CONNECTICUT
Health Strategy

Report of Pharmacy Benefit Manager Practices

Pursuant to Public Act 23-171 § 7

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Commissioner

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Update History: This report was updated to include the addition on Appendix B.

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Executive Summary

PURPOSE OF REPORT

The Connecticut Office of Health Strategy (OHS) is responsible for developing health policy that improves health outcomes and limits health care cost growth. Pursuant to Public Act 23-171 § 7, the OHS is conducting an analysis of pharmacy benefit managers' (PBMs') practices of prescription drug distribution, including, but not limited to, spread pricing arrangements, manufacturing rebates and transparency, fees charged, and financial incentives for adding drugs to health plan formularies. OHS has retained Milliman to perform an independent analysis of PBM pricing practices in Connecticut and provide a report outlining the findings of the analysis.

This study and report seek to: (1) understand the impact of PBM practices on providers and consumers in the state, (2) compare these practices to those of PBMs operating in other states, and (3) provide state policy considerations and trends that may lower the cost of prescription drugs for consumers and increase transparency with PBM practices.

As part of this study, summary level paid claims data (including amounts paid by plan sponsor and member, and amounts paid to pharmacies) and summary rebate data (including amounts passed through and retained) were requested from several of the largest PBMs operating within the state. The majority of PBMs were unable to negotiate data releases within identified time constraints for the initial release of this report. OHS lacks regulatory authority to collect the additional data needed to prepare this analysis. A supplemental report (see Appendix B: Pharmacy Benefit Manager Practice Report Supplement - Estimated Connecticut PBM Revenue, Rebates, Pricing Spread, and Profit) has subsequently been added to this report, and provides estimates of PBM revenue and profitability in the state of Connecticut, including a breakout of key revenue sources described in the main report.

REPORT OVERVIEW

The report begins by outlining the current landscape of PBMs in Connecticut. It provides a summary of the distribution of covered lives by insurance segment and PBM, along with details on the ownership structures of the top five PBMs in the state. Additionally, it examines existing PBM legislation in Connecticut. The report then delves into PBM market dynamics, exploring the roles and responsibilities of PBMs, their pricing strategies, and evolving profit margins for PBMs and their affiliated businesses.

The report includes a scan of PBM legislation across the United States, with a focus on state-level laws and a summary of federal legislative activities. We also discuss significant litigation involving PBMs and their plan sponsors,[1] which could potentially impact future PBM market dynamics.

Finally, we discuss potential conflicts of interest within the pharmacy supply chain, such as those related to high list price / high rebate strategies, PBM-affiliated businesses, and pharmacy reimbursement. This discussion leads to considerations for improving PBM oversight at the state

[1] Plan sponsors may refer to a health plan or employer

level which could potentially reduce drug prices for consumers. A glossary with key terms is included at the end of this report.

PBM OVERVIEW

A PBM is a third-party administrator of prescription drug programs for health plans, employers, and other entities. The core functions of a PBM include:

- Claims Processing: PBMs handle the processing of prescription drug claims, with the goal of ensuring that transactions between pharmacies, plan sponsors, and patients are efficient and accurate.

- Negotiating Drug Prices: PBMs negotiate with drug manufacturers to obtain discounts (e.g., rebates) on medications. They leverage their scale to secure larger rebates, which can help reduce overall drug costs.

- Formulary Management: PBMs develop and manage formularies, which are lists of covered medications. A formulary determines which drugs are covered and at what tier, influencing patient access to certain medications and the amount a patient pays for a prescription to encourage the use of clinically appropriate, cost-effective options.

- Pharmacy Network Management: PBMs establish and manage networks of pharmacies where patients can fill their prescriptions. They determine the amount network pharmacies are reimbursed and ensure that network pharmacies meet specific standards.

- Utilization Management: PBMs implement various strategies to control drug use and to ensure that medications are used safely and appropriately. This can include requiring approval to obtain a specific medication (i.e., prior authorization) or requiring the trial and failure of an alternative, possibly less expensive drug prior to pursuing more costly therapy (i.e., step therapy).

- Patient Services: PBMs often provide services to help patients manage their medications, such as mail-order pharmacy services, medication adherence programs, and specialty pharmacy services for complex or high-cost medications.

The top five PBMs in Connecticut that account for approximately 95% of lives in the state are Express Scripts, Gainwell Technologies, CVS Caremark, Optum Rx, and CarelonRx. Gainwell Technologies solely operates in the Medicaid market in Connecticut, while the other four PBMs operate in other markets (e.g., commercial, Medicare). Express Scripts, CVS Caremark, and Optum Rx are collectively known as the “Big 3” PBMs and provide pharmacy benefit management services for 84% of commercially-insured lives in Connecticut. The Big 3 PBMs are vertically integrated, meaning they are part of larger parent organizations that often include a health insurer, PBM, rebate group purchasing organization (GPO), pharmacies (retail, mail, and / or specialty), provider services, and, most recently, drug distribution entities. These organizations control a large portion of the pharmacy supply chain – from partnering with drug manufacturers to produce medications, to filling prescriptions at their affiliate pharmacies.

Key Takeaways:

- The Big 3 PBMs (Express Scripts, CVS Caremark, Optum Rx) manage pharmacy benefits for 84% of commercially-insured lives in Connecticut.
- PBMs have expanded vertically, controlling significant portions of the pharmaceutical supply chain.
- Traditional PBM profit models are evolving, shifting from traditional revenue sources (e.g., rebate retention and spread pricing) towards revenue from affiliated businesses like specialty pharmacies and rebate GPOs.
- Specialty drug spending is one of the fastest-growing areas in pharmacy expenditures, with a significant portion of the market accessed through specialty pharmacies affiliated with the largest PBMs.

THE RELATIONSHIP BETWEEN LIST PRICE AND NET COST

The relationship between a formulary and drug rebates is intrinsically connected, as the structure and composition of a formulary can significantly influence the rebates that PBMs receive from drug manufacturers. A formulary is a list of covered medications, organized into tiers that dictate the cost-sharing amounts for plan members. Drug manufacturers negotiate with PBMs to secure favorable formulary placement for their products, often in exchange for rebates. These rebates are financial incentives given by manufacturers to ensure their drugs are more accessible to patients by being placed on lower, more preferred tiers of the formulary.

In turn, PBMs use these rebates to manage plan costs, either by passing the savings to plan sponsors to help lower premiums or by directly reducing out-of-pocket costs for members at the point of sale. This negotiation process is crucial for PBMs, as it directly impacts their ability to offer competitive pricing and rebate guarantees to plan sponsors. Therefore, the formulary design, including which drugs are included and their tier placement, plays a pivotal role in determining the rebate amounts PBMs can secure, ultimately affecting the overall cost management strategies of the health plans they administer.

A high list price / high rebate strategy is a pricing approach commonly used in the pharmaceutical industry. This strategy involves preferring products with a high list price (i.e., high gross cost) and high manufacturer rebates. While the list price is high, the actual cost (i.e., net cost) to the plan sponsor (i.e., health plan or employer) can be significantly lower after rebates. Plan sponsors often use rebates to subsidize premiums for all members, rather than returning the rebate to the member whose claims generated the rebate. It is possible for a drug with a high list price and high rebate value to have a lower net cost to the plan sponsor than lower list price alternatives; however, this can result in higher costs for patients when their cost share (e.g., coinsurance) is based on the higher list price (excluding rebate value). There are several other dynamics in the pharmacy supply chain that perpetuate high list price / high rebate strategies. For example, many participants in the pharmacy supply chain have the potential to benefit from higher costs of drugs. Whenever a stakeholder's profitability is tied to a percentage of the list cost of a drug, higher prices can lead to higher profitability. These potential misaligned incentives, and others, are discussed in greater detailed in the Discussion section of the report.

Key Takeaways:

- High list price / high rebate strategies benefit PBMs and plan sponsors but can increase patient costs at the pharmacy.
- Rebate value is often applied to overall plan costs, lowering premiums for all members, not just those utilizing the drug that generated the rebate.
- A high list price / high rebate strategy can generally disadvantage biosimilars and generics, which typically have lower list prices and often do not offer comparable rebates.
- Stakeholders that generate profit tied to list prices of pharmaceutical products can benefit from higher drug costs, creating potential misaligned incentives. Many participants in the pharmacy supply chain, including manufacturers, wholesalers, PBMs, rebate GPOs, and pharmacies, have the potential to benefit from higher costs of drugs.
- It is possible for PBMs to earn more revenue by preferring a product that has a higher net cost to the payer. This higher revenue may be earned through sources such as retained rebates or a percentage of the cost of the product through PBM affiliate pharmacies.
- Rebate GPOs retain a fee from manufacturers, which is often based on a percentage of the list price of the drug. This revenue may not be shared with rebate GPO participants or PBMs.

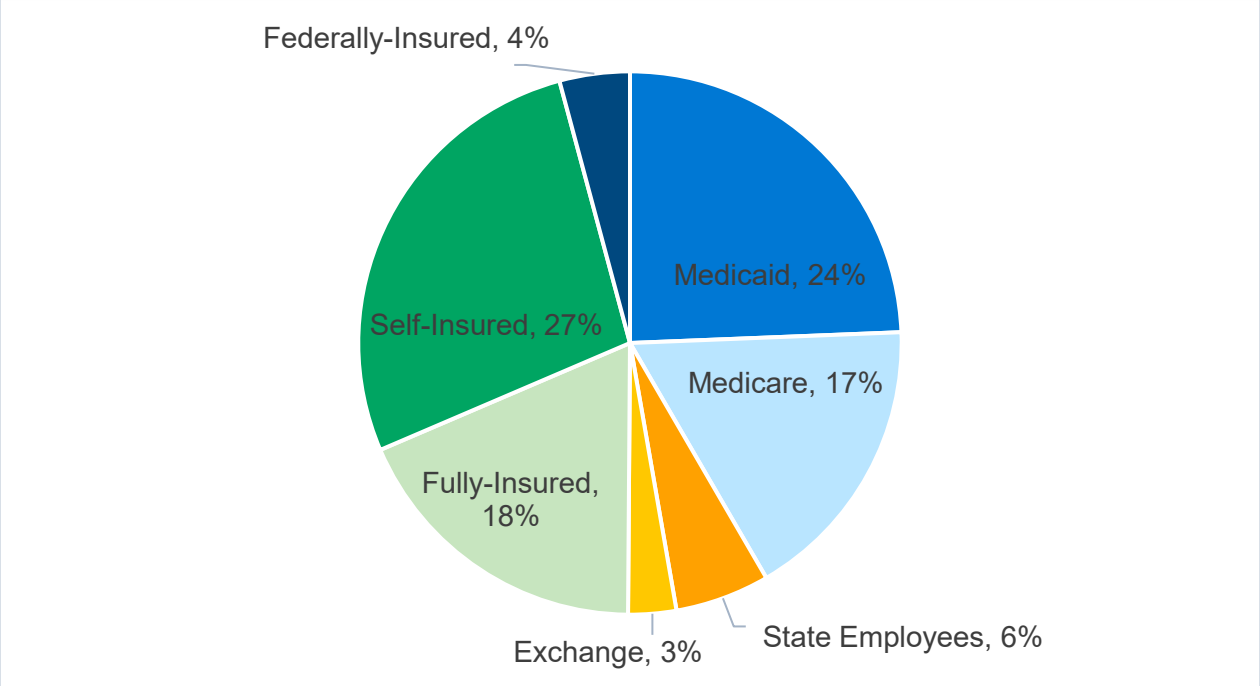
Considerations of these dynamics and others, are discussed in greater detail in the Considerations section of the report.

Current PBM Landscape in Connecticut

HEALTH BENEFIT COVERAGE LANDSCAPE

Connecticut's health insurance markets each have unique characteristics and challenges. This report focuses on three primary markets: Medicaid, Medicare, and commercial insurance (fully-insured, self-insured, Health Exchange, and State employee / municipal partnership). Each of these markets operates under different regulatory frameworks, funding mechanisms, and administrative structures, which subsequently influence the role and functioning of PBMs within them. Figure 1 below shows the breakdown of lives in Connecticut by insurance coverage. Please note, there were approximately 195,000 uninsured people in Connecticut in 2023, comprising approximately 5.6% of the population.[2]

FIGURE 1. CONNECTICUT LIVES BY INSURANCE COVERAGE (2023)



Source: Milliman analysis of data from Managed Markets Insight & Technology (MMIT) and CMS enrollment data for Medicaid and Medicare Part D.
Note: Members eligible for both Medicare and Medicare (dual eligibles) are classified as Medicare.

