are structured in tiers that influence both drug utilization and member out-of-pocket costs. PBMs often implement utilization management (UM) strategies to better contain the total cost incurred by the plan, including:

- **Prior authorization** - requiring pre-approval before dispensing certain drugs, often based on FDA or other clinical indications and guidelines to ensure safety and proper utilization,

- **Step therapy** - requiring patients to try lower-cost alternatives first before approving higher-cost options, and,
- **Quantity limits** - restricting how much medication can be dispensed at one time.

These tools are intended to promote cost-effective prescribing and reduce unnecessary or duplicative drug use.

Please note, the above information on formulary design and management is specific to non-Medicare prescription drug plans. The Centers for Medicare & Medicaid Services (CMS) has specific formulary requirements for the administration of Medicare Part D plans, including Employer Group Waiver Plans (EGWP), which the State of Delaware currently administers for enrolled Medicare retirees.

3.) Specialty Drug Management

PBMs often develop specialty pharmacy programs as part of benefit design to control spending on high-cost drugs used to treat chronic or rare conditions. These programs may include:

- Limited distribution networks
- Mandatory use of PBM-owned specialty pharmacies
- Additional clinical monitoring and support

Please note, specialty medications and other prescriptions provided at certain in-person sites of service, including inpatient hospital settings, emergency rooms, long-term care facilities, etc., are billed through the *medical* plan, not the prescription drug plan, and are not subject to the same provisions as detailed above.

4.) Cost-Sharing Structure

PBMs can advise plan sponsors on member cost-sharing models, which may include:

- Copayments - fixed dollar amounts for different drug tiers,
- Coinsurance - a percentage of the drug's cost paid by the member,
- Deductibles and out-of-pocket maximums - annual limits on what members pay for medications.

PBMs use data and actuarial analysis to forecast how different cost-sharing models impact both utilization and overall plan costs, typically pulling large book of business (BOB) datasets to forecast and model likely scenarios for future utilization based on historical data.

5.) Pharmacy Network Management

PBMs contract with retail, mail-order, and specialty pharmacies to create pharmacy networks. They determine which pharmacies are included, set reimbursement rates, and often offer financial incentives for plan members to use preferred or in-network pharmacies.

6.) Claims Processing and Benefit Administration

PBMs handle claims adjudication, ensuring that prescriptions are covered under a member's benefit plan, and reimburse appropriately. This includes verifying patient eligibility, determining any applicable copayments and coinsurance, and facilitate pharmacy and provider payment. PBMs also provide customer service to assist with member issues, answer questions related to formularies and benefit coverage, and can act as an intermediary between the plan sponsor, medical providers, and health plans.

7.) Cost Containment and Generic Substitution

PBMs can help provide education on and promote the use of lower-cost generics and biosimilars when appropriate. Through education, formulary placement, and substitution protocols, PBMs help shift utilization toward more affordable therapies, resulting in savings to employers and other plan sponsors.

8.) Administration of Disease Management Programs

PBMs often play an important role in managing certain chronic diseases and promoting better health outcomes through integrated clinical programs, often for diabetes management and the management of other metabolic conditions. These programs provide resources and services beyond the dispensing of medication and provide focus on member education, medication adherence, care coordination, and can recommend laboratory testing when appropriate.

Section 2- Group Health Insurance Plan (GHIP) Current State

The State of Delaware last procured for Pharmacy Benefit Management Services in 2020 for a non-Medicare prescription drug contract effective July 1, 2021 and a Medicare Part D Employer Group Waiver Plan (EGWP) contract effective January 1, 2022. The contract for both plans was awarded to CVS Caremark for an initial three-year term with two one-year optional renewal periods. The SBO is entering into the final year of the contract for both plans with the contract end dates being June 30, 2026 for the non-Medicare prescription plan and December 31, 2026 for the EGWP.

What is an Employer Group Waiver Plan (EGWP)?

An Employer Group Waiver Plan (EGWP) is a federally approved Medicare Part D plan offered by a private plan sponsor (typically a PBM or health insurer) on behalf of an employer to provide prescription drug coverage to Medicare-eligible retirees (Employer Group Waiver Plans (EGWPs) | CMS).

