The devil is in the Part D-etails: PBM contracting for Part D plans

Michelle Angeloni, FSA, MAAA
Scott McEachern, FSA, MAAA
Sean Hilton, FSA, MAAA

Medicare Part D is a highly competitive, regulated, and complex market, with pharmacy benefit managers (PBMs) heavily influencing Part D profitability and success. Part D plans that leverage actuarial and Medicare pricing expertise in the PBM evaluation process are best positioned to optimize PBM contracting decisions. This paper discusses critical considerations for Part D plans as they contract with a PBM.

PBM contracts are important as they determine pharmacy costs, define PBM responsibilities, and outline the plan's audit and other rights. All health plans must manage their PBM relationship through the tools available to them: the request for proposal (RFP), audits, market checks, and contract optimization (e.g., review of contract definitions, exclusions, and performance guarantees). This is especially true for Medicare Part D plans due to the competitive landscape in which they operate. Medicare Advantage Prescription Drug (MAPD) and Prescription Drug Plan (PDP) sponsors must utilize these tools and, in doing so, must apply their expertise in Medicare pricing and strategy. Collaborating with an expert in both Part D bidding and PBM contract evaluation will provide plan sponsors with the specialized knowledge necessary to optimize a PBM contract.

Financial contract evaluation

PART D CONTRACT EVALUATION IS COMPLICATED

Part D claim costs are paid for by the member, plan sponsor, federal government, and drug manufacturers, with each stakeholder's portion varying based on the phase of the Part D benefit. As a result, computing the portion of claims paid for by the plan (i.e., the net plan liability or NPL) is more complex for Part D plans, including Employer Group Waiver Plans (EGWPs). We define Part D NPL as follows:

Part D NPL = Allowed Cost – Member Cost Sharing – Net Federal Reinsurance – Direct and Indirect Remuneration

Where:

- NPL is the plan sponsor's claim responsibility
- Allowed Cost is the drug cost reflecting negotiated discounts and including dispensing fees and sales tax (if applicable)
- Member Cost Sharing is the beneficiary cost sharing, which includes low-income cost-sharing subsidies and Coverage Gap Discount Program (CGDP) payments from drug manufacturers
- Net Federal Reinsurance is the federal reinsurance subsidy paid to the plan, less the Direct and Indirect Remuneration (DIR) that plans must share with the federal government
- DIR includes all funds exchanged after the point-of-sale (POS) affecting the overall cost of Part D drugs (e.g., drug manufacturer rebates, preferred pharmacy network rebates, price protection payments, and contracting overperformance settlements)

When evaluating PBM contracting changes, plans must consider the impact on the plan's NPL and premium. Plans seeking to optimize their premium rates and focus on the most impactful contract provisions will therefore need a deep understanding of their anticipated membership profiles and Part D bid dynamics. For example, plans should account for the portion of DIR shared with the federal government in their PBM contract evaluations. Because DIR amounts are collected post-POS, they are not reflected in the POS allowed cost used to compute the federal reinsurance subsidy. As a result, the Centers for Medicare

and Medicaid Services (CMS) requires plans to share a portion of the collected DIR with the federal government in proportion to the amount of annual allowed claims paid for by federal reinsurance (which varies by plan). Failure to account for these and other plan-specific Part D dynamics will likely lead to suboptimal PBM contracting decisions.

WHAT SHOULD PLANS CONSIDER AS THEY EVALUATE THEIR PART D PBM CONTRACTS?

Figure 1 shows the allowed cost, NPL, and premium differences between three illustrative sets of PBM contracting terms. Scenarios 1 and 2 show a 3% additive improvement to the effective discount applied to the Average Wholesale Price (AWP), by generic and brand drug types, respectively. Scenario 3 shows a 3% additive increase to total DIR as a percentage of allowed cost.

FIGURE 1: ILLUSTRATIVE FINANCIAL IMPACT OF CONTRACTING CHANGES

		BASELINE*	SCENARIO 1 GENERIC DISCOUNT +3%		SCENARIO 2 BRAND DISCOUNT +3%		SCENARIO 3 DIR +3%	
		AMOUNT PMPM	AMOUNT PMPM	$ CHANGE	AMOUNT PMPM	$ CHANGE	AMOUNT PMPM	$ CHANGE
(1)	Allowed Cost	$329.00	$316.50	-$12.50	$322.80	-$6.20	$329.00	$0.00
(2)	DIR	$85.20	$85.20	$0.00	$85.20	$0.00	$95.20	$10.00
(3)	NPL	$44.50	$39.60	-$4.90	$43.00	-$1.50	$38.00	-$6.50
(4)	Premium	$47.30	$42.40	-$4.90	$45.80	-$1.50	$40.70	-$6.60
(5)	% of Gross Cost** Savings Retained as Premium Savings			39%		24%		66%

* Baseline scenario represents an illustrative Part D plan, and is not representative of all Part D plans in the market.

