The State of Delaware

Pharmacy Benefit Manager (PBM) Overview

State Employee Benefits Committee

April 25, 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

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

*CMS = Centers for Medicare and Medicaid.

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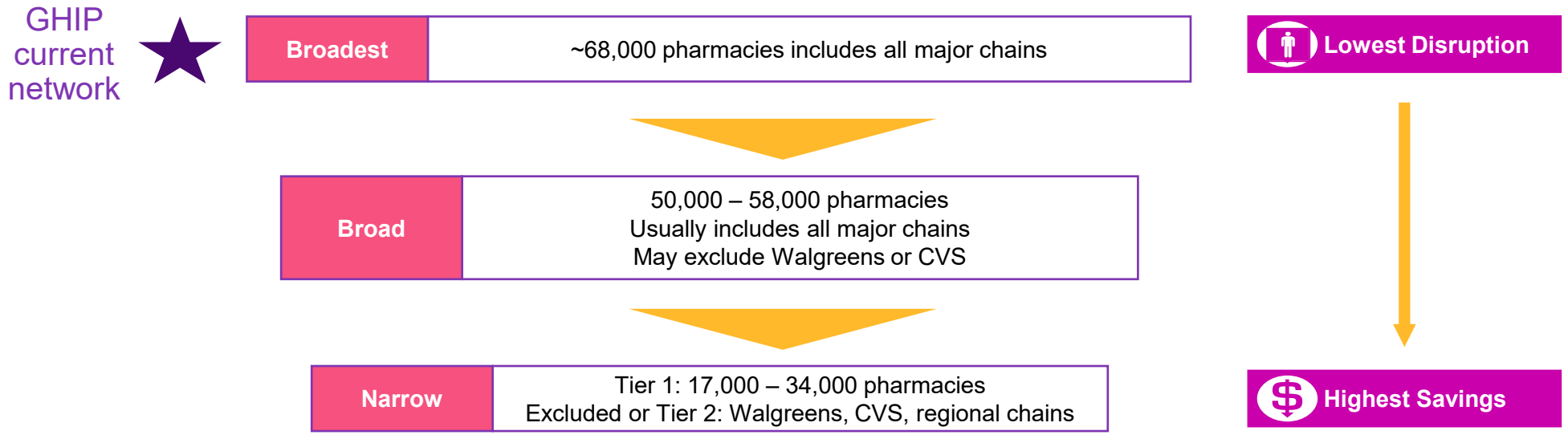
Pharmacy networks

- 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	• A smaller network of retail pharmacies that generally will include at least one major pharmacy chain (i.e., CVS, Walgreens)
Advantages	• Deeper discounts on retail claims • Modeling is available to ensure that members have adequate access to the pharmacies within the narrow network
Considerations	• Narrows member choice to select pharmacies, typically leads to some disruption • Possible State level regulatory concerns with excluding pharmacies



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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.

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Formularies (continued)

Types of formularies

Open Formulary	Formulary with Exclusions	High-Performance Formulary
• All brand and generic drugs are covered	• Select brand drugs are excluded from coverage • SOD current state (Commercial and EGWP)*	• Limited coverage of brand drugs; predominantly generic coverage • Utilization management edits typically included in design

Formulary Considerations

- Two primary functions of a Formulary
  1. Help plan sponsors manage drug spend through use and selection of drug therapies
  2. Allow PBMs to negotiate with drug manufacturers for the lowest net cost for Formulary brand products
- Factors taken into consideration:
  - Attaining the most aggressive brand pricing
  - Product price inflation
  - Availability of lower cost alternatives
  - Copay cards

Decisions as to placement and exclusion on the formulary are made with the advice of a Pharmacy and Therapeutics (P&T) Committee**

*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).

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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

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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.