Rather than having each retiree enroll in an individual Medicare Part D plan, the employer contracts with a PBM or insurer to set up a group plan tailored to their retiree population. These plans operate under a waiver from certain Medicare rules, allowing greater flexibility in design and allowing employers to provide better coverage and other enhancements not generally seen in the marketplace.

GHIP Current State

- Employees and participating group members enrolled in one of the State's health care plans, as provided by Aetna or Highmark Delaware, are automatically enrolled in the prescription drug plan managed by CVS Caremark. The State of Delaware, in partnership with CVS Caremark, has designed and implemented a comprehensive prescription drug program to provide members with the medications required in a cost-effective and efficient manner.
- Retirees enrolled in the State of Delaware Medicare supplement plan, administered by Highmark Delaware, have the option to also enroll in a Medicare Part D Prescription Plan. SilverScript, administered by CVS Caremark, is the pharmacy benefit manager for the State of Delaware.
- CVS Caremark provides an Automatic Refill and Renewal program for home delivery, CVS Pharmacy Pickup and Delivery Options, CVS Specialty Pharmacy and over 66,000 pharmacies are available under the CVS Caremark network.
    - CVS Caremark provides Caremark® Cost Saver™, which is powered by GoodRx® and helps ensure members receive the lowest available cost for commonly prescribed, non-specialty generic drugs. Note, this is only available for the non-Medicare prescription plan, not the EGWP.
    - CVS Caremark provides RxSavingsPlus®, which is a drug discount program that can be utilized by State of Delaware Employees who are not enrolled in a State of Delaware Health Plan.
- 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.

- For the non-Medicare prescription plan, the State has implemented the PrudentRx solution. PrudentRx is an independent third-party organization that CVS has partnered with to offer cost savings for specialty medications. It allows members to get specialty medications at **no cost** to them by obtaining copay assistance from drug manufacturers.
  - Specialty medications are limited to a 30-day supply and are required to be filled at a participating CVS Specialty® pharmacy. This currently includes CVS Specialty Mail order and Biotek Remedys
- The State of Delaware receives 100% pass-through of all retail network discounts and dispensing fees, meaning the State pays the same amount that the PBM pays pharmacies.
- The State of Delaware receives 100% pass-through of all pharmaceutical manufacturer rebates, revenue, and other monies received as a result of State of Delaware plan utilization. This was a requirement in the 2020 PBM RFP.
- CVS is the exclusive mail order and specialty drug provider for the Commercial plan. CVS has agreed to meet discount guarantees for these medications, but they do have the opportunity to retain margin as they are also the dispensing pharmacies for these channels.
- The State pays certain administrative fees to the PBM for plan administration.
- Flat discounts vary by drug and are typically not acquisition cost; acquisition cost is the cost paid by the pharmacy to acquire the drug from their supplier.
- At the end of the initial contract term, the SBO, alongside SEBC consultants Willis Towers Watson (WTW), conduct a market check to ensure that CVS pricing guarantees for the GHIP remain competitive with the pharmacy benefit marketplace. This is typically done for each optional renewal year and results in contract improvements and additional savings being negotiated into both the non-Medicare and EGWP plan contracts.
- The State has decision-making authority to determine which programs and services are provided to the population; the State also has the ability to make exceptions to plan coverage determinations via the State Employee Benefits Committee (SEBC).

- Summary of Non-Medicare Prescription Plan Benefits can be found here - plan-booklet-fy26.pdf.
- Summary of Medicare Part D (EGWP) Prescription Plan Benefits can be found here - plan-booklet-2025.pdf.
- Summary of Prescription Drug Plan Level Exclusions can be found here - plan-level-exclusions.pdf

Non-Medicare Prescription Plan Member Drug Costs
(https://dhr.delaware.gov/benefits/cvs/costs.shtml)

Up to a 30-Day Supply (Available at a **participating** retail pharmacy)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$10 Copay	Not Covered
Preferred Brand Name (Formulary)	$32 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$60 Copay	Not Covered