Commercial

The commercial insurance market, which includes employer-sponsored plans and individual policies, caters to a broad demographic, providing diverse plan options and coverage levels. Figure 1 shows the commercial market split between fully-insured, self-funded, Health Exchange, and State employee lives. Together, these commercial groups comprise 54% of the 3.5 million insured lives in Connecticut. A brief description of each of these is provided below.

[2] https://www.kff.org/statedata/election-state-fact-sheets/connecticut/

- **Fully insured plans (18%)**: The employer pays a fixed premium to a health insurance plan for covered employees and often their families. The insurance company assumes the risk of paying all medical and pharmacy claims. This arrangement is subject to state mandates, premium taxes, and regulations under the Affordable Care Act (ACA). Employers have less control over the plan design and claims data, as these are managed by the insurer and the insurer's contracted PBM.
- **Self-insured plans (27%)**: The employer (i.e., plan sponsor) assumes the risk of paying medical and pharmacy claims directly, and shares costs with their employees. The employer may partner with a third-party administrator (TPA) to manage claims processing and administrative tasks for a fee. This arrangement offers more flexibility in plan design and control over claims data. Self-insured plans are generally subject to fewer regulations, primarily those under the Employee Retirement Income Security Act (ERISA) and are not subject to state mandates or premium taxes. Pharmacy services may be provided by a TPA or health plan, or the employer may choose to carve-out their pharmacy benefits to a separate PBM not affiliated with the administrator.
- **Health Exchange (3%)**: A marketplace created by the ACA to help individuals and small employers find and enroll in health insurance plans. The Health Exchange may offer various programs to assist small employers in enrolling their employees in qualified health plans. Pharmacy benefits and coverage must meet certain minimum standards within each state. The Health Exchange operates similar to a fully insured plan, with subsidies from the federal and / or state government. The Health Exchange in Connecticut is known as Access Health CT.
- **State employees (6%)**: The State employee insurance offers comprehensive health care benefits to State government employees, non-Medicare-eligible retirees, and eligible dependents. The State of Connecticut Medical Benefit Plan is a self-funded health plan that is not subject to ERISA. The State contracts with Anthem Blue Cross and Blue Shield (BCBS) to provide claims processing and other administrative services. The State also contracts with Quantum Health to provide utilization management services and healthcare navigation services for members.[3] Eligible members have access to a variety of Anthem BCBS plans and the prescription drug member cost share depends on the plan, drug type (generic, preferred brand, non-preferred brand, specialty), as well as the network status (e.g., in-network, out-of-network).[4,5,6,7,8] The prescription benefit is managed by CVS Caremark.[9] The State of Connecticut also offers the CT Partnership Plan[10] to non-state public employees who work for municipalities, boards of education, quasi-public agencies, and public libraries.

[3] https://carecompass.ct.gov/wp-content/uploads/2024/03/State-of-CT-2023-Medical-Plan_Rev0318.2024-1.pdf
[4] https://carecompass.ct.gov/state/medical/
[5] https://carecompass.ct.gov/wp-content/uploads/2024/06/State-of-CT-POE-G-Primary-Care-Access-SBC-2024-2025.pdf
[6] https://carecompass.ct.gov/wp-content/uploads/2024/06/State-of-CT-Quality-First-Select-Access-SBC-2024-2025.pdf
[7] https://carecompass.ct.gov/wp-content/uploads/2024/06/State-of-CT-POE-Standard-Access-SBC-2024-2025.pdf
[8] https://carecompass.ct.gov/wp-content/uploads/2024/06/State-of-CT-Quality-First-Select-Access-SBC-2024-2025.pdf
[9] https://carecompass.ct.gov/wp-content/uploads/2024/10/State-of-CT-2023-Pharmacy-Drug-Plan-Document.pdf
[10] https://osc.ct.gov/ctpartner/docs/Partnership2_0_brochure_2024_2025.pdf

Medicaid

Medicaid, the state-federal program known as HUSKY Health in Connecticut, serves as the primary source of health coverage for low-income individuals and vulnerable populations and covers 24% of the population. Connecticut does not have a comprehensive Medicaid managed care program, instead HUSKY Health operates under a fee-for-service (FFS) model with administrative services only (ASO) contracts.[11,12] Gainwell Technologies is the single PBM for HUKSY Health and its responsibilities include: processing claims, financial refunds and recoupments; issuing payments and remittance advices; performing provider enrollment and re-enrollment; offering a provider call center dedicated to assisting providers with billing questions; providing a dedicated provider relations team to perform provider training and respond to complex program issues; providing a client assistance call center; and providing pharmacy prior authorization service and call center.[13] Note, Magellan manages the preferred drug list for HUSKY Health, which aims to shift utilization to preferred products that often have supplemental rebates.[14] Connecticut participates in one of the three largest interstate drug purchasing pools, which were created to increase negotiation power for supplemental rebates across state Medicaid agencies. Connecticut is one of seven states that participates in the Prime Therapeutic's Top Dollar Program (TOP$).[15,16] HUSKY Health covers approximately 24% of insured lives in Connecticut.

Medicare

Medicare, which provides federally-funded coverage for individuals aged 65 and older, as well as certain younger individuals with disabilities, covers 17% of insured lives in Connecticut. Medicare Part D is the part of the Medicare benefit that provides prescription drug coverage. Medicare Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PD) are the two main types of plans that provide prescription drug coverage under Medicare Part D. PDPs are standalone plans that provide prescription drug coverage only and are designed to complement original Medicare (Part A and Part B). MA-PDs are part of Medicare Advantage plans that provide integrated medical and drug coverage. For State employees who are Medicare eligible, the Office of the State Comptroller has contracted with Aetna to provide medical and prescription drug coverage.[17]

Other Federal Programs

Lastly, four percent (4%) of Connecticut's population receives health benefits through other federal programs, including the Department of Defense's TRICARE program, the Veterans Health Administration, the Indian Health Service, and the Federal Employee Health Benefit Program. These federal programs are managed by multiple different insurers and PBMs.

[11] https://www.cga.ct.gov/2015/rpt/2015-R-0010.htm

[12] https://www.managedhealthcareexecutive.com/view/connecticut-bucks-the-medicaid-managed-care-trend

[13] https://www.ctdssmap.com/CTPortal/Provider/Provider-Services

[14] https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20230714/DSS%20Presentation.pdf

[15] https://www.primetherapeutics.com/tops

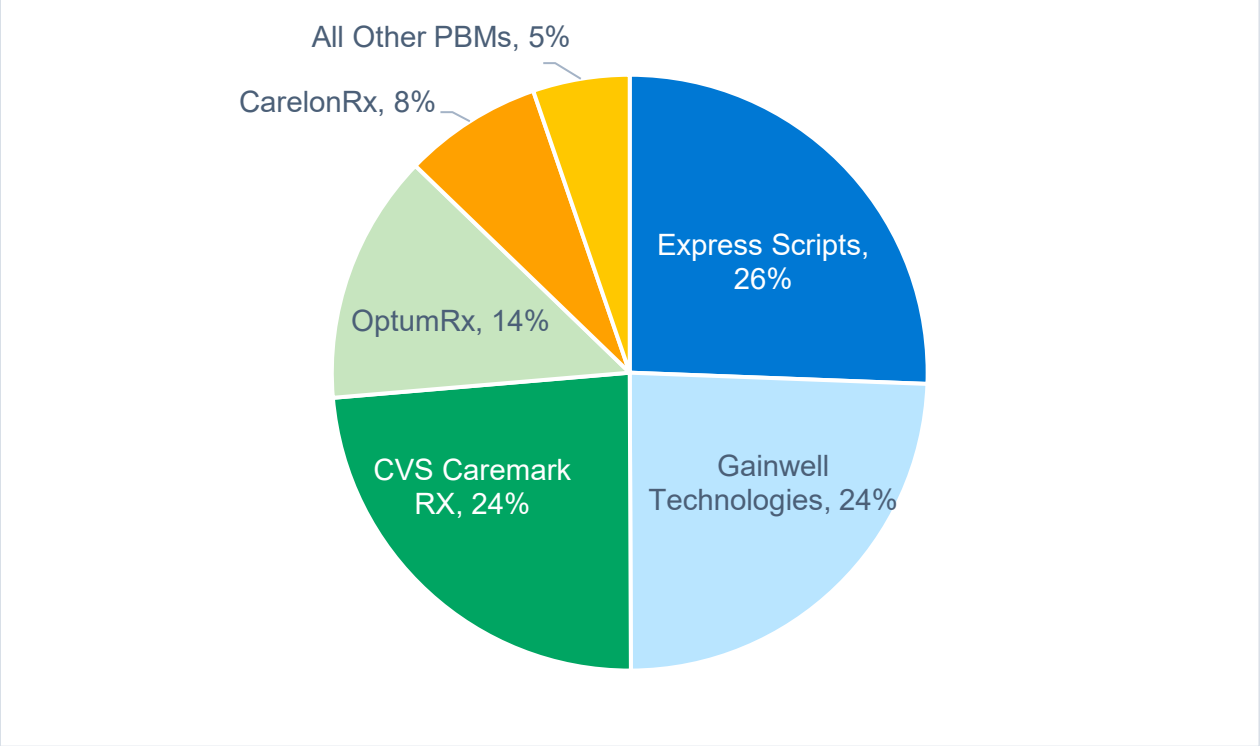
[16] https://www.ncsl.org/health/bulk-purchasing-of-prescription-drugs

[17] https://ct.aetnamedicare.com/

PBM LANDSCAPE

Using 2023 data from Managed Market Insight & Technology[18] (MMIT), we identified approximately 20 PBMs operating in Connecticut. The top five PBMs in Connecticut that account for approximately 95% of lives in the State are Express Scripts, Gainwell Technologies, CVS Caremark, Optum Rx, and CarelonRx. CarelonRx, a division of Elevance, is shown separately here but currently outsources many of their PBM functions to CVS Caremark. This is discussed in more detail in the next section.

FIGURE 2. CONNECTICUT LIVES BY PBM, ALL MARKETS (2023)



Source: *Milliman analysis of data from MMIT and CMS enrollment data for Medicaid and Medicare Part D.*

However, PBM coverage varies by market. For example, there is a single PBM for Medicaid enrollees, Gainwell Technologies. Similar to the HUSKY Health program, one PBM, CVS Caremark, covers all State employee lives. A summary of the lives by PBM and market can be found in Table 1 below.

[18] https://www.mmitnetwork.com/about-mmit/

TABLE 1: ESTIMATED NUMBER OF LIVES IN CONNECTICUT BY PBM AND MARKET (2023)

MARKET	EXPRESS SCRIPTS	GAINWELL TECHNOLOGIES	CVS CAREMARK	OPTUM RX	CARLONRX	ALL OTHER PBMS	TOTAL LIVES
Medicaid	0%	100%	0%	0%	0%	0%	**844,000**
Medicare	10%	0%	39%	39%	7%	5%	**598,000**
State Employees	0%	0%	100%	0%	0%	0%	**195,000**
Exchange	68%	0%	0%	0%	32%	0%	**99,000**
Fully-Insured	37%	0%	6%	22%	28%	6%	**639,000**
Self-Insured	50%	0%	34%	10%	1%	5%	**944,000**
Federal Employees	32%	0%	23%	0%	0%	44%	**145,000**
Total Lives	**887,000**	**844,000**	**822,000**	**470,000**	**261,000**	**182,000**	**3,464,000**

Source: Milliman analysis of data from MMIT and CMS enrollment data for Medicaid and Medicare Part D.
Note: Totals may not tie due to rounding.

OWNERSHIP STRUCTURE OF PBMS IN CONNECTICUT

Below is a summary of the ownership structure for the five top PBMs in Connecticut by number of lives – Express Scripts, CVS Caremark, Optum Rx, Gainwell Technologies, and CarelonRx. Together, these five PBMs account for approximately 95% of the insured lives in the State. Due to similarities in ownership structure, we have grouped Express Scripts, CVS Caremark, and Optum Rx into one section, titled The Big 3 PBMs. Information on corporate structures for Gainwell Technologies and CarelonRx is provided separately below.