** Gross cost savings are computed as the sum of allowed (row 1) and DIR (row 2) changes.

Note: All numbers in Figure 1 are rounded and stated on a per member per month (PMPM) basis. The scenarios in Figure 1 are for illustrative purposes only and do not represent the full range of potential premium impacts due to PBM contracting changes.

Figure 1 illustrates the following key considerations for Part D plans:

- **Premium impact is less than allowed cost impact:** Scenario 1 shows only about $5 (row 4) of the $12.50 allowed cost per member per month reduction (row 1) is retained as premium savings. This is because the allowed cost savings is distributed across the various stakeholders (i.e., the plan, beneficiaries, federal government, and drug manufacturers).
- **Generic and brand discount improvements do not reduce premium equally:** Row 5 shows the percentage of gross cost savings (due to the illustrative discount improvement) retained as premium savings for this particular plan. Generic and brand discount improvements reduce premium at different rates, in part because the plan's liability varies across the Part D benefit phases and by drug type. For instance, brand and specialty drugs tend to represent higher proportions of claims in the catastrophic phase of the benefit, where federal reinsurance covers 80% of the allowed drug cost.
- **Plan contracting decisions must consider NPL:** Row 4 shows Scenario 3's contracting terms reduce premium by more than Scenario 1's contracting terms, even though Scenario 1's allowed cost savings exceeds Scenario 3's DIR improvement. Plans basing their financial comparisons on total DIR and allowed cost (while ignoring plan-specific NPL impacts) are not evaluating the true financial impact to the plan.
- **DIR and discount improvements do not reduce NPL equally:** Discount improvement is applied at the POS, and is thus shared with all stakeholders across the Part D benefit phases. In contrast, DIR is a post-POS financial item and is shared only with the plan and federal reinsurance. In general, $1 of DIR improvement will reduce NPL by more than $1 of allowed cost reduction (via discount improvement), though the magnitude of the difference varies based on plan characteristics.

While only a portion of discount, dispensing fee, and DIR changes are retained as premium changes (see row 5 of Figure 1), changes in non-benefit expenses (NBE) are fully retained by the plan and impact premium on a dollar-for-dollar basis. The illustrative evaluation in Figure 1 reflects equal NBE across the three scenarios, though PBM administrative fees typically vary by contract. PBM administrative fees may be assessed in a variety of ways (e.g., PMPM, per script, and subject to minimum or maximum fee amounts) and can cover a range of services (e.g., core services, custom offerings, supplemental clinical or administrative support). The PBM admin fee may also depend on whether terms are under a traditional (i.e., spread, or lock-in) or a pass-through (i.e., transparent) arrangement. Plans comparing these two types of

financial arrangements will need to understand and incorporate CMS's specific bidding requirements into their contract evaluations. Part D bids must be developed using pass-through pricing (i.e., drug costs must reflect the negotiated amount paid to the provider), with any anticipated spread (the difference between what the PBM negotiates with providers vs. the plan) incorporated into NBE.[1]

- Plans will also need to leverage their Part D pricing expertise when evaluating PBM offerings such as shared savings arrangements. In a shared savings arrangement, the PBM may retain a percentage of any overperformance relative to contract minimum guarantees. Because overperformance payments are settled post-POS and considered DIR, Part D plans should consider the impact of sharing DIR with federal reinsurance when assessing the true value of such arrangements.

BID DYNAMICS ARE IMPORTANT; PLAN-SPECIFIC BID DYNAMICS ARE EVEN MORE IMPORTANT

Figure 1 demonstrates the importance of incorporating Part D bid dynamics into a PBM contract evaluation. However, this alone is not enough to ensure sound contracting decisions. Plans must also consider how their specific member and plan cost profiles will interact with these bid dynamics. Figure 2 provides an illustrative financial comparison of two sample contracts, given a range of plan-specific information. Contract A represents a 5% additive increase to DIR as a percentage of allowed cost, while Contract B represents a 3% improvement in the average effective discount applied to AWP, for all drugs.