Up to a 90-Day Supply (Available at a **participating** retail pharmacy or through Home Delivery)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$20 Copay	Not Covered
Preferred Brand Name (Formulary)	$64 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$120 Copay	Not Covered

Preventive Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Drugs classified as preventive under the Affordable Care Act may be covered at 100%.	$0 Copay (no member cost)	Not Covered

Up to a 30-Day Supply (Available **ONLY** at CVS Specialty® Pharmacy through Home Delivery)		
Specialty Drugs	Enrolled in PrudentRx	Not Enrolled in PrudentRx
The PrudentRx® program applies to all specialty medications on the CVS Caremark Specialty Drug List.	$0 Copay (no member cost)	30% Coinsurance

**PrudentRx is an independent third-party organization that allows members to get specialty medications at no cost by obtaining copay assistance from drug manufacturers. Members must take action to ensure proper participation in the program.*

Fertility Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
There is a $15,000 lifetime maximum for all prescriptions for fertility under the State of Delaware prescription plan.	25% Coinsurance	Not Covered

Medicare Part D Prescription Plan Member Drug Costs
(https://dhr.delaware.gov/benefits/cvs/medicare/costs.shtml)

The amount a member pays for their prescription depends on whether the medication is:

- A generic, preferred or non-preferred brand, or specialty drug,
- On the SilverScript Medicare Part D Formulary, and
- Filled at the appropriate participating pharmacy

Up to a 31-Day Supply (Available at a **participating** retail pharmacy – including all major chains)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$10 Copay	Not Covered
Preferred Brand Name (Formulary)	$32 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$60 Copay	Not Covered

Up to a 90-Day Supply* (Available at a **participating** retail pharmacy or through Home Delivery)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$20 Copay	Not Covered
Preferred Brand Name (Formulary)	$64 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$120 Copay	Not Covered

** Not all drugs are available at a 90-day supply. Some retail pharmacies in your plan only provide a one-month supply of your covered prescriptions at the one-month supply copayment.*

Up to a 31-Day Supply (Available at CVS Specialty® Pharmacy through Home Delivery)		
Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$10 Copay	Not Covered
Preferred Brand Name (Formulary)	$32 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$60 Copay	Not Covered

Minimum Requirements in the State of Delaware's 2020 PBM RFP

- Required the vendor be able to accept data elements in file feeds from Highmark Delaware and Aetna along with claims submission to the Delaware Health Information Network (DHIN) and SBO data warehouse vendor, Merative.

- Allowed the State the ability to carve-out specialty dispensing and management to an outside best practice carrier of their choice should the State decide to take an alternative specialty approach, with no impact to pricing for either EGWP or Commercial pricing offers
- Vendors provided separate pricing offers for EGWP and Commercial.
- For the EGWP plan, required vendors be licensed with CMS and had been performing EGWP services for a minimum of 10 years to ensure expertise and legal compliance with the administration of such a complex Medicare Part D plan.
- Required the vendors be a PBM with a minimum of five consecutive years of experience providing the Scope of Services requested in the RFP for both commercial and EGWP.
- Required the vendor have experience managing at least 10 large and complex clients similar to the State (commercial and EGWP) with greater than $250 million in annual drug spend and 100,000 lives.
- Required the Proposed Account Executive and Account Manager have a minimum of 10 years' experience in the healthcare industry, either working for a health insurer or PBM, and have worked with clients of similar size and complexity. In addition, the Proposed Account Executive and Account Manager will have worked for the organization a minimum of 5 years in their current role.
- Vendors agreed to pass through 100% of all rebates received from pharmaceutical manufacturers as a result of the State utilization, including manufacturer administration fees. "Rebate" in this context means a discount or other price concession, or a payment that is: (i) based on utilization of a prescription drug; and (ii) that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy on or after a claim has been processed and paid. "Rebate" includes without limitation incentives, disbursements, and reasonable estimates of a volume-based discount.
- Provided an acquisition cost pricing proposal to the State
- Required the State be allowed to audit the plans up to three years following the termination of the contract.
- Required compliance with all Federal and State laws.
- For a full list of requirements in the State of Delaware 2020 PBM RFP, please review the full RFP found here - https://bidcondocs.delaware.gov/DHR/DHR_21002PharmacyBenefit_rfp.pdf.