The "Big 3" PBMs

Express Scripts, CVS Caremark, and Optum Rx are collectively known as the "Big 3" PBMs and are large, vertically integrated companies that provide pharmacy benefit management services to approximately 64% of lives in Connecticut according to 2023 MMIT data. For context, these PBMs managed 79% of prescription drug claims in the U.S. in 2023.[19] In the commercial market (state employees, Health Exchange, fully insured, and self-insured) the Big 3 PBMs account for 84% of lives in Connecticut. These PBMs are part of organizations that often include a health insurer, PBM, group purchasing organization (GPO), pharmacies (retail, mail, and / or specialty), provider services, and, most recently, drug distribution. A summary of ownership structures and consolidation among the Big 3 PBMs and related organizations is provided in Table 2.

[19] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

TABLE 2. VERTICAL INTEGRATION IN THE BIG 3 PBMS

Parent Company	Health Insurer	Pharmacy Benefit Manager	Group Purchasing Organization	Retail / Specialty Pharmacy	Provider / Clinical Delivery System	Drug Distributor
Cigna Group	Cigna	Express Scripts	Ascent and Econdisc	N/A / Accredo (Specialty)	Evernorth Health Services, Alegis Care, MD Live	Quallent Pharmaceuticals
CVS Health	Aetna	CVS Caremark	Zinc and Red Oak Sourcing	CVS (Retail Pharmacies) / CVS Specialty	CVS Minute Clinic, Health Hub, Oak St Health	Cordavis
UnitedHealth Group	United Healthcare	Optum Rx	Emisar	N/A / Optum	Optum Care	Nuvaila

Source: Based on internal Milliman research.

Health Insurers

The three largest health insurers in the country cover approximately 92.6 million members nationwide.[20] Each of their affiliated PBMs provide pharmacy benefits for a majority of their members. For example, CVS Health's PBM, CVS Caremark, provides PBM services for the majority of Aetna's fully-insured health plan members.

Rebate Group Purchasing Organizations

A rebate GPO is an entity formed to negotiate drug rebates with pharmaceutical manufacturers on behalf of its participants, which typically include PBMs and other payer entities. PBM-affiliate rebate GPOs began to emerge in 2019, with the formation of Ascent Health Services by Express Scripts. Since that time CVS Health (Zinc, formed in 2020) and Optum Rx (Emisar, formed in 2021) have also created their own rebate GPOs. Note, rebate GPOs currently operate only in the commercial line of business. The PBMs delegated manufacturer rebate negotiations to rebate GPOs to leverage additional discounts and revenue streams from manufacturers. A majority of plan sponsors, health plans, and smaller PBMs obtain their rebates through one of these three major PBMs and, by extension, the PBM's affiliated rebate GPOs, rather than directly engaging with a separate rebate GPO. An illustration outlining the flow of medication, rebates and payment through the pharmacy supply chain can be found in the Appendix A.

In addition to drug rebates, rebate GPOs typically collect additional fees from manufacturers for other services or access provided. The revenue from these additional fees is often not disclosed and is not necessarily passed through to downstream plan sponsors. While rebate GPOs may allow commercial payers to obtain additional rebate value through their scale and purchasing power, these new stakeholders also provide potential new layers of retention and profit for the parent organization. Rebate GPOs are discussed in more detail in the Rebates section of this report.

[20] https://www.beckerspayer.com/payer/150-things-to-know-about-the-big-6-health-insurers.html?oly_enc_id=7997D0213056D2B

Retail, Mail Order, and Central Fill Specialty Pharmacies

Currently, CVS Health is the only Big 3 PBM that has an affiliate network of retail pharmacies, with over 9,000 locations.[21] However, each of the Big 3 PBMs owns its own specialty pharmacy, which provides an increasing portion of revenue for these entities, growing from 16% of gross profit in 2012 to 39% in 2023.[22] Due to both horizontal consolidation and vertical integration, the Big 3 PBMs now control almost 70% of all specialty drug revenue.[23,24] For commercial insurance, the Big 3 PBMs are able to offer limited networks to payers where they are the exclusive provider of specialty prescriptions, allowing them to drive increased market share in exchange for more favorable pricing for the plan sponsor. In these instances, non-affiliate specialty pharmacies may be excluded from commercial networks. Note, Medicare (FFS and Medicare Advantage) and Medicaid FFS (e.g., HUSKY Health) require PBMs to maintain "any-willing provider" networks where the health plan must contract with any interested pharmacy that meets the plan's standard terms and conditions for network participation.

The Big 3 PBMs also own mail order pharmacies. PBM-affiliated mail order pharmacies offer a range of services, including receiving and filling prescriptions, providing toll-free access to pharmacists and customer care representatives, and delivering medications directly to patients' homes. They also provide computerized drug interaction monitoring, programs for generic substitution, and pharmaceutical cost containment services. PBMs will often offer limited mail networks in the commercial market where they are exclusive providers of mail order, offering more favorable rates to payers in exchange for increased volume. Approximately 10% of prescriptions are filled at mail order / online pharmacies.[25]

Providers / Clinical Delivery System

A significant number of medical providers (e.g., physicians, clinics) are affiliated with each of the Big 3 PBMs, with this number growing in recent years due to several acquisitions.[26] These providers prescribe or administer medications which may be filled by or directed to the PBMs and their affiliated pharmacies. In fact, Optum Rx is affiliated with approximately 10% of the physician workforce in the U.S.[27]

Drug Distributors

A recent addition to these vertically integrated organizations is the establishment of pharmaceutical distributors. Each of the Big 3 has expanded into the pharmaceutical commercialization business, primarily focusing on biosimilars. Drug distributors source pharmaceuticals from drug manufacturers or partner with manufacturers to co-develop pharmaceuticals, and then distribute these pharmaceutical products in the market.

In 2021, The Cigna Group established Quallent Pharmaceuticals, a private label pharmaceutical distributor. In May 2024, Quallent Pharmaceuticals entered into an agreement with two manufacturers (Boehringer Ingelheim and Alvotech) to commercialize and distribute Humira®

[21] https://www.cvshealth.com/services/pharmacy/neighborhood-pharmacy.html

[22] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[23] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[24] There is no uniform definition of a specialty drug and the designation of a drug as "specialty" varies by PBM.

[25] https://www.mckinsey.com/industries/healthcare/our-insights/meeting-changing-consumer-needs-the-us-retail-pharmacy-of-the-future

[26] https://www.beckershospitalreview.com/legal-regulatory-issues/optum-added-nearly-20-000-physicians-in-2023.html

[27] https://www.medpagetoday.com/special-reports/features/107598

biosimilars on behalf of Quallent Pharmaceuticals.[28,29] Similarly, CVS Health launched Cordavis in 2023 and partnered with Sandoz to commercialize a relabeled version of their Humira biosimilar.[30] CVS Health also partnered with AbbVie to launch their own version of a Humira branded product. Following the launch of their biosimilar, on April 1, 2024 CVS Health removed Humira coverage from their major national commercial formularies, replacing coverage with Humira biosimilars.[31] Lastly, UnitedHealth Group launched Nuvaila, another private label pharmaceutical distributor and announced that effective January 1, 2025, Optum Rx will add two Nuvaila-labeled biosimilars (for Humira and Stelara®) to three of its commercial formularies for a $0 copay.[32]

While the expansion of these organizations into biosimilar distribution may increase access to biosimilars and potentially reduce out-of-pocket costs for members, these new stakeholders also provide new layers of retention and profit for their parent organizations. Two Senators recently requested that the FTC open a new study on the impacts of these biosimilar distributors due to concerns over reduced competition.[33]

Gainwell Technologies

Gainwell Technologies is the second largest PBM in Connecticut by number of lives, solely providing PBM services to Medicaid beneficiaries in the state. Gainwell Technologies is a private company founded in October 2020 following the sale of DXC Technology's State & Local Health and Human Services business, creating a standalone company.

CarelonRx

CarelonRx (formerly known as IngenioRx) is the fifth largest PBM in Connecticut by number of lives, operating primarily in the commercial and Medicare markets. CarelonRx is owned by Elevance Health, a publicly traded company, that also owns / operates Blue Cross and Blue Shield plans in 14 states. Elevance Health also owns pharmacies and provider organizations.[34,35] CarelonRx has relied on CVS Health since 2019 for PBM administrative services, such as claims processing and rebate services. Note, CarelonRx lives are often reported as CVS Health PBM lives when compiling shares of lives in reporting. While CarelonRx and CVS Health have an active PBM Services contract, CarelonRx has announced several acquisitions (e.g., CarelonRx purchase of Kroger's specialty pharmacy, BioPlus Specialty Pharmacy, Paragon Healthcare) and investments (e.g., CarelonRx Pharmacy, DomainiRx claims administration platform) that may signal a future that is less intertwined with CVS Health.[36,37]

[28] https://www.boehringer-ingelheim.com/us/new-agreement-quallent-expands-biosimilar-access

[29] https://www.bioprocessintl.com/deal-making/alvotech-to-manufacture-humira-biosimilar-for-quallent

[30] https://www.cvshealth.com/news/pbm/cvs-health-launches-cordavis.html

[31] https://www.cvshealth.com/news/pbm/cvs-caremark-accelerates-biosimilars-adoption-through-formulary-changes.html

[32] https://www.optum.com/content/dam/o4-dam/resources/pdfs/forms/PharmacyPassages_Direct_August_2024_FINAL.pdf

[33] https://www.finance.senate.gov/imo/media/doc/093024_wyden_brown_letter_to_ftc_on_pbm_practices.pdf

[34] https://www.carelonrx.com/perspectives/carelonrx-pharmacy-launch

[35] https://www.elevancehealth.com/who-we-are/companies/affiliated-companies-and-health-plans

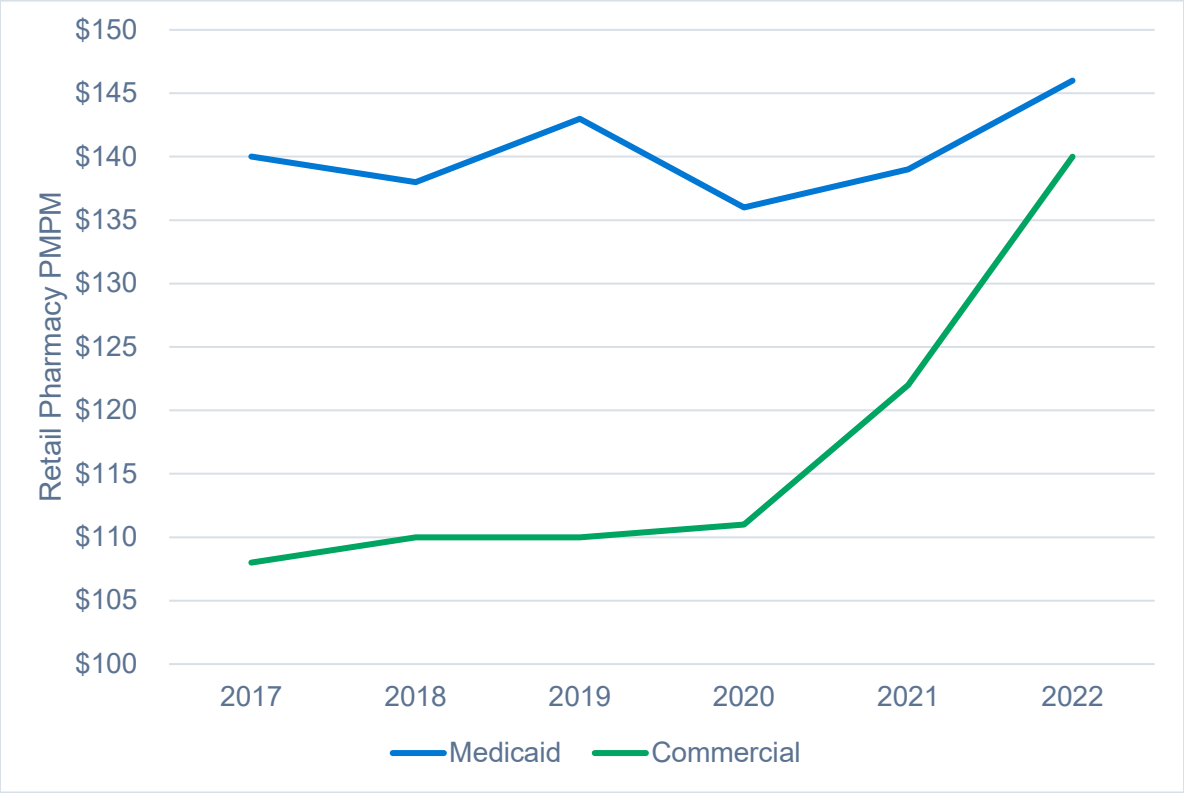
[36] https://www.drugchannels.net/2024/03/drug-channels-news-roundup-march-2024.html