FIGURE 2: FINANCIAL IMPACT OF DIR AND AWP DISCOUNT CONTRACTING CHANGES BY PLAN

SCENARIO DESCRIPTIONS	CONTRACT A PREMIUM	CONTRACT B PREMIUM	WINNER (SHADED GREEN)
Scenario 1 – Defined Standard plan applied to illustrative Part D population	$37.40	$39.60	Contract A by $2.20 PMPM
Scenario 2 – Same as Scenario 1, but with an Enhanced plan design, low generic copays, and higher generic dispensing rate (GDR)	$65.80	$63.30	Contract B by $2.50 PMPM
Scenario 3 – Same as Scenario 2, but applied to a plan with higher cost and risk score	$80.70	$87.80	Contract A by $7.10 PMPM

The scenarios in Figure 2 are for illustrative purposes only and do not represent the full range of potential premium impacts due to PBM contracting changes.

Figure 2 shows that a PBM contract's competitiveness depends on the underlying population characteristics. The amount of member cost sharing, generic dispensing rate (GDR), mix of brand and specialty medications, and the distribution of claim spending across the Part D benefit phases are all examples of plan characteristics affecting the overall value of a contract. In other words, a sound analysis of whether Contract A or Contract B offers more favorable terms for a plan must account for the plan-specific experience.

Beyond the bid math

OTHER IMPORTANT NUANCES SHOULD FACTOR INTO A PART D PLAN'S PBM SELECTION

Part D plans should ensure that their internal and external pharmacy contracting and bid pricing teams work together closely when evaluating PBM contracting terms. Doing so will optimize contract negotiations and ensure PBM decisions are based on the true value to the plan. Part D plans should also consider the following factors when evaluating their PBM:

- **Proper expertise helps plans prioritize and focus:** PBMs may vary their contract terms based on factors such as plan size, deviations from the PBM's standard formulary, cost-sharing requirements (e.g., copay differential between tiers), and ability to achieve member steerage (e.g., based on the distribution of non-low-income and low-income members, or due to preferred pharmacy arrangements), among other factors. For example, some EGWPs limit disruption for members transitioning from commercial pharmacy benefit plans by offering open formularies and pharmacy networks to their enrollees. EGWPs providing such broad coverage could limit their ability to steer members to specific drugs and providers, potentially reducing rebate negotiation leverage with manufacturers and pharmacies. Part D plans should understand the types of contracting terms potentially achievable and should focus negotiation efforts on the most material

[1] See CMS's "Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2021" for additional guidance.

contracting elements. Plan sponsors may benefit from engaging external experts who have experience working with different Part D plans and can offer benchmarking services and broader market perspectives. Outside consultants can provide specialized support to internal subject matter experts within the Part D plan, or they can provide complete support to plans without such expertise based on a variety of experiences and overall knowledge of the market.