Section 3 – Reverse Auctions

State governments are increasingly rethinking how they procure and contract with PBMs to gain more control over drug costs, improve transparency, and ensure better value for the members and the State. Many states are exploring a mix of policy, procurement, and regulatory strategies to rein in costs.

Reverse Auctions

Reverse auctions are a procurement methodology used by multiple state governments in recent years to procure for PBM services. A PBM reverse auction is a competitive, online bidding process a state can use to select an entity to manage the state's prescription drug plan. Reverse auctions are commonly used in the public sector for non-professional services and are generally known for their potential to generate savings.

- "Nonprofessional services" are often defined as services that do not require a professional license or specialized accreditation. These services are typically administrative, operational, support or supply-oriented in nature.

- "Professional services" means services which generally require specialized education, training or knowledge and involve intellectual skills. PBM services are considered a professional service.

Is a Reverse Auction for PBM services currently allowed under Delaware Procurement Law?

No, Delaware Procurement Law only allows for reverse auctions for non-professional services. Changes would need to be made to Delaware Code to allow the SEBC to conduct a Reverse Auction for a PBM contract.

Per Title 29, Chapter 96 of Delaware Code, "Reverse auctioning" means an online procurement method wherein bidders bid on specified goods and **nonprofessional services** through real-time electronic competitive bidding, with the award being made to the lowest responsive and responsible bidder. During the bidding process, bidders' prices are public and are revealed electronically, and bidders shall have the opportunity to modify their bid prices for the duration of the time period established for the auction.

What is the process other states have used in a PBM reverse auction?

For other states who have procured for a PBM contract under a reverse auction, they first needed to pass legislation to allow the reverse auction to take place for this professional service.

It is important to note that for these states that passed legislation allowing or requiring a reverse auction for PBM services, the reverse auction process was not to be the only method used to generate and validate savings. These states allowed/required a reverse auction for PBM services to be used alongside real-time, electronic, line-by-line, claim-by-claim review of invoiced PBM pharmacy claims using an automated claims adjudication technology platform that allowed for online comparison of PBM invoices

and auditing of other aspects of the services provided by the PBM and PBM- related services (https://pub.njleg.gov/bills/2016/S3000/2749_I1.HTM).

The states' first contracted with or procured for a technology vendor who had the ability to meet the above requirements of conducting a reverse auction, as well as providing the real-time pharmacy claims adjudication to ensure and validate savings.

Once the technology vendor was awarded and a contract was in the place, the following steps took place to procure for the PBM contract:

- The buyer (in this instance, the state) defines the scope of services and requirements for a PBM, such as formulary design, rebate handling, pricing guarantees, transparency, customer service expectations, legal compliance, etc.
- PBMs are invited to participate in the reverse auction. These may include big names like CVS Caremark, Express Scripts, OptumRx, or transparent/pass-through PBMs.
- Prior to the reverse auction taking place, all qualified bidders must agree to the same contract terms as set by the state, meaning the negotiation process that is typically done *after* award is done *prior* to the reverse auction to ensure the final determining factor is the overall price and that all bidders can meet the expectations of the buyer (the state). This exact process varies by state.
- During the live auction, PBMs submit bids in real-time, typically through a technology platform that is selected by the state ahead of time. Each PBM sees how their bid compares to competitors but cannot see who the competitors are.
- The lowest (or most cost-effective) bid wins, assuming all other service requirements are met (Webinar: How States Can Control Pharmacy Benefit Manager Contract Costs through Reverse Auctions - NASHP).

What were the results of PBM reverse auctions in other states?

Multiple states have implemented a reverse auction for PBM services. Below are details on a few states commonly addressed in research on this topic, a larger list can be found here - Three More States Enact Reverse Auction Laws to Reduce Prescription Drug Spending - NASHP.