[37] https://www.cvshealth.com/news/health-insurance/cvs-health-signs-five-year-agreement-anthem-inc-provide-services.html

RETAIL PHARMACY SPEND IN CONNECTICUT

Statewide gross expenditures on retail pharmacy saw one of the largest increases in per-member-per-month (PMPM) spending between 2021 and 2022, increasing 14.1% in the commercial market and 5.0% in Medicaid, to $140 PMPM and $146 PMPM in 2022, respectively.[38] Medicare gross PMPM spend on retail pharmacy was not available in the OHS Cost Growth Benchmark Initiative 2021-2022 Performance report. OHS used the Connecticut All-Payer Claims Database (APCD) to review pharmacy spend from 2017 through 2022. The data do not include information on drug rebates, and as such, the numbers in Figure 3 represent Medicaid and commercial gross (i.e., before rebates) retail pharmacy per-member-per-month (PMPM) spend in Connecticut. In 2022, commercial retail pharmacy spend was driven by an increase in utilization, as well as an increase in unit cost. In Medicaid, retail pharmacy utilization decreased while unit cost increased.[39]

FIGURE 3. GROSS PMPM RETAIL PHARMACY SPEND IN CONNECTICUT, 2017-2022[40]



Source: Connecticut Health Strategy Cost Growth Benchmark Initiative 2021-2022 Performance.

[38] https://portal.ct.gov/-/media/ohs/cost-growth-benchmark/reports-and-updates/ohs-cost-growth-benchmark-report-cy2022.pdf

[39] https://portal.ct.gov/-/media/ohs/cost-growth-benchmark/reports-and-updates/ohs-cost-growth-benchmark-report-cy2022.pdf

[40] Connecticut Health Strategy Cost Growth Benchmark Initiative 2021-2022 Performance

EXISTING PBM LAWS IN CONNECTICUT

Connecticut has passed PBM legislation related to PBM reporting, patient out-of-pocket expenses, pharmacy reimbursement, and 340B. While this section of the report outlines existing PBM legislation in Connecticut, a summary of PBM legislative activity from other states is discussed in the PBM Legislative Scan section of the report.

PBM Reporting

PBMs that operate in Connecticut are mandated to register with and provide annual aggregated rebate reports to the Connecticut Insurance Department (CID) per C.G.S. §38a-479bbb and 38a §479ppp. They must also comply with statutory requirements regarding claims payments, pharmacy audits, and contract provisions (e.g., limits on gag clauses and PBM recoupments).[41] According to the CID's most recent annual rebate reports, there has been a decrease in the percentage of rebates retained by PBMs from 2022 to 2023. In 2022, $3,112,259 in rebates, or 1.5%, was retained, or kept by PBMs in Connecticut, decreasing to $1,392,681, or 0.3% retained, in 2023.[42,43] We note, this reported decrease in the percentage of retained rebates may not represent a change in underlying PBM business practices, but could be from a change in the basis of reporting or variability in data contribution from year to year, as there are material changes (both increases and decreases) in total rebates reported each year, and overall retained rebates show no consistent trend. The reported retained rebates are limited to the fully insured commercial market. Rebate retention may be higher for segments that do not report, including the self-insured market. Lastly, the Big 3 PBMs have recently asserted that their pass-through rates are between 95 and 98% of collected rebates.[44] One of the Big 3 PBMs publicly committed to increasing rebate pass through to 100% by 2028.[45]

Patient Out-of-Pocket Expenses

Copay Accumulators: Copay accumulator programs work by disallowing manufacturer copay assistance from counting towards a member's deductible or maximum out of pocket limits. Connecticut statutes CGS § 38a-477ff and § 38a-477gg require health carriers and PBMs to apply third party discounts or payments to an individual's cost sharing liability for a covered benefit, effectively banning copay accumulator programs as of January 1, 2022.[46,] A copay accumulator indirectly decreases plan liability, but generally increases member cost sharing, and therefore negatively impacts patient affordability, as manufacturer copay assistance does not apply to member cost sharing obligations.[47] By prohibiting copay accumulators, Connecticut ensures that manufacturer-provided financial assistance directly benefits patients, reduces out-of-pocket expenses, and makes medications more affordable. Connecticut is among 19 states that have enacted laws prohibiting the use of copay accumulator programs.[48] However, the Connecticut statute only applies to coverage regulated by state insurance laws (e.g., fully insured plans), so these provisions generally do not apply to self-insured plans which are pre-empted under ERISA.

[41] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[42] https://portal.ct.gov/cid/-/media/cid/reports/pbm-rebate-report/2023-pharmacy-benefit-manager-rebate-report.pdf?rev=230980e7096243d3a67f0bc3142f2931

[43] https://portal.ct.gov/cid/-/media/cid/reports/pbm-rebate-report/2024-pharmacy-benefit-manager-rebate-report.pdf?rev=01838181d06846ed8b7b0ecc6c278218

[44] https://www.pcmanet.org/pcma-blog/big-pharma-highlights-how-pbms-secure-significant-savings-on-prescription-drugs/08/12/2024/

[45] https://www.healthcarefinancenews.com/news/unitedhealth-group-praises-optum-hits-4003-billion-revenue

[46] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0034.pdf

[47] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[48] https://avalere.com/insights/state-copay-accumulator-bans-impact-11-of-us-commercial-lives

Approximately 27% of Connecticut lives are in ERISA-covered self-insured plans and legislation prohibiting copay accumulators does not apply to those members' plans.[49]

Additionally, while copay accumulator protections ensure that manufacturer assistance counts toward a patient's deductible requirements, they do not address situations where patients independently pay for lower-cost prescriptions. This includes prescription drugs purchased out-of-network at lower prices than what the patient would have paid at an in-network pharmacy, which may not be credited toward their cost-sharing obligations. Deductible credit policies adopted in states like Texas and Tennessee have helped close this gap by requiring insurers to apply such out-of-pocket payments toward patients' annual deductibles and maximum out-of-pocket limits, further promoting prescription drug affordability.

Prohibiting Gag Clauses: Another Connecticut statute impacting PBMs is CGS § 38a-477cc(a)(1), effective January 1, 2018, prohibiting the use of gag clauses.[50] These clauses previously restricted pharmacists from informing patients about more affordable medication alternatives.[51] For example, a patient could have a copay higher than the cost of certain generic drugs without insurance. In this instance, a patient could pay less for medication without using insurance. By prohibiting gag clauses, the State empowers pharmacists to provide patients with better information about coverage options, potentially leading to patient cost savings.

Protections for Patient Out-of-Pocket Costs: The same section of CGS § 38a-477cc(b) also effective January 1, 2018 also includes provisions to protect members' out-of-pocket costs. Specifically, the law mandates that PBMs and health plans cannot require members to pay more for covered prescriptions than the lowest of the applicable copay, the allowable claim amount, or the amount a member would pay if he or she did not use their plan or other drug benefit coverage.[52] This ensures that patients are not overcharged for their medications and helps to maintain transparency in drug pricing.

Formulary Requirements

CGS § 38a-477jj(b), effective January 1, 2022, prohibits health plans from removing a prescription drug from the formulary or list of covered drugs during a plan year. It also prohibits health plans from moving a prescription drug to a higher cost-sharing tier where a member would pay a higher coinsurance, copay, or deductible during a plan year, unless that drug is subject to cost-share no greater than $40 per prescription per month. Health plans may move a brand-name prescription to a greater cost-sharing tier if the health plan adds a generic that is an alternative to the brand drug at a lower cost-share tier to the brand.[53]

Pharmacy Reimbursement

In addition to these consumer protections, CGS § 38a-477cc(a)(2), effective January 1, 2020, prohibits PBMs and health plans from recouping any portion of a paid claim from a pharmacy (directly or indirectly), except in the case of a pharmacy audit (allowed per CGS § 38a-479iii) or if required by another applicable law. This measure protects the financial interests of pharmacies by ensuring that once a claim is paid, the pharmacy is not subject to retroactive claw backs, which

[49] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0034.pdf

[50] https://www.cga.ct.gov/2017/ACT/pa/2017PA-00241-R00SB-00445-PA.htm

[51] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[52] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[53] https://law.justia.com/codes/connecticut/title-38a/chapter-700c/section-38a-477jj/

can create financial instability and uncertainty for these entities.[54] Retroactive fees charged by PBMs can include network participation fees, fees for non-compliance or lower performance with quality measures, and reimbursement reconciliation. These fees are typically not reflected in the initial price paid at the point of sale, instead they are calculated and applied retrospectively which can be confusing for pharmacies. For example, pharmacies may receive lower reimbursement than initially expected due to these retroactive adjustments, and not have insight into how much these fees may be, creating financial uncertainty for pharmacies. The Centers for Medicare and Medicaid Services (CMS) issued a final rule prohibiting retroactive applications of direct and indirect remuneration (DIR) fees in Medicare (i.e., fees must be applied at point-of-sale) to provide greater transparency for patients and pharmacies in 2024.[55]

340B Entities

Connecticut has also enacted CGS § 38a-479jjj to safeguard 340B entities,[56] healthcare organizations that participate in the federal 340B Drug Pricing Program effective January 1, 2024. The 340B program provides financial assistance to entities serving vulnerable populations. This statute prohibits contracts between Connecticut 340B covered entities and PBMs from containing discriminatory terms against 340B entities. This ensures that prescription drug reimbursement rates for 340B pharmacies are not lower than those for non-340B pharmacies. Additionally, the law prevents 340B pharmacies from facing fees or adjustments that are not uniformly applied to all providers or pharmacies. Furthermore, Connecticut provides additional protections to 340B covered entities by banning contract clauses that could limit a patient's choice to receive prescriptions or drug administration from a 340B entity. For example, the law prohibits excluding a 340B entity from a network solely because of its 340B status. PBMs are also barred from considering 340B status when determining reimbursement rates or retaliating against 340B entities for exercising their legal rights.[57,58] The goal of these regulations is to ensure that 340B entities can continue to serve their members, especially low-income members, effectively.

Pharmacy Networks

Mandatory mail order is prohibited for fully-insured plans in Connecticut under CGS § 38a-510 and CGS § 38a-544. This regulation prevents health plans and associated PBMs from requiring the member to obtain their prescription from a mail order pharmacy as a condition of obtaining benefits for the drug. Regarding pharmacy network access and adequacy, CGS § 38a-472f requires fully-insured plans sold in Connecticut to submit an annual network adequacy survey to the CID. Within this survey, plans are required to certify that members have access to a pharmacy within 20 minutes / 10 miles in Fairfield County, and within 20 miles / 30 minutes in all other counties.

This report section summarizes the current laws in Connecticut aimed at regulating PBMs. A summary and assessment of PBM legislation in other states is provided in the PBM Legislative Environmental Scan section of the report.

[54] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[55] https://www.pharmacist.com/Advocacy/Issues/CMS-Eliminates-Retroactive-DIR-Fees

[56] Examples of covered entities include federally qualified health centers, Ryan White HIV/AIDS Program grantees, children's hospitals, critical access hospitals, disproportionate share hospitals, etc., as defined in Section 340B(a)(4) of the Public Health Service Act.