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Cost Plus Pricing Models - FAQs

- **What is a Cost Plus Model?**
  - Under a Cost Plus model, drug prices are set based on the cost of acquiring the drug plus a fixed cost or percentage mark-up
- **How does the State's formulary compare to typical "Cost Plus" formularies?**
  - The State's current formulary with CVS is comparable to other formularies associated with other PBMs "Cost Plus" pricing models. For example, the State would be able to keep their current formulary in place if moving from current "Pass-Through" pricing model to a "Cost Plus" pricing model with CVS.
- **How are specialty drugs considered in Cost Plus models?**
  - Pharmacy pricing will be aligned with acquisition cost, plus administration and dispensing fees. Drugs may be priced higher or lower than they are today, usually with a significantly higher dispensing fee. Specialty generics are more likely to see a lower cost and specialty brand drugs are more likely to see a higher cost.
- **How does the State's current formulary with CVS compare to the Mark Cuban Cost Plus Drug model?**
  - Mark Cuban Cost Plus Drug Company specializes in generic medications and stocks a limited number of branded medications. Because the State's current formulary covers numerous brand medications, the Mark Cuban Cost Plus Pharmacy would not be considered a full replacement for the State's current formulary with CVS.
  - Mark Cuban Cost Plus Pharmacy currently only dispenses about 30 brand medications and 800 generic medications whereas members of the State commercial plan utilized ~2,600 medications in 2024
- **Should we expect to see a net savings in moving from a "Pass-Through" to a "Cost-Plus" pricing model?**
  - While there is a greater degree of transparency that will be gained, on average we typically would not expect to see savings. Plan specific utilization will determine if the model would be more or less advantageous.

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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 (137th 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
- Compliance with applicable State and Federal law including, but not limited to,
  - Delaware Code – Title 18, Chapter 33A and Chapter 73
  - Delaware Code – Title 29, Chapter 52 specific to GHIP pharmacy coverage

*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.

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PBM RFP Scope of Services and Market Check

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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
- 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
- This section 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

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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**
- **Transparency in contracting terms** with drug manufacturers and pharmacy networks for both traditional and specialty drugs and rebates
- **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
- **Improved audit rights** to ensure greater transparency and allow for more frequent retrospective audits including possible real-time processes

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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
  - Minimum years of experience requirement for PBMs to bid
    - In 2020 RFP, used minimum of 5 consecutive years experience providing scope and performing EGWP services for 10 years
- **What pricing models does the SEBC want to receive quotes for?**

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

- **Confirm PBM sources of revenue**
  - Currently the CVS contract has the following language:
    - **Manufacturer Relationships.** CVS Caremark affiliated pharmacies may contract with pharmaceutical companies for the purchase of products and these contracts may provide for prompt pay discounts and other concurrent or retrospective purchase discounts on products purchased for pharmacy dispensing inventories. CVS Caremark and its affiliates may also contract with pharmaceutical companies for the provision of services, such as care management, program administration, adverse event and other data reporting, and fulfillment services. CVS Caremark may receive and retain compensation for such services. For clarity, the discounts, fees and other compensation described in this paragraph and the Manufacturer Administrative Fees are independent of the Rebates.
  - This language covers several areas where PBMs could make revenue, primarily including:
    - Purchase discounts – this would be discounts that the PBM owned pharmacy would receive when acquiring the medication to be dispensed. This is essentially the margin the PBM would make on the cost of the drug and the agreed upon contract price
    - Manufacturer administrative fees – these are fees paid to the PBM by the manufacturer. These fees are passed through to the State under the current contract and it is recommended to retain this provision in the 2025 RFP

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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
- WTW requested a proactive market check offer from CVS
  - CVS responded indicating that there is no opportunity for improvements; therefore, they did not provide an offer
- WTW made an additional request for improvements from CVS
  - CVS was unable to make improvements due to being underwater on the rebate guarantees, but provided 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
    - For the Commercial plan, the rebalancing would have resulted in lower overall discount guarantees estimated at a cost of $2.2M, so that offer was not accepted
    - For the EGWP plan, the rebalancing would result in improved discounts valued at $3.1M for 2026 based on projected spend, so the proposal was accepted

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Appendix

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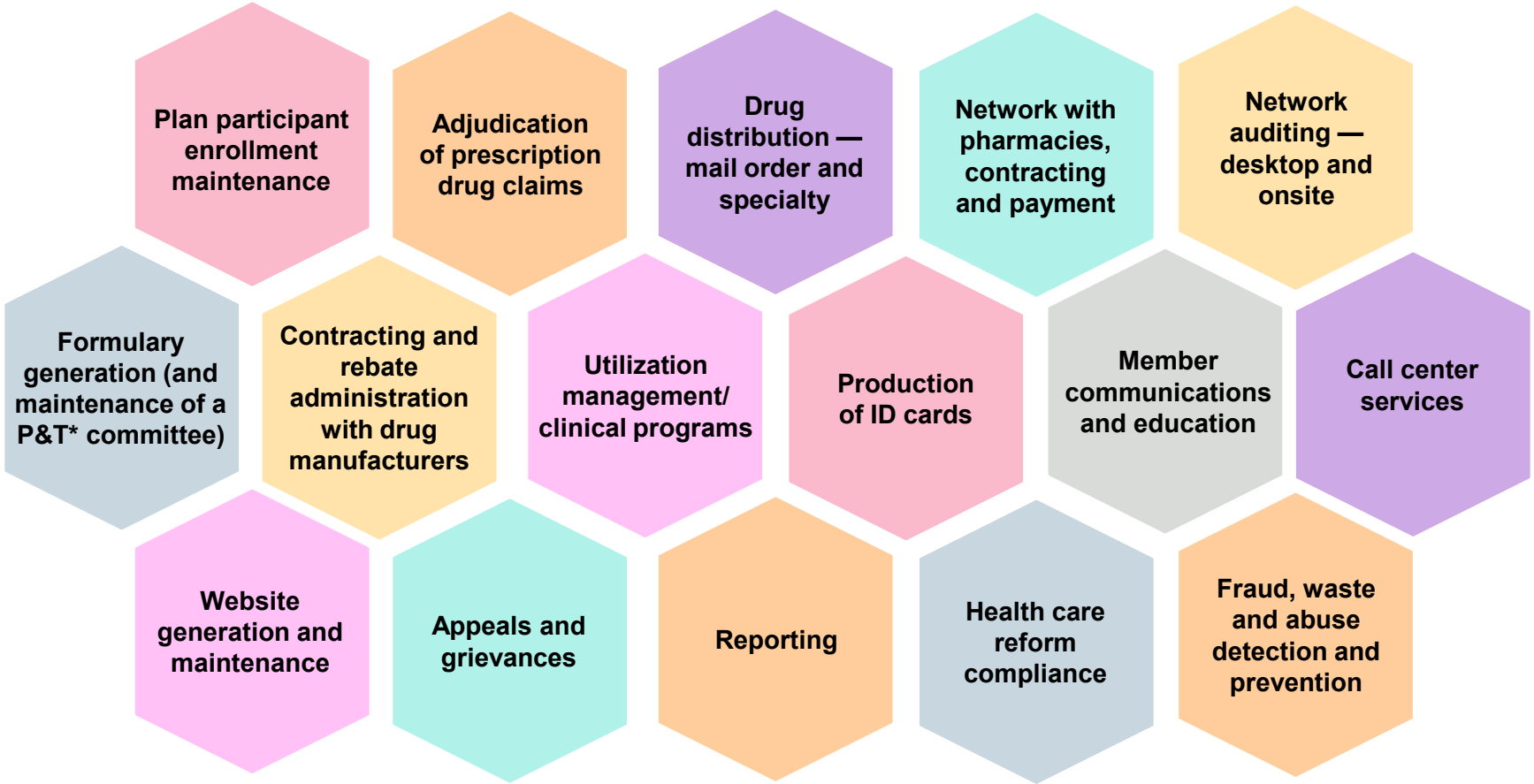
What do PBMs do?

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

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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

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PBM terminology (continued)

Specialty pharmacy arrangements

Exclusive Specialty	
Description	• An exclusive arrangement with one specialty pharmacy for fulfillment of specialty drugs
Advantages	• Deeper discounts on specialty drugs • Specialty pharmacy typically provides enhanced member support and clinical services – 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	• Members must use the exclusive mail PBM owned specialty pharmacy or incur cost-share penalties

Open Network	
Description	• An arrangement with more than one specialty pharmacy for fulfillment of specialty drugs
Advantages	• Allows member choice
Considerations	• 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

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