New Jersey – In 2016, New Jersey passed legislation allowing the state to use a reverse auction to procure for PBM services, alongside the requirement that the awarded vendor be subject to real-time claim-by-claim audit adjudication (S2749). New Jersey selected Truveris to conduct the reverse auction and complete the claims adjudication. In 2017, New Jersey was the first state to procure for PBM services using a reverse auction platform. This approach led to a contract award being made to OptumRx for a projected net savings of $2.5 billion in drug spend for its 800,000+ covered public employees and retirees between 2017 and 2022.

This award was challenged in 2018 by Express Scripts, the incumbent PBM provider for the state's prescription drug plans. The New Jersey Superior Court ruled that the state's award of a PBM contract to OptumRx was invalid. The court found that OptumRx's bid included a provision allowing it to adjust pricing based on certain benefit plan changes, which violated the bidding specifications and provided the company with a competitive advantage over other bidders. The court ordered the state to rebid the contract (New Jersey court rips up Optum's $6.7B prescription drug contract, orders rebid | Fierce Healthcare).

New Jersey conducted a second, three-round reverse auction resulting in a new three-year contract with OptumRx, resulting in $485 million in expected savings.

An evaluation has yet to take place to determine if the projected savings in this contract were realized. New Jersey is currently in the process of conducting a procurement for PBM services; the RFP can be found here: https://www.nj.gov/dobi/financial/PharmacyBenefitManagersRFP250115.pdf.

Minnesota – In 2021, Minnesota passed bipartisan legislation requiring a reverse auction take place for the upcoming PBM contract, alongside a requirement to procure for a technology vendor who also had the capacity to complete real-time pharmacy claims adjudication to validate savings (Ch. 43A MN Statutes). Minnesota awarded the technology contract to Truveris and used their truBid® technology to conduct the reverse auction.

Following the conclusion of the reverse auction, Minnesota awarded the PBM contract to CVS Caremark, who was also the incumbent vendor. Minnesota was projected to save $28.5 million in drug costs and fees, with an additional $75 million in 2023 and 2024 due to improved rebates from drug manufacturers.

In March 2025, the State of Minnesota published a legislative report to evaluate the outcome of the reverse auction and determine if the projected savings were realized (MMB Pharmacy Benefit Manager Reverse Auction Report - March 2025).

Minnesota determined that spend associated with the current PBM contract came in 2-3% lower than it would have been under the prior contract, which translates to approximately $7.2 million in savings in 2023 and $8.9 million in 2024. At the same time, their state employee health plan overall pharmacy spend increased by 13%. The majority of the savings initially projected were in the form of minimum rebate guarantees, which the State exceeded each year, meaning no savings were actually realized under that provision.

The State of Minnesota's Management and Budget Office, as well as the Office of the Legislative Auditor (OLA-Letter-RE-Pharmacy-Benefit-Manager-Review.pdf) agreed that the comparison required by the statute did not constitute sufficient evidence to conclude that the reverse auction process resulted in a net savings for the state and that the same level of savings may also have been realized under a standard procurement.

Colorado - In 2022, Colorado passed legislation which allowed the reverse auction process for selecting PBMs. Similar to New Jersey and Minnesota, this legislation also required the state select a technology partner responsible for conducting the reverse auction, as well as provide real-time pharmacy claims adjudication (C.R.S. 24-50-1202 – Legislative declaration (2024)).

MedImpact was awarded the contract for a projected net savings of $22 million over the next five year (Colorado Set to Save Millions in Healthcare Costs Following Competitive Selection of State's New PBM). At this time, no evaluation has publicly been shared validating these projections.

What are some advantages of a reverse auction?

- Ability to focus PBMs on pricing components that are most important to the client.
- Allows PBMs to see their financial rank before and after rebates to push them to improve their offer.
- Plan sponsor can see full ranking of all PBMs live during the auction process.
- Other states have projected savings due to a reverse auction process, primarily due to the requirements of 100% pass through rebates and minimum rebate guarantees.

What are the disadvantages or risks of a reverse auction?