[57] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[58] https://www.jdsupra.com/legalnews/connecticut-places-checks-on-pbm-8991197/

PBM Market Dynamics

PBM ROLES AND RESPONSIBILITIES

The core functions of a PBM include prescription drug claims processing, administering the pharmacy benefit design based on the plan sponsors' specifications, establishing a list of covered drugs (i.e., formulary, preferred drug list), administering utilization management and other cost containment strategies, negotiating rebates with drug manufacturers, and managing pharmacy networks.

Formulary development

A formulary is a list of covered drugs that is updated to account for new product launches, indications, clinical evidence, and financial considerations. Generally, formularies are organized into tiers, with variable member cost share amounts at different tiers. Lower formulary tiers may include more cost-effective generic drugs, while brand drugs are typically on higher co-pay or specialty tiers. When there are multiple drugs in a therapeutic class that are clinically similar, PBMs may grant favorable formulary placement (i.e., lower or preferred tiers) to drugs in exchange for higher manufacturer rebates. In turn, these rebates can be used to help keep plan premiums low or may be passed through to members (i.e., point-of-sale rebates).

While some plan sponsors have the option to customize their formulary, it is more common for commercial plan sponsors to utilize a PBM's standard formulary, which is generally designed to maximize rebate value, while providing appropriate access to clinically appropriate therapies for patients. According to a national survey of employers and health plans, 62% relied on a PBM's national / preferred formulary with exclusions, 11% used the PBM's national basic formulary with no exclusions (i.e., open formulary), 24% used a custom formulary, and the remaining three percent (3%) were unsure.[59]

Formulary design directly influences the financial and clinical outcomes of PBM contracts by affecting rebate structures, drug mix, member experience, and overall cost management strategies. Strategic contracting with PBMs can optimize value for the plan sponsor, but it requires careful consideration of how formulary changes impact overall plan costs and member access. Formularies can lower drug costs for plan sponsors through several strategies:

- Increasing generic dispensing rate (GDR): By prioritizing the inclusion of generic drugs over brand-name drugs, formularies can significantly reduce costs. Generics produced from multiple manufacturers are typically much cheaper than their brand-name counterparts, and a higher GDR can lead to substantial savings.
- Prior authorization and step therapy programs: Implementing robust prior authorization and step therapy programs for high-cost drugs ensures that these medications are only used under certain clinical guidelines. This can prevent unnecessary spending on expensive treatments by driving utilization to lower cost alternatives.
- Tier placement and drug exclusions: Placing high-cost brand drugs on higher tiers or excluding them altogether can encourage the use of lower-cost alternatives. Restrictive formularies that eliminate duplicate therapies and drugs that have high cost and relatively low clinical value can further reduce costs while still providing necessary treatments to members.

[59] https://www.psgconsults.com/industry-report/2023-trends-in-benefit-design-report/

- Negotiating price concessions: As formulary control tightens, manufacturers may offer additional rebates to keep their products on the formulary in a preferred position.

Some of these strategies, particularly those involving utilization management (e.g., prior authorization and step therapy) are interdependent with rebates. Increased rebates may be achieved if the PBM agrees to waive or limit utilization management, increasing patient access to certain drugs. Further, while they aim to control costs by preventing inappropriate or ineffective treatments, they may also have implications for member experience and access (e.g., treatment delays, treatment abandonment).[60]

In the last five years there has been an increase in the number of drugs excluded from the PBMs' standard commercial formularies. There may be several reasons for this increase, including an increase in therapy options within heavily rebated drug categories, an increased number of therapies on the market, along with market demand from payers for increased rebates. However, this has also raised concerns about patient access.[61] While mandating coverage of medications may have unintended consequences of reducing rebates, increasing payer, and increasing member costs, there are examples of more balanced approaches in the market today.[62] The Medicare prescription drug program requires plans to meet minimum coverage requirements within each drug class (at least two unique drugs), along with designated "protected classes" and requiring clinical justifications for utilization management and certain other exclusions.[63] In the ACA market, plan formularies must annually meet or exceed the benchmark formulary that determines the number of drugs that must be covered within each class, as designated by the state.[64,65] This design helps ensure a minimum level of drug coverage across different plans while allowing some flexibility for individual plans to choose specific drugs within each class based on the benchmark plan's structure.[66]

[60] https://www.techtarget.com/healthcarepayers/feature/What-Utilization-Management-Strategies-Do-Payers-Use-to-Lower-Costs

[61] https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf

[62] https://www.drugchannels.net/2023/01/the-big-three-pbms-2023-formulary.html

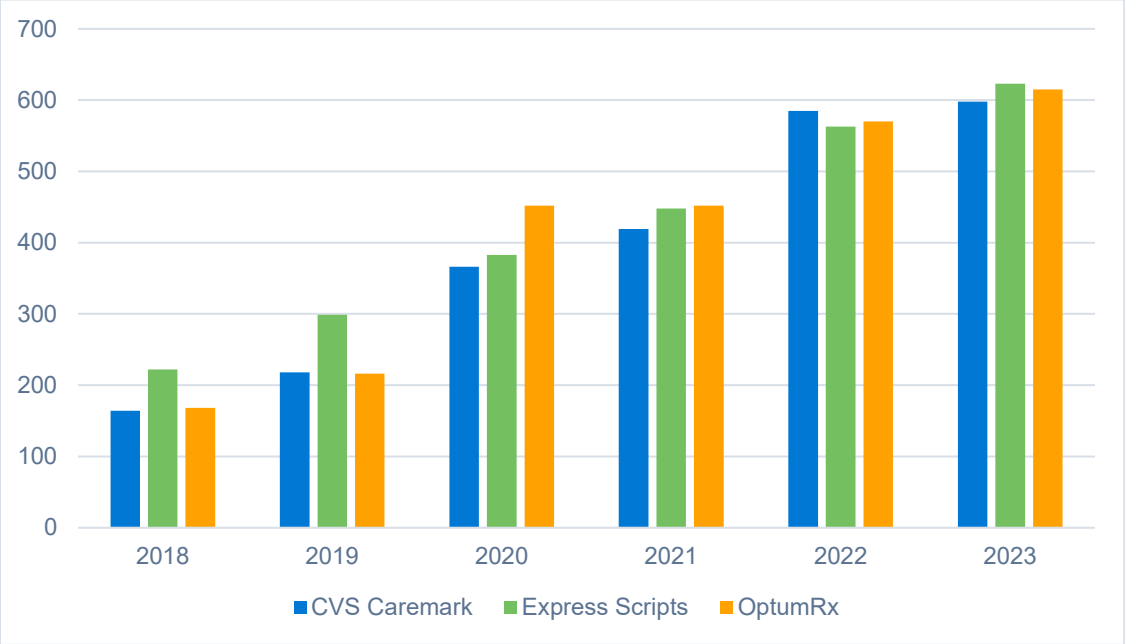
[63] https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf

[64] https://www.cms.gov/marketplace/resources/data/essential-health-benefits#Connecticut

[65] https://portal.ct.gov/cid/-/media/cid/1_bulletins/bulletin-hc-113-24.pdf?rev=c3b5038224e144e9acfcc37510489f5e&hash=BE49B59F68956022AEEECCEECACB9DD3

[66] https://www.webmd.com/health-insurance/aca-prescription-drug-costs-faq

FIGURE 4. THE NUMBER OF DRUGS EXCLUDED FROM BIG 3 PBM STANDARD COMMERCIAL FORMULARIES BY YEAR AND PBM, 2018-2023[67,68]



Note, while the number of drug exclusions has increased year-over-year, this does not necessarily reflect the proportion of drugs excluded.

An industry report on PBM formulary exclusions expresses concern that these formulary exclusions are at least partially driven by misaligned PBM incentives, citing instances where PBMs have excluded lower list price authorized generics or biosimilars, in favor of higher list price counterparts with higher rebates that may drive more revenue for PBMs.[69] The dynamic where higher list price drugs are covered and / or preferred over lower-cost alternatives is often driven by the manufacturer rebate negotiations, since manufacturers will often offer rebates as an incentive for favorable formulary placement. High list price products that offer substantial rebates can have a lower net cost for plans than alternatives, reducing financial liability for plans and making it more cost-effective to include these drugs in the formulary despite their high list prices. However, the higher list prices can be accompanied by a higher member cost share, particularly in plans where members have deductibles or coinsurance. Preferring the higher list cost product may provide benefits to the payer if the net cost after rebates is lower than the net cost of the lower list price product. However, there is the potential for misaligned incentives with high list price, high rebate drugs when lower net cost alternatives are available. In these cases, PBMs can earn more revenue by preferring a product that has a higher net cost to the payer. This higher revenue may be earned through sources, such as retained rebates or a percentage of the cost of the product through PBM affiliate pharmacies.

[67] https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf
[68] https://www.drugchannels.net/2023/01/the-big-three-pbms-2023-formulary.html
[69] https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf

While formulary decisions significantly influenced by the potential for rebates help to manage plan premiums and overall drug costs, this strategy can also lead to higher out-of-pocket expenses for members, raising patient affordability and / or access concerns.[70] However, a significant portion of high cost, high rebate drugs are in therapeutic classes with high brand competition and no low-cost alternatives for PBMs to consider, where drug manufacturers have increased prices to offset large rebates. This is discussed in greater detail in the Discussion section of the report.

Rebates

Rebates are direct renumeration (compensation) provided by drug manufacturers to PBMs, rebate group purchasers, or plan sponsors for prescription drugs, in exchange for formulary placement or formulary coverage of their drugs. Rebates may also depend on utilization management criteria. For example, lack of utilization management can lead to higher rebates from manufacturers. PBMs negotiate various types of pharmaceutical manufacturer renumeration, each serving different purposes and incentives.

The definition of “rebates” within contracts plays a crucial role in determining which manufacturer payments are shared with plan sponsors and which manufacturer payments may be kept by PBMs and / or rebate GPOs

Types of rebates include:

- Base Rebates: These are traditional rebates paid by drug manufacturers to PBMs for formulary placement of their products. Base rebates are sometimes only paid when the product is not "disadvantaged," meaning it is given a formulary status that is equal to competing drugs in the same therapeutic category.
- Price Protection Rebates: Also known as inflation protection rebates, these are additional rebates provided by manufacturers to ensure that drug price increases do not exceed a predetermined threshold. If the list price of a drug increases beyond this threshold within a given time, the manufacturer refunds the excess cost to PBMs.
- Market Share Rebates: These rebates are paid by manufacturers based on PBMs achieving or exceeding specific volume requirements for a drug relative to competitive products within the same therapeutic class. The goal is to increase the market share of the manufacturer's drug.
- Manufacturer Administrative Fees (MAF): These are fees paid by drug manufacturers to PBMs for administering the rebate program. These fees might not always be shared with plan sponsors or defined as rebates in contracts. They can represent significant portion of manufacturer renumeration and are often used to cover the administrative costs associated with managing rebate agreements.

In the last few years, the Big 3 PBMs established their own rebate GPOs to negotiate rebates with manufacturers. For additional background on these PBM-affiliated rebate GPOs, see the Ownership Structure of PBMs in Connecticut Section of this report. These GPOs allowed PBMs to have increased negotiating power with drug manufacturers, while also added a source of

[70] https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf

revenue (e.g., GPO fees) for PBM parent organizations. Rebate GPOs can be PBM agnostic which enables them to contract with competing PBMs and other payer entities to aggregate larger volume. Typically, rebate GPOs retain a fee from manufacturers, which is often based on a percentage of wholesale acquisition cost (WAC), so that manufacturers might gain access to certain services including data analytics and reporting. This revenue may not be shared with rebate GPO participants or PBMs. As PBMs do not hold rebate contracts with manufacturers, it may be more difficult for plan sponsors to audit rebates received by PBMs and ensure that the appropriate rebate value is passed through to the plan sponsor. Note, rebate GPOs only operate in the commercial line of business, with Ascent and Zinc also participating in the health exchange (Access Health CT) and Emisar focused solely on non-health exchange commercial business.[71]

Rebate Guarantees

A rebate guarantee is a commitment made by PBMs to a health plan or plan sponsor to provide a minimum amount of rebate savings from pharmaceutical manufacturers over a specified period. PBMs guarantee that the plan sponsor will receive at least a specified minimum amount of rebates, regardless of the actual rebates collected from the manufacturers, and / or the full pass-through of rebates received. Rebate guarantees provide financial predictability for plan sponsors, helping them to budget more effectively for prescription drug costs. If actual rebates fall short of the guaranteed amount, PBMs are at risk for the difference. This risk incentivizes PBMs to negotiate higher rebates with drug manufacturers to meet PBM guarantees.

The terms of rebate guarantees can vary, including the duration and the specific drugs or drug categories covered. Rebate guarantees are often split into different “channels” - by retail 30-day supply, retail extended days supply, retail specialty, mail order, and specialty. They are often provided as a “per qualified brand claim” amount for each channel, with the definitions of brand, qualified, specialty, and extended days being critical components of guarantee calculations. Reducing the number of claims that fall into each category by narrowing definitions can significantly increase rebate guarantees per claim without increasing the value of the rebates.

PBMs compete with one another on rebate guarantees for plan sponsor business. These rebate guarantees are typically projected out for multiple years (often three-year periods). As such, PBMs may consider their ability to offer higher rebate guarantees to win business, maintain business, and meet these projected guarantees when deciding which medications to place on their formularies. PBMs may also prefer drugs with higher list prices and higher rebates to improve their ability to meet rebate guarantees. By carefully selecting these medications, PBMs can increase competitiveness, reduce the risk of failing to meet rebate guarantees, and increase profit margins. Some PBMs may offer formularies with higher rebate guarantees but use a drug mix that results in higher net costs. Other PBMs may focus on achieving lower net costs by optimizing the drug mix, even if it means accepting lower rebate guarantees.

Pharmacy Network

In addition to managing formularies and drug rebates, PBMs also develop and maintain pharmacy networks. A pharmacy network is a system of pharmacies that have entered into an agreement with a PBM or a client to provide prescription services to members. This network can include various types of pharmacies, such as retail, mail-order, and specialty. The pharmacies within this network are responsible for dispensing prescription drugs and providing related services to members under the terms of the agreement. PBMs may charge participating pharmacies a

[71] https://www.eversana.com/insights/peeking-behind-the-pbm-led-gpo-curtain/

transaction fee to be included in the network. PBM pharmacy network design significantly impacts drug costs through several mechanisms:

- Negotiated Discounts and Dispensing Fees: PBMs negotiate discounts and dispensing fees with pharmacies on behalf of the plan. Typically, a PBM will negotiate a pharmacy effective rate guarantee where the PBM ensures pharmacies that the overall cost of prescription drugs, including discounts and dispensing fees, meets specific targets. These guarantees are typically categorized by drug types (e.g., brand, generic, and specialty) and are reconciled over a defined period (typically annually). These effective rate guarantees ensure that PBMs meet a certain level of cost savings for plan sponsors.
- Broad, Preferred, and Limited Networks: In a broad network there is a large number of pharmacies and members have the most access; however, PBMs are not able to negotiate the most competitive discounts. As such, plan costs may be higher if they decide to use a broad network. With a preferred network, there is a large group of pharmacies in network, with a smaller group designated as "preferred." Patients typically have lower copays at preferred pharmacies, creating financial incentives to use these locations. Limited networks are more restrictive, including fewer pharmacies, and as such, PBMs are able to negotiate higher discounts with pharmacies in exchange for limited access to the network. PBMs will often offer a limited network for mail order service, steering members to their affiliate mail-order pharmacy in exchange for more aggressive pricing or other favorable terms within the payer agreement. This can lead to cost savings for plan sponsors but can lead to greater inconvenience for plan members. Each type of network offers different benefits and cost structures, and the choice of network can significantly impact both plan costs and member access to medications.
- Exclusive Specialty Networks: PBMs often manage specialty drug costs by using an exclusive specialty network where members are required to fill specialty prescriptions at designated specialty pharmacies. PBMs may offer financial savings for plan sponsors who choose to use an exclusive specialty network. As there is no industry standard definition of a specialty drug, the definition of a specialty drug varies by PBM.

Effective Rate Guarantees

PBMs often have contracts with pharmacies to negotiate a minimum overall reimbursement rate for the pharmacy. PBMs leverage their group purchasing power to negotiate contracts with pharmacies that typically include both brand and generic effective rate guarantees. Effective rate guarantees are designed to ensure that PBMs meet a certain minimum overall reimbursement rate for their drug claims with that pharmacy or group of pharmacies. These agreements often use industry pricing benchmarks, such as the average wholesale price (AWP)[72] to set reimbursement rate guarantees. For brand-name drugs, PBMs may offer pharmacies a percentage discount off the AWP, whereas for generics, the reimbursement is often based on a maximum allowable cost (MAC) list, which sets a cap on

what PBMs will pay for a unit of a particular drug. Even with drug level pricing in place, many of these contracts are still reconciled in aggregate at the overall brand effective rate (BER) and generic effective rate (GER) over a defined period. Because of this aggregate reconciliation process, PBMs may not be as concerned with the pricing of individual claims or drugs and may

[72] AWP is pricing index and does not represent an actual "average" of actual wholesale prices. It is used as a reference point for pharmacy pricing and reimbursement and does not reflect the actual cost of the drug.

allow inflated pricing on certain drugs to achieve the overall agreed upon reimbursement rates with pharmacies. As a result, patients may experience variable out-of-pocket costs depending on the pricing structure.

Network Discount Guarantees

PBMs will typically also have network discount guarantees with plan sponsors, where PBMs commit to achieving specific discount rates on prescription drug prices within a pharmacy network over a defined period. These guarantees are designed to ensure that the plan sponsor receives a certain level of cost savings on medications dispensed through PBM networks. These discount guarantees are often reconciled at certain levels (e.g., retail generic drugs, retail brand drugs, mail-order brand drugs, etc.). These guarantees are often average annual rates and are not reconciled on an individual claim basis. If PBMs fail to meet guaranteed discount rates, they may have to pay the plan sponsor the shortfall amount. Overall, pharmacy network discount guarantees are a way for PBMs to provide predictable pricing to plan sponsors by negotiating and managing drug prices within their pharmacy networks.

PBM PRICING ARRANGEMENTS

A plan sponsor can set up different pharmacy reimbursement arrangements with their PBM, each with unique impacts on cost efficiency and transparency. The three widely accepted reimbursement arrangements are pass-through pricing, spread pricing, and cost-plus pricing.

- Spread pricing, also known as traditional pricing, is a contractual model where PBMs charge the plan a different amount than what they reimburse the pharmacy for the dispensed drugs. PBMs retain the difference, referred to as the "spread," as profit rather than charging administrative fees.[73] PBMs manage spread pricing arrangements by maintaining multiple price lists, such as various maximum allowable cost (MAC) lists, and selecting from these lists to determine the reimbursement rates for pharmacies. This approach allows PBMs to frequently adjust prices and manage their financial outcomes effectively. However, this practice can lead to a lack of transparency, as the plan sponsor (i.e., health plan, employer) may not have visibility into the actual costs and reimbursements involved.[74]
- Pass-through pricing is a contractual model where PBMs charge the plan the exact amount they reimburse pharmacies for dispensed drugs, at the point of sale. In this arrangement, PBMs typically charge the plan an administration fee, rather than making a profit from the difference in claims costs. This model is often seen as more transparent since PBM revenue comes from the administrative fee instead of the margin between what the plan pays and what the pharmacy receives; however, it does not always achieve the lowest cost.[75,76] PBMs' effective rate guarantees for pharmacies often differ from network discount guarantees that PBMs have with plan sponsors in both terms and rates. This allows the PBMs to blend a variety of guarantees to meet effective rate guarantees.
- Cost-plus pricing is a model where pharmacy reimbursement is based on the actual acquisition cost, plus a markup and / or fixed per claim dispensing fee. This approach ensures that pharmacies are reimbursed for the actual cost of drugs along with an additional amount

[73] https://www.rxbenefits.com/blogs/5-questions-to-evaluate-current-pricing-model/

[74] https://www.managedhealthcareexecutive.com/view/your-pbms-mac-list-impacts-your-bottom-line

[75] https://www.rxbenefits.com/blogs/5-questions-to-evaluate-current-pricing-model/

[76] https://www.managedhealthcareexecutive.com/view/your-pbms-mac-list-impacts-your-bottom-line

to cover dispensing and other related costs.[77] Commonly used in fee-for-service (FFS) arrangements, this method aims to provide a straightforward and transparent pricing structure. For example, drug reimbursement can be based on the National Average Drug Acquisition Cost (NADAC), a survey-based actual acquisition cost benchmark maintained by the Centers for Medicare and Medicaid Services (CMS).[78] A few PBMs and many Medicaid agencies (including Connecticut's) use NADAC as a reimbursement benchmark for cost-plus offerings. NADAC has the benefit of approximating acquisition cost and generally trends downward over time; however, it has drawbacks, including recent concerns from pharmacies about a significant drop in NADAC prices in April 2024.[79] Predictive Acquisition Cost (PAC) is another acquisition-based cost benchmark which is independently auditable and readily available from third parties (e.g., GlassBox Analytics), and it has seen increased use in newer pricing models.[80]

Pharmacy Reimbursement Models and Member Costs

The system of confidential reimbursement and discount contracts, list pricing (often unassociated with acquisition cost), and unknown actual acquisition costs creates potential for large discrepancies in what patients pay at the pharmacy counter. PBMs may vary pricing due to contracting differences or to meet their reimbursement targets with pharmacies or plan sponsors. PBMs may also use higher pricing in certain categories or drugs to maximize the reimbursement or cross-subsidize with other drug categories at their affiliate pharmacies, which is discussed in more detail in the Discussion section of this report. These pricing variations, and the fact that individual claims do not have consistent reimbursement in relation to a pricing benchmark tied to actual acquisition cost, mean that consumers may end up paying an outsized amount based on inflated reimbursements, depending on benefit design (e.g., high coinsurance, high deductible health plan) or what phase of the benefit the consumer is in (e.g., deductible phase or maximum out-of-pocket phase). While this inflated reimbursement may not have a negative impact on overall drug costs for plan sponsors (because they are balanced out by other claims or drug rates ineffective rate guarantees), they may have significant consequences for individual patients.

Evolving PBM Profit Pools

PBMs have experienced significant shifts in their profit pools due to evolving market dynamics and regulatory changes. Historically, PBMs derived a larger proportion of profits from retained rebates and spread pricing.[81,82] However, the importance of retained rebates as a source of profits has decreased, with more rebates being passed through to plan sponsors.[83] In fact, between 2017 and 2022 the percentage of large employers who chose a 100% pass-through contract increased from 53% to 73%. In 2022, Express Scripts stated they passed through over 95% of rebates collected for their clients, while CVS Caremark stated that they pass through more than

[77] https://www.rxbenefits.com/blogs/5-questions-to-evaluate-current-pricing-model/

[78] https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/nadac-plus.ashx

[79] https://ncpa.org/newsroom/qam/2024/06/05/whats-going-nadac

[80] https://pharmaboardroom.com/articles/drug-price-prediction-where-do-machine-learning-and-ai-stand/

[81] https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/legislative_session/2024/pbm_campaign/nephron_pbm.pdf

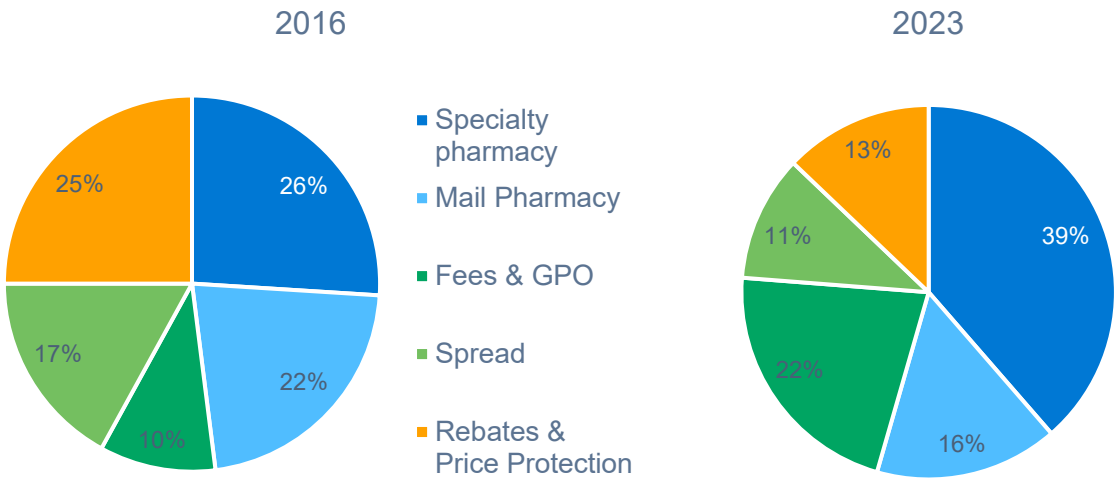
[82] https://www.drugchannels.net/2023/12/surprising-data-on-employer-pbm-rebate.html

[83] https://www.healthaffairs.org/content/forefront/new-regulation-pharmacy-benefit-managers

98% of all rebates to their clients, in aggregate.[84,85] Rebate retention is fairly low in the commercial market, very low (less than 1%) in Medicare,[86] and does not exist in Medicaid FFS.

Similarly, PBM profitability from spread pricing is decreasing. While spread pricing made up approximately 17% of PBM profits in 2016, that number has decreased to 11% in 2023.[87] However, this shift is accompanied by PBMs introducing new types of fees, including GPO data portal fees, contracting entity vendor fees, and transaction fees for processing claims, to offset reductions in profits from traditional sources.[88] Additionally, PBMs have increasingly focused on specialty pharmacy services, capitalizing on the rise of high-cost specialty medications to maintain and enhance profitability.[89] Between 2016 and 2023, PBM profits from specialty pharmacy increased from 26% to 39%, which is now the largest source of PBM profit, as shown in Figure 5 below.[90]

FIGURE 5. SOURCES OF PBM GROSS PROFIT, 2016 TO 2023



Source: Nephron's Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Not specific to Connecticut.

Considerations for Vertical Integration

Increased legislation regulating PBMs and market events (e.g., the introduction of Humira biosimilars and insulin list price reductions), have further impacted traditional PBM profitability by affecting contractual language on rebates, PBM fee structures, and overall profitability. PBMs responded to these pressures by changing their business models, furthering increasing their

[84] https://www.help.senate.gov/imo/media/doc/Kautzner%20Express%20Scripts%20HELP%20Hearing%20Testimony%2005102023.pdf

[85] https://www.help.senate.gov/imo/media/doc/Statement%20of%20David%20Joyner_050823_FINAL1.pdf

[86] https://www.gao.gov/assets/gao-19-498.pdf

[87] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[88] https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/legislative_session/2024/pbm_campaign/nephron_pbm.pdf

[89] https://www.pbmaccountability.org/_files/ugd/b11210_264612f6b98e47b3a8502054f66bb2a1.pdf?index=true

[90] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

vertical integration within pharmacy supply chains. Increased vertical integration allows these entities, such as the parent companies of the Big 3 PBMs, to shift profits pools to other vertically integrated entities (e.g., rebate GPOs and drug distributors) and create new payment retention structures. For example, rebate GPOs have introduced new manufacturer fees into the supply chain, which are largely expected to be retained as profit. These fees can total as much as eight percent (8%) of WAC.[91]

The latest type of vertically integrated entity introduced by the Big 3 PBMs is the pharmaceutical distributor. This new vertically integrated entity offers several benefits to the parent organization, including a guaranteed volume in exchange for lower prices and additional quality oversight. Additionally, it provides another profit pool for the parent organization in the face of decreasing profits from the traditional PBM model (e.g., rebate retention and spread pricing).[92] Table 3 below summarizes sources of PBM revenue, including revenue from affiliate organizations.

[91] https://www.eversana.com/insights/peeking-behind-the-pbm-led-gpo-curtain/

[92] https://www.drugchannels.net/2023/09/whats-behind-cvs-healths-novel-vertical.html

TABLE 3: SOURCES OF PBM REVENUE

REVENUE CATEGORY	DETAIL
Manufacturer revenue and contracting	▪ Rebates (base rebates, market share rebates, price protection, manufacturer admin fees, portfolio rebates, and formulary access rebates): These may be passed through to plan sponsors up to 100%. ▪ Other manufacturer revenue, such as data fees, clinical fees, value-based contracting, GPO fees, portal access fees, and formulary compliance fees: Some of these fees are considered bona fide service fees and protected under safe harbor. Some are not passed through to plan sponsors because of contractual reasons. ▪ Earnings from interests on funds not yet disbursed to plan sponsors
Retail networks	▪ Pharmacy transaction fees ▪ Direct spread ▪ Indirect spread from cross subsidizing between plan sponsor contracts or line of business ▪ Performance-based fees, such as fees tied to adherence to formulary requirements or generic dispensing rates
Affiliate mail and specialty pharmacies	▪ The difference between the purchase price of the drug and what the pharmacy sells to the payer, specific to payer contract ▪ Bona fide service fees[93] or rebates or market share incentive payments between the pharmacy and supplier, or manufacturer ▪ GPO fees between the pharmacy and purchasing wholesaler ▪ Data fees and clinical fees between pharmacy and manufacturer ▪ Discount card provider revenue (e.g., fees charged to give network access to discount card)
Affiliate pharmaceutical distributors	▪ The difference between the pharmaceutical distributors list price and the supplier net price
Administrative fees	▪ Administrative fees exist across all channels and provide plan sponsors with access to PBM supply chain contracts, formulary, manufacturer rebates, clinical programs, claims processing and other services and programs. These fees vary by client size and may be priced on a PMPM or per claim level.

[93] A bona fide service fee refers to fees for services that meet specific criteria, representing fair market value for the service provided. Examples of services include data analysis, patient support programs, and drug utilization reviews.

PBM-Affiliate Specialty Pharmacy

Specialty drug spending is one of the fastest growing areas of pharmacy expenditures, accounting for more than 40% of retail drug spending in 2021.[94] Specialty pharmacies focus on dispensing specialty medications that are often high-cost, complex, and used to treat chronic or rare conditions, such as cancer, multiple sclerosis, and rheumatoid arthritis. These medications typically require special handling, storage, and administration, and they often come with a need for additional patient support services.

Each of the Big 3 PBMs owns its own specialty pharmacy. These services comprise the largest source of PBM profit in 2023, making up an estimated 39% of PBM overall profit.[95] PBMs often implement narrow and preferred pharmacy networks that include their owned specialty pharmacies, which enables them to steer members to these pharmacies. In some cases, contracts between PBMs and commercial plan sponsors require the use of PBMs' affiliated specialty pharmacy for drugs designated as specialty. PBMs also control which drugs are designated as specialty within their benefit, influencing which medications are required to be dispensed at their affiliated pharmacies in limited network arrangements. A recent report from the Federal Trade Commission (FTC), found that 55% of commercial specialty prescriptions were filled at PBM-affiliated pharmacies which accounted for 69% of dispensing revenue.[96] PBM-affiliate specialty pharmacies are discussed in more detail in the Discussion section of the report.

[94] https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

[95] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[96] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

PBM Legislative Environmental Scan

EVOLUTION OF LEGISLATIVE LANDSCAPE

The legislative landscape for PBMs has seen significant changes in the last five to ten years. The case of *Rutledge v. Pharmaceutical Care Management Association* (PCMA) resulted in a significant legal decision by the U.S. Supreme Court with major implications for the regulation of PBMs. Ultimately, the ruling clarifies that state regulations affecting PBM reimbursement are not preempted by ERISA, enabling states to independently regulate PBMs in certain areas that do not impact benefit design.

ERISA was originally enacted to govern commercial employer plans and unions. It was designed to ensure that multistate employers could maintain employee benefit plans under a single set of federal rules. Under ERISA, fully insured plans are subject to state insurance regulations, while self-insured plans are exempt from these regulations and instead subject to federal regulations.[97]

However, the *Rutledge v. PCMA* decision significantly altered the scope of ERISA's preemption of state rules, allowing states to regulate some PBM practices. The Supreme Court upheld Arkansas Act 900, which required PBMs to reimburse pharmacies at least the pharmacy's drug acquisition cost. This decision ruled that Act 900 was not preempted by ERISA, thereby allowing states to impose some stipulations on PBM pricing and practices. While states generally cannot regulate the coverage of products themselves, the decision confirmed that states have the authority to regulate certain aspects of PBM practices, particularly concerning pricing and transparency.[98]

Since the Rutledge v. PCMA decision, over 150 state laws targeting PBM activities have been enacted.[99] The pace of state legislation continues to grow, with hundreds of bills in various stages of consideration.[100] Although most legislative activity has occurred at the state level, there are additional bills pending at the federal level.[101]

The PCMA continues to argue that ERISA preempts certain aspects of PBM regulation for self-insured plans, in a case recently taken up by the Supreme Court (*Mulready v. PCMA*).[102] This case focuses on regulation of pharmacy networks and patient access and the 10th U.S. Circuit Court of Appeals ruled in favor of the PCMA on appeal in 2023. The outcome of this case, now pending at the Supreme Court, is expected to further clarify what states can and cannot regulate in relation to PBMs and self-insured employer plans.[103,104]

STATE-LEVEL LEGISLATIVE ACTIVITIES

State legislators have concentrated on a handful of key PBM issues: access, transparency, and pricing. Access has been a significant focus, with efforts to ensure patients have sufficient access to pharmacies within their network. Transparency is another critical area of focus, with many

[97] https://www.natlawreview.com/article/pharmacy-benefit-managers-licensing-and-compliance-developments

[98] https://www.natlawreview.com/article/pharmacy-benefit-managers-licensing-and-compliance-developments

[99] https://nashp.org/state-drug-pricing-laws-2017-2023

[100] https://www.ncsl.org/health/prescription-drug-state-bill-tracking-database-2015-present

[101] https://www.afslaw.com/perspectives/alerts/pending-pbm-reform-legislation-capitol-hill

[102] https://www.supremecourt.gov/DocketPDF/23/23-1213/309553/20240510143219702_2024-05-10%20Final%20OK%20PCMA%20cert%20petition.pdf

[103] https://www.benefitspro.com/2024/10/11/supreme-court-takes-up-pbm-case-does-erisa-preempt-states-efforts-to-regulate-drug-prices/?slreturn=20241112131019

[104] https://ncpa.org/newsroom/qam/2024/10/10/supreme-court-asks-federal-government-input-whether-take-pbm-case

states introducing or passing laws requiring PBMs to report their activities and increase transparency in their operations. Pricing regulations generally aim to ensure appropriate reimbursement for pharmacies, as well as ensure patients pay the lowest possible amount for their medications. These legislative efforts collectively seek to enhance patient access, ensure fair payment practices, and provide more options for patients while maintaining a fair and transparent market for all stakeholders.[105,106,107,108] While most of these regulations focus on patient and / or provider protections, the impact on overall cost of healthcare for payers and consumers is less clear.

Access

Access to pharmacies has become a significant focus of legislative action, with efforts to establish network adequacy standards, limit mandatory mail order requirements, restrict pharmacy steerage, and limit restrictions or discrimination against 340B covered entities and contract pharmacies among the major legislative efforts. A summary of PBM legislation that impacts pharmacy access is provided below.

Many self-insured employers, including the Connecticut state employee prescription drug program, utilize limited networks for maintenance medications and specialty medications.[109] These arrangements typically allow a payer to obtain deeper discount rates at the preferred provider in exchange for known additional volume.

- **Network Adequacy Standards**: These regulations ensure that beneficiaries have adequate geographical access to pharmacies, considering travel time and distance. Standards for pharmacy network adequacy typically differ based on whether the area is rural or urban and may include components for mail-order pharmacies. States like Montana and Kentucky have pharmacy network adequacy standards.[110] Additionally, some states specify that mail-order pharmacies cannot be used to meet these adequacy standards. Examples of states with legislation related to pharmacy network requirements include Pennsylvania and Virginia, among others. Connecticut currently has network adequacy requirements defined for fully insured commercial insurers within the state. Medicare also has network adequacy standards that apply to these plans and members in Connecticut.
- **Restricting Mandatory Mail Order**: Some plan designs require patients to obtain their medication through a mail-order system rather than a retail pharmacy. This practice, also known as mandatory mail order, is typically implemented for certain maintenance medications. These mandatory or limited network options are typically offered to payers in exchange for lower reimbursement rates at those pharmacies. However, there are concerns with delayed delivery of prescriptions due to shipping problems, weather conditions, logistical issues, or even loss or theft of packages. Additionally, there are potential privacy issues with medications delivered to homes. In response, states, such as Florida have passed laws that

[105] https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers

[106] https://nashp.org/state-action-on-pharmacy-benefits-managers-pbms-to-address-prescription-drug-pricing/

[107] https://www.ncsl.org/health/prescription-drug-legislation-database

[108] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[109] https://carecompass.ct.gov/wp-content/uploads/2024/04/2024_2025_ActiveEmployees_Healthcare_Planner.pdf

[110] https://www.ncsl.org/health/health-insurance-network-adequacy-requirements

prohibit mandatory mail-order arrangements.[111] Mandatory mail-order arrangements are prohibited for fully insured commercial plans in Connecticut.[112]

- **Restricting Pharmacy Steerage**: Anti-pharmacy steering laws prevent PBMs from requiring members to use a PBM-affiliated pharmacy, applying to retail, mail, and / or specialty pharmacies. Twenty-four (24) states have enacted such legislation as of 2024.[113] These legislative measures aim to create a level playing field for all pharmacies and prevent PBMs from using their influence to direct patients to their own affiliated pharmacies, which could lead to anti-competitive practices, access issues, and potentially higher costs for consumers on certain claims or medications. However, limiting these network options may also increase plan and member costs by requiring pharmacy options that have higher reimbursement rates. Examples of states with legislation prohibiting discrimination against non-affiliated pharmacies include Arkansas and Louisiana, among others.
- **Non-Discrimination Against Non-Affiliated Pharmacies and 340B Covered Entities**: These laws prevent PBMs from reimbursing non-affiliated (i.e., non-PBM owned) pharmacies at lower rates than affiliated pharmacies and may also prohibit more restrictive contract terms on non-affiliated pharmacies. Arkansas and Louisiana, for example, have laws that prevent PBMs from reimbursing non-affiliated pharmacies less for filling a prescription than they would for an affiliated pharmacy.[114] This type of legislation may also prohibit a PBM from reimbursing a 340B-covered entity or contract pharmacy at a lower rate than a non-340B pharmacy in their network, and prohibits PBMs from refusing to contract with a 340B entity.[115] Connecticut currently has legislation in place that prevents PBMs from discriminating against 340B covered entities or contract pharmacies. However, there is no legislation in Connecticut preventing PBMs from reimbursing non-affiliated pharmacies differently than affiliated pharmacies.[116] Other examples of states with legislation prohibiting discrimination against 340B covered entities include Arkansas and Mississippi, among others.
- **Any Willing Provider**: Any willing provider laws generally require PBMs to allow pharmacy providers to join their network if they are willing to accept PBM's terms and conditions.[117] The goal of any willing provider legislation is to promote competition and transparency in the pharmacy marketplace, ensuring that beneficiaries have access to a wide range of pharmacy options and that certain pharmacies (e.g., non-PBM affiliate pharmacies) are not disadvantaged. While it may increase pharmacy access, any willing provider legislation may lead to higher pharmacy costs, as PBMs are able to achieve savings by owning or operating in-house pharmacies and maintaining a limited pharmacy network.[118] Note, in Medicare Part D there is an any willing provider provision that requires Part D plan sponsors to contract with any pharmacy that meets the standard terms and conditions for network participation and applies to all types of pharmacies (e.g., retail, mail order, and specialty pharmacies). Similarly, as Connecticut's Medicaid program is all FFS, patients are permitted to select their providers, mirroring the spirit of any willing provider legislation. Potential any willing provider legislation

[111] https://ogletree.com/insights-resources/blog-posts/florida-pbm-law-limits-mail-order-prescription-drug-programs-requires-state-filings-by-employer-plans/

[112] https://law.justia.com/codes/connecticut/2012/title-38a/chapter-700c/section-38a-510/

[113] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[114] Arkansas Code § 23-92-505(c); LA Rev. Stat. § 22:1867

[115] https://www.nachc.org/wp-content/uploads/2024/01/05_03_24_nachc_state-level-340b-laws-and-legislation_tracker.pdf

[116] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[117] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Boards/RBHPB/Meetings/2018/35%20States%20with%20AWP.pdf

[118] https://www.amcp.org/legislative-regulatory-position/any-willing-provider-legislation

in Connecticut would only affect the commercial market. Kentucky is an example of a state with any willing provider legislation that applies to pharmacies.[119]

Transparency

Transparency is another critical area of focus. Many states have introduced or passed laws requiring PBMs to disclose their activities and increase operational transparency. Common legislative themes include prohibiting gag clauses that prevent pharmacists from informing patients about cheaper medication options and establishing oversight mechanisms to regulate PBM activities more closely. Additionally, some states are implementing rules related to fiduciary duties to ensure PBMs act in the best interest of the plan sponsors.[120]

- **PBM Reporting and Oversight**: Legislation in various states mandates that PBMs report specific data to state agencies, including details on aggregate rebate amounts. As of 2023, 27 states implemented such reporting requirements, primarily focused on rebate reporting.[121] For instance, Louisiana requires PBMs to disclose aggregate rebates from manufacturers, the percentage of rebates retained by PBMs, and administrative fees to the Louisiana Department of Insurance.[122] Alaska has a regulation in place that requires full disclosure of all financial terms and arrangements for remuneration between a PBM and a manufacturer to the plan sponsor.[123] Additionally, 33 states require PBMs to be licensed or registered before conducting business and may impose further reporting obligations.[124] PBMs that operate in Connecticut are required to register with and provide annual rebate reports to the Connecticut Insurance Department.[125] While Connecticut does require annual rebate reporting through the Connecticut Insurance Department, which provides some transparency on rebate retention for fully insured commercial plans, it does not collect data from PBMs on other revenue streams, such as spread pricing, rebate Group Purchasing Organization fees, administrative fees, or other affiliate business revenue. Other states with PBM reporting requirements include Alabama, Arkansas, California, among others.
- **Prohibition of Gag Clauses**: Laws in 44 states prohibit PBMs from including gag clauses in contracts with pharmacies, with New Hampshire and Vermont being two examples. These clauses prevent pharmacies from sharing cost or plan design information with patients. The legislation ensures that pharmacies can inform patients about lower-cost therapeutic alternatives, copayment or coinsurance details, and the option to pay the cash price, thereby helping patients reduce their prescription costs.[126] Connecticut prohibits the use of gag clauses.[127]
- **Fiduciary Duties**: Certain state laws require PBMs to act in the best interest of the plan sponsor, establishing a fiduciary duty. Other states mandate that PBMs operate "in good faith and fair dealing," ensuring that their actions benefit the plan sponsors.[128] Currently, two states, Vermont and Maine, have legislation requiring PBMs to act as the health plan's agent with a

[119] https://www.frierlevitt.com/articles/new-kentucky-law-levels-the-playing-field-for-independent-pharmacies/
[120] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[121] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[122] https://legis.la.gov/Legis/Law.aspx?d=1108782
[123] https://www.akleg.gov/PDF/33/Bills/HB0226Z.PDF
[124] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[125] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf
[126] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[127] https://www.cga.ct.gov/2017/ACT/pa/2017PA-00241-R00SB-00445-PA.htm
[128] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

fiduciary duty to the health plan's prescription drug benefit.[129] Connecticut statutes do not currently impose fiduciary duty requirements on PBMs. There has been an effort to clarify and legislate these responsibilities at the federal level. [130] Employers are also under pressure from recent litigation to exercise their fiduciary duty to their employees (see ERISA litigation section of this report). This is expected to put pressure on PBMs to provide transparency and loyalty to self-insured payers indirectly.

Pharmacy Pricing

Some states regulate pharmacy pricing and reimbursement by implementing laws that limit or prohibit spread pricing, regulate maximum allowable cost (MAC) lists, limit retroactive fees, and implement patient cost share requirements.[131]

- **Limiting or Prohibiting Spread Pricing and Rebate Requirements**: Legislation in 16 states aims to curb spread pricing by prohibiting PBMs from charging health plans more than they reimburse pharmacies for prescription drug claims. Florida and Louisiana are two examples of states with such legislation. Some laws also require PBMs to disclose spread pricing arrangements. Additionally, certain states mandate that PBMs disclose aggregate rebate amounts obtained on behalf of the plan and specify the portion of rebates retained by PBMs.[132] The intention of this type of legislation is to increase transparency and fairness in the pricing of prescription drugs. Spread pricing obscures the true cost of the drug, making it difficult for payers to understand how much is being spent on prescription drugs and how much is being retained by PBMs as profit. When spread pricing is eliminated, PBMs charge a transparent administrative fee instead. By prohibiting spread pricing, states aim to ensure that the amount paid by the health plan for a prescription drug is more closely aligned with the amount of reimbursement to the pharmacy, and that PBMs' administration fee and profit are more aligned with the value of the service provided. Connecticut does not currently have any regulations or restrictions on pharmacy spread pricing for PBMs or health plans.
- **MAC List Requirements**: MAC lists set pricing caps for generic (and sometimes multi-source brand) drugs. Some states have established requirements for PBMs regarding these lists, including conditions for drug inclusion, the provision of MAC lists to network pharmacies, minimum price requirements, the frequency of updates, and the establishment of an appeals process for changes.[133] This type of legislation is intended to protect providers by ensuring that pricing is administered equitably, is above the actual acquisition cost of the drug, and stays in line with current market pricing. There are currently 25 states with established MAC list requirements.[134] There are currently no restrictions or requirements related to MAC pricing in Connecticut. Maine and New Hampshire are two examples of states that have established MAC list requirements.
- **Limitations on Retroactive Fees**: These laws prohibit PBMs from implementing retroactive reimbursement reductions to pharmacies, often referred to as claw backs or retroactive fees.[135] Existing legislation in Connecticut prohibits PBMs and health plans from recouping

[129] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[130] https://www.eric.org/wp-content/uploads/2024/09/PBM-Reform-Deem-PBMs-a-Fiduciary-Under-ERISA-September-2024-compressed-compressed.pdf

[131] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[132] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[133] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[134] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[135] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

any portion of a paid claim from a pharmacy, directly or indirectly. Arkansas and Pennsylvania also limit retroactive fees, among others.

- **Patient Cost Sharing**: Various laws protect patients from excessive cost-sharing. For example, New York prohibits PBMs from charging members copays higher than what the PBM pays the pharmacy.[136] Arkansas requires that member cost-sharing reflect the drug cost after rebates (known as point of sale rebates).[137] New Hampshire is an example of a state that requires a portion of all rebates be remitted directly to the patient at the point of sale, with the remainder being required to be remitted to the insurer and used to offset premiums.[138]
- **Copay Accumulators**: Additionally, 19 states, including Connecticut, have banned copay accumulator programs to ensure manufacturer copay assistance counts towards a patient's cost-sharing obligations.[139,140] Connecticut also enacted legislation prohibiting PBMs and health plans from requiring members to pay more for covered prescriptions than the lowest of the applicable copay, the allowable claim amount, or the amount a member would pay if he or she did not use their plan or other drug benefit coverage.[141] Texas and Florida are two other examples of states have limits on patient cost-sharing.

FEDERAL LEGISLATIVE ACTIVITIES

The Consolidated Appropriations Act of 2021

The Consolidated Appropriations Act of 2021 (CAA), signed into law on December 27, 2020, created additional transparency within the prescription drug and healthcare system, particularly in the commercial market. This Act includes several provisions aimed at identifying major drivers of increases in prescription drug and health care spending; understanding how prescription drug rebates impact premiums and out-of-pocket costs; and promoting transparency in prescription drug pricing.[142] This legislation also instituted the federal prohibition of gag clauses.[143]

One of the key provisions impacting PBMs is the disclosure requirements of insurance companies and employer-based health plans, known as the Prescription Drug Data Collection (RxDC). The RxDC requires annual reporting of total pharmacy spend, the 50 most frequently dispensed brand drugs, the 50 most costly drugs, and the 50 drugs with the greatest increase in plan expenditure. The CAA also mandates that PBMs disclose all forms of compensation, including direct and indirect remuneration (DIR) fees, rebates, and other financial arrangements with drug manufacturers, