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Wakely Briefing Series

Part 1: The Basics of Evaluating PBM Contracts

Payors today face unprecedented degrees of complexity when conducting a pharmacy benefit manager (PBM) request for proposal (RFP) or evaluating PBM contracts. To stay competitive, payors must navigate an ambiguous and changing pricing environment. That requires a solid understanding of PBM contracting.

Part I of this Wakely Briefing series provides an overview of the basic financial elements of a PBM contract. Evaluation of a traditional RFP or PBM contract should begin with financial analysis of the following four key elements: discount guarantees (typically understood as point-of-sale ingredient costs), dispensing fees, rebate guarantees, and PBM administrative fees. This paper addresses various points of consideration when attempting a financial analysis of these contract elements.

Discount Guarantees

Discount guarantees are the most basic component of a PBM contract. Discounts are the percentage difference between the average wholesale price (AWP) and the point-of-sale ingredient cost of a specific drug (i.e. the PBM-negotiated cost charged at the time the drug is filled and received by the member).[1] The ingredient cost is the cost of the drug itself and excludes any dispensing fee also charged by the pharmacy. The point-of-sale ingredient cost for *brand* drugs is typically based on a percentage discount of average wholesale price (AWP), while *generic* drugs tend to be priced based on a drug-specific maximum allowable cost (i.e. MAC list).

Almost all PBM contracts will offer ingredient cost discount guarantees, ensuring that a minimum level of savings is achieved in aggregate. Most commonly, that guarantee is presented as a schedule of discounts off AWP, varying by some combination of the following:

- Drug type (e.g. brand, generic, specialty)

[1] Under pass-through pricing, discounts do not include any amount of profits that the PBM would retain. Alternatively, under traditional (i.e. spread) pricing, discounts consider and reflect some level of profit retained by the PBM such that the ingredient cost charged to the payor may be higher than the ingredient cost paid to the pharmacy.

- Pharmacy channel (e.g. retail, mail, specialty, long-term care [LTC])
- Day supply (e.g. 30-day vs. 90-day)

AWP is the published wholesale unit price of a drug at a National Drug Code (NDC) level, and is maintained by companies such as Medi-Span or First Databank. AWP can be thought of as analogous to the manufacturer's suggested retail price, which is the price car manufacturers recommend dealerships sell their vehicles for. AWP is useful as a benchmark, but very few end buyers will pay the list price of a drug. Therefore, PBM contracts typically offer price protection in the form of guaranteed minimum discounts off AWP since this is widely used as the industry standard for drug pricing. Specialty discounts can vary based on a drug- or NDC-specific schedule, but may still guarantee it will achieve an overall effective discount in aggregate. If the PBM contract includes an overall effective discount guarantee for specialty, it will often exclude new-to-market drugs, or guarantee a distinct discount for these drugs. Additionally, any specialty drug discount guarantees almost always stipulate that the guarantees are dependent on dispensing the specialty drugs specifically through a specialty pharmacy, which is separate from a standard retail or mail order pharmacy.

In regards to discount guarantees by pharmacy channel, mail order discounts are typically deeper than retail discounts. Retail discount guarantees tend to be further divided into extended day supplies (e.g. 84+ day supply scripts) and standard day supplies (e.g. < 84 day supply scripts). Discount guarantees for extended day supplies are typically deeper than standard day supplies. Any scripts purchased outside of the pharmacy types specified in the contract may not be subject to these guarantees.

Table 1 illustrates a sample schedule of discount guarantees that could be found in a standard PBM contract or RFP response. The sample discounts are fabricated and purely illustrative but within range of what a health plan or employer might reasonably expect to see in a PBM offer.

Table 1: Sample AWP Discount Guarantees

Drug Category	Discount Off AWP
Generic Drugs	
Retail: Standard Day Supply	80.00%
Retail: Extended Day Supply	82.00%
Mail Order	84.00%
Brand Drugs	
Retail: Standard Day Supply	18.00%
Retail: Extended Day Supply	24.00%
Mail Order	24.00%
Specialty Drugs	
New Drugs	15.00%
All Others	17.50%

Dispensing Fees

When a drug is filled at a pharmacy, a dispensing fee is charged at the point of sale in addition to the ingredient cost of the drug. Dispensing fees tend to be insignificant relative to the cost of brand drugs and more so for specialty drugs; however, these fees can be significant relative to low-cost generic drugs. While the majority of drug costs *are not* attributable to generic drugs due to their low ingredient cost, the vast majority of scripts filled *are* typically attributable to generic drugs. As a result, nominal dispensing fees can add up and should be considered in the financial analysis of a PBM contract.

PBM contracts normally include a schedule of dispensing fees that vary by pharmacy channel and day supply. Dispensing fees tend to be at their lowest for mail order pharmacies and extended day supplies and at their highest for LTC pharmacies; however, the vast majority of scripts tend to be filled in retail pharmacies for a standard day supply and have a dispensing fee falling somewhere in between. A sample schedule of dispensing fees is shown in Table 2.

Table 2: Sample Dispensing Fees

Drug Category	Dispensing Fee
Retail: Standard Day Supply	$0.75
Retail: Extended Day Supply	$0.00
Mail Order	$0.00
Specialty	$0.25
Long Term Care	$3.50

Rebate Guarantees

Another key component to the financial analysis of a PBM contract is rebates, which provide additional cost reductions for the payor. Rebate guarantees are refunds offered by drug manufacturers or pharmacies that are typically paid to the PBM on a quarterly basis three to six months after the initial purchase of the drug. The PBM then passes on a pre-negotiated portion of those rebates to the payor. Unlike discounts, which apply a percentage cost reduction relative to an external benchmark like AWP, rebate guarantees will usually be presented as a schedule of dollar-per-script amounts in the PBM contract. Although the PBM will report exact point-of-sale ingredient costs and dispensing fees at a claim level, the actual rebates that the PBM receives for each drug are typically considered proprietary information to the PBM and not shared with the plan.

A schedule of manufacturer rebate guarantees may vary by pharmacy channel, day supply, and specialty versus non-specialty brand drugs; however, manufacturer rebates are not typically collected on generic drugs. Similar to discounts, rebate guarantees may be grouped by retail standard day supply, retail extended day supply, and mail order drugs. Specialty drugs will frequently have separate, higher rebate guarantees. PBMs may also specify higher rebates for more specific drugs or categories, such as a higher average rebate for hepatitis C drugs or other specified therapeutic classes.

A sample schedule of manufacturer rebate guarantees is shown in Table 3.

Table 3: Sample Manufacturer Rebate Guarantees

Drug Category	Rebate
Brand Drugs	
Retail: Standard Day Supply	$100
Retail: Extended Day Supply[2]	$350
Mail Order	$400
Specialty Drugs	
All Drugs	$1,200

Another type of rebate—pharmacy rebates—are those collected from pharmacies rather than from drug manufacturers. Pharmacy rebates can apply to generic drugs in addition to brand and specialty drugs. These rebate amounts are similarly presented to payors as an average dollar per script and may vary based on pharmacy. Historically, higher pharmacy rebate amounts have been collected from pharmacies in the PBM's preferred network, while lower pharmacy rebate amounts have been collected from non-preferred pharmacies, if any were collected at all.[3] These types of rebates will be prohibited from post-point-of-sale transactions beginning in 2024 for Medicare and Medicaid. This will be an area of focus for payors and PBMs during contracting and re-contracting negotiations, and may have spill-over effects for Commercial payors.

Contract language should be reviewed to see if the PBM retains any portion of the rebates, either in total or for the share collected above the minimum guarantee. Rebate spreads (i.e. the difference between the collected rebate amounts and the rebate amounts paid to the payor) can be large and may be a significant source of revenue to the PBMs. Typically, the PBM would retain a portion of the rebates in lieu of charging higher administrative fees. These retained rebates can be defined as either collected or shared from the first dollar, or only shared after the minimum rebate guarantees have been met. Therefore, payors should carefully review any language on retained rebates in the PBM contract and be diligent in quantifying the impact of the retained rebate amounts on the total contract value.

PBM Administrative Fees

PBMs can earn revenue in the following ways:

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[2] The definitions of standard day supply and extended day supply for retail categories may not necessarily be the same for rebate guarantees as they are for discount guarantees. For example, the minimum day supply to be considered an extended retail fill may be 84 for discount guarantees but 35 for rebate guarantees.

[3] Pharmacy rebate terms can vary substantially – they are not always related to preferred and non-preferred network inclusion. They can also be based on performance (especially common in Medicare, to incentivize Star rating improvements), volume of scripts filled, and various other measures.

1. Retaining a portion of the rebates collected.
2. Including a measure of profit in the negotiated cost of the drug at point-of-sale (i.e. “spread” pricing). This type of pricing arrangement is allowable in Commercial and Medicaid lines of business but is prohibited in Medicare Part D, which permits “pass through” pricing only.
3. Charging explicit administrative fees.

PBM administrative fees come in many forms, but the most significant and common forms of administrative expenses are per script or transaction fees and per-member-per-month fees (PMPM). The PBM may also charge fixed annual fees and list various other fees that may be charged as per the PBM contract, including for the following:

- Appeals
- Clinical programs and other communications
- Eligibility maintenance
- Explanation of benefits
- Formulary customization
- Member grievances and call centers
- On-site audits and surveys
- Prior authorizations and step therapy
- Trend management and benchmark reporting

The savings offered by PBMs through higher discounts, lower dispensing fees, and higher rebates must be weighed against the costs associated with PBM administrative expenses in the financial analysis of a PBM contract.

Settlement of Guarantees

In order to accurately compare your existing PBM contract with a proposed PBM contract, it is important to understand how your current contract is performing. Unfortunately, this is often not as straight-forward as it seems, as the price charged for a specific drug at the point of sale often has an effective discount that is different from the guarantees specified in the PBM contract. Sometime after the end of the plan year, the PBM will perform an analysis to determine whether or not the actual achieved discounts and rebates are at least as favorable as the guaranteed rates.

For discounts, this calculation is typically done in aggregate across all categories of the schedule of guarantees, such that more favorable performance in one category (e.g. a higher-than-guarantee generic retail discount) will offset less favorable performance in another (e.g. a lower-than-guarantee brand mail

order discount). If the achieved discounts have underperformed relative to the guarantees in aggregate, then the PBM will compensate the payor for the shortfall. Alternatively, if the achieved discounts have outperformed the guarantees in aggregate, then no settlement is necessary and the payor reaps the benefit of the higher discount. An illustration of this cross-subsidization in the settlement of discount guarantees is shown in Table 4 below.

Table 4: Example Settlement of Discount Guarantees

Drug Category	Drug Ingredient Costs (in millions)		
	Actual Amount Incurred [A]	Estimated Amount Using Minimum Discount Guarantees [B]	Shortfall / (Additional Savings) [C] = [A] - [B]
Generic Drugs			
Retail: Standard Day Supply	$30	$34	($4)
Retail: Extended Day Supply	$28	$21	$7
Mail Order	$3	$4	($1)
Brand Drugs			
Retail: Standard Day Supply	$110	$115	($5)
Retail: Extended Day Supply	$60	$61	($1)
Mail Order	$9	$8	$1
Specialty Drugs			
New Drugs	$12	$8	$4
All Others	$100	$108	($8)
Total (All Drug Categories)	**$352**	**$359**	**($7)**

The example in Table 4 shows a shortfall in three drug categories (i.e. generic retail extended day supply, brand mail order, and new specialty drugs), where the actual ingredient costs charged to the plan exceeded the amounts estimated using the minimum discount guarantees. However, the $12 million shortfall for these three categories in total is more than outweighed by additional savings achieved in all other drug categories, where the actual costs fall below the amounts estimated using the minimum discount guarantees. The end result is a net additional savings of $7 million to the payor, and therefore the PBM may not be obligated to issue a settlement payment for the contract's discount guarantees.

Actual manufacturer rebates collected by the PBM in aggregate may also end up being more or less favorable than the rebates that the schedule of guarantees would produce. Similar to discount guarantee settlements, the comparison of actual manufacturer rebate amounts to guarantees is typically done in aggregate across all categories, allowing for over-performance in one category to offset underperformance in another. In the event that actual manufacturer rebates collected by the PBM fall below the rebate guarantees in aggregate, then the PBM will pay at the rate of the guarantees, thereby compensating the payor for any shortfall. Conversely, if the rebates collected by the PBM exceed the

guarantees in aggregate, then the PBM will pay the actual rebates, less any portion retained by the PBM as per the contract, such that the net rebate amount is at least as great the guaranteed amount.

Conclusion

Any analysis of a pharmacy contract, whether it involves several PBM proposals in an RFP process or an exclusive re-contracting process with a payor's incumbent PBM, must begin with a basic analysis of the drug costs (i.e. discounts and dispensing fees), rebates, and PBM administrative fees outlined in the contract. In a proposal, some PBMs may offer better AWP discounts while other PBMs offer better rebate guarantees. Alternatively, a payor may find a PBM that offers the best discounts and rebates but charges significantly higher administrative fees. Such analysis will consider the impacts of these key components together with historical and projected drug mix. While any PBM analysis must start with the elements discussed in this paper, a complete analysis must dive below the surface and into the fine print underlying these items. Wakely explores these topics further in Part Two of this series.

Please contact us with any questions or to follow up on any of the concepts presented here. Our team can support you in all facets of PBM RFPs and PBM/payor contract negotiations.

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OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

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Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

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