- **DIR impacts bids, even if the PBM retains it:** PBMs are not required to (and often do not) pass through all DIR received on a plan's behalf. One example of this is the Manufacturer Administrative Fees (MAF), which PBMs frequently collect and retain as service fees from drug manufacturers. Part D plans are still required to report and include these fees as DIR and, as a result, Part D plans pay a portion of these fees toward federal reinsurance, just as they do with all other DIR. This means that even though a PBM may not pass through MAF amounts to the plan sponsor, the plan must still pay a portion of the PBM's MAF to the federal government.
- **Evaluate network and formulary changes:** Part D plans should evaluate their PBM's proposed pharmacy network and formulary to ensure they are appropriate for their members. Plans electing a preferred network will typically have cost-sharing and contracting differences between their preferred and standard pharmacy networks, and the contract's competitiveness may depend on the percentage of members expected to utilize the preferred pharmacy network. Plans can conduct formulary and network disruption analyses to understand how proposed changes will impact members.
- **Contract language matters:** Part D plans should understand the definitions and exclusions outlined in the PBM contract. Clear, auditable definitions and exclusions are important for modeling and monitoring experience under a PBM arrangement, and can have a material impact on Part D plan profitability.[2]
- **Timing is key**: Part D plans (except EGWPs) are subject to risk sharing via a federal risk corridor program. Under this program, plans share profits or losses with the federal government, based on actual net claims compared to the bid projected target amount. If PBM contracting changes are negotiated after the bid is submitted (and not included in the projected bid), then any improvement to net claims relative to the bid may be partially paid to the federal government in the form of risk corridor payments.
- **Transparency is important:** Plans will benefit from contracting with a PBM that is transparent in its communication. For example, plans receiving detailed DIR reports from their PBMs can better track the total DIR affecting their Part D risk corridor and federal reinsurance settlement calculations. Detailed DIR reporting can also help plans more accurately project their future DIR payments above any minimum guarantees. While transparency is generally beneficial, pass-through contracting does not necessarily mean full transparency nor does it always equate to lower costs. Plans should consider the total cost impact of both spread and pass-through arrangements, and estimate the potential savings associated with each.
- **Don't forget about Part B rebates**: Medicare Part B provides coverage for certain medically necessary drugs not typically self-administered (e.g., drug injections or infusions given during office visits or in outpatient settings). Historically, CMS prevented Medicare Advantage organizations (MAOs) from limiting beneficiary access to treatments required by national and local Part B coverage determinations (however, plans were allowed to have preferred vendors for some Part B medications, like insulin supplies). Effective January 1, 2019, CMS allows MAOs to apply step therapy[3] requirements to their Part B-covered drugs newly prescribed to beneficiaries.[4] This policy change has increased flexibility for Medicare Advantage plans to manage the utilization of Part B drugs and provides more leverage for plan sponsors to negotiate stronger rebates on Part B medications.
- **Maximize the Medicare star rating:** PBMs can favorably or adversely affect an MAO's Part D star rating, depending on the quality of support provided to the plan. Plans should be aware of the PBM's reputation for supporting Part D plans and seek detailed information from the PBM on services such as management of chronic conditions, customer service, timely resolutions of beneficiary complaints and appeals, and compliance with the latest Medicare regulations, all of which may affect the plan's Part D star rating metrics. In particular, plans should evaluate the PBM's programs in place to improve medication adherence for populations with chronic conditions (e.g., diabetes, hypertension, and cholesterol), which are associated with three separate, triple-weighted Part D star rating metrics.[5]

---

[2] For additional discussion of PBM contract language and effective PBM contract management, see "PBM Contracts: Understand then Optimize," by Scott McEachern and Patrick Cambel, available at https://www.milliman.com/en/insight/pbm-contracts-understand-then-optimize.

[3] Step therapy is a form of utilization management in which the plan requires utilization of a specified "first-line" drug before transitioning to second line treatments.

[4] CMS (August 7, 2018). Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage. Retrieved November 19, 2020, from https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.

[5] CMS (October 1, 2019). Medicare 2020 Part C & D Star Ratings Technical Notes. Retrieved November 19, 2020, from https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf.

- **Minimize audit risk:** Choosing the right PBM may limit a plan's risk of receiving findings during CMS audits. CMS notes a primary audit concern is the "ability to provide beneficiaries with access to medically necessary services and prescription drugs," which PBMs are key partners in securing for Part D populations. Plans should understand a PBM's historical experience with Part D (and with the plan's specific product in particular), including whether or not the PBM has Part D experience by way of operating its own Part D plan.
- **Find the right partner:** Part D plans come in a variety of "shapes and sizes," and require a range of guidance and expertise. For example, a new-to-market Part D plan may require a different level of PBM support than an established plan, or an Institutional Special Needs Plan may benefit from formulary and care management expertise customized to its population. The PBM plays a critical role in the success of a Part D plan. As a result, Part D plans should invest significant time and resources to ensuring they select the right PBM.

Conclusion

A Part D plan's PBM does more than just adjudicate the benefit. The PBM determines the claim cost, impacts the beneficiary's experience, and affects the plan's good standing with CMS. Unfortunately, PBM contracting is complex and sometimes not given the due diligence it deserves. All plans negotiating with PBMs must consider important issues such as contract definitions and exclusions. However, Part D plans in particular must additionally consider the impact of plan-specific Medicare bid dynamics and regulatory requirements. To navigate the competitive, highly regulated Part D landscape, plans must have the internal and external subject matter expertise to strategically evaluate the PBM in the context of the Medicare environment, and then vigilantly monitor and manage the PBM relationship.

Milliman

CONTACT

Michelle Angeloni, FSA, MAAA
michelle.angeloni@milliman.com

Scott McEachern, FSA, MAAA
scott.mceachern@milliman.com

Sean Hilton, FSA, MAAA
sean.hilton@milliman.com