- For Delaware, legislation would need to be introduced and passed to allow for a reverse auction. The SEBC would also need to consider the additional requirement of requiring real-time automated adjudication of claims to support and validate this process. This will likely require 1-2 years to have all necessary components implemented and will have an additional cost to the State.
- Typically removes the ability of the state to negotiate a best and final financial offer as revisions to prices already took place during the reverse auction.
- Other states governments that have conducted reverse auctions for PBM services have noted that the new, smaller PBMs (including transparent pass-through PBMs) tend not to submit proposals for these RFPs as they cannot proactively meet the same contract terms as the larger PBMs and may not meet all initial contract requirements.
- May not be compatible with some new pricing PBM pricing models.
- Some PBMs may not be able to react quickly and provide meaningful pricing improvements in the short time the auction is run.
- SEBC consultants, Willis Towers Watson (WTW), have not seen meaningful differences in savings when an auction is conducted; savings levels have been on par with RFPs conducted without the auction step.
- PBMs may expect to win the business if they have the best pricing offer, potentially opening the State up to legal challenges.

Section 4– Other Savings Opportunities

Transparent Pass-Through Pricing Contracts

Transparent PBM contracting is a PBM model that prioritizes clarity, accountability, and cost control in the relationship between the plan sponsor and the PBM.

Key Features of Transparent PBMs:

- Pass-Through Pricing - PBMs pass through 100% of rebates, discounts, and fees from drug manufacturers and pharmacies to the plan sponsor. PBM profits are limited to a clearly defined administrative fee, which is established in the RFP process.
- No Spread Pricing - Plan sponsors pay the exact price that pharmacies are reimbursed—no markup. Eliminates hidden margins on the difference between what the PBM charges the plan and pays the pharmacy.
- Audit Rights & Data Access - Sponsors receive full access to claims-level data and have the right to audit PBM operations. Promotes accountability and allows for accurate financial and performance tracking.

Prescription Drug Affordability Boards (PDABs)

PDABs are independent professional bodies created by the state to analyze the cost of high-priced prescription drugs and, in some cases, set limits on how much payors (like state employee health plans, Medicaid, and other public programs) can be charged for those drugs.

PDABs can conduct drug cost reviews, establish and conduct affordability studies, and some can set upper payment limits, though that varies by state and is often limited (Q&A on NASHP's Model Act to Reduce the Cost of Prescription Drugs by Establishing a Prescription Drug Affordability Board - NASHP).

Maryland is an example of successfully implemented PDAB - Prescription Drug Affordability Board.

Contracting for Medical and Pharmacy in an Integrated RFP

Oregon has explored integrated contracting models for its public employee health plans, focusing on holistic care management that includes both medical and pharmacy services. This resulted in recent contract awards being made to health plan TPAs who subcontract for PBM services, meaning copays and coinsurance for medications, as well as what drugs are covered under the formularies, vary by which health plan the member enrolls in. A comparison of current plans can be found here - https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-698450_2%20mail.pdf.

Outcomes-Based Contracts

Unlike traditional drug pricing, outcomes-based contracts hold the manufacturer accountable for its product by linking its revenue to whether or not the medication delivers on its intended outcomes.

A PBM negotiates a price and measurable outcomes with the drug manufacturer on behalf of a health plan. If the treatment delivers the intended outcomes, the plan will pay the agreed-upon price. But if a patient does not respond as expected, experiences adverse effects, or is unable to complete a course of treatment requiring a change to a different medication, the drugmaker will issue a rebate for part, or all, of the cost.

Oklahoma, Colorado, and Michigan have implemented outcome-based amendments/contracts for their Medicaid population, using alternative payment models (APMs) for prescription drugs in the form of outcome-based contracts with pharmaceutical manufacturers (Oklahoma Signs the Nation's First State Medicaid Value-Based Contracts for Rx Drugs - NASHP) (A New State Tool to Manage Drug Costs: Experts Share Insights into Outcome-Based Contracts for Medicaid Pharmacy Claims - NASHP).

These type of contracts are very new and outcomes are yet to be shared, though savings and increased adherence to costly medications is anticipated (Outcomes-Based Contracts Can Shape the Future of Health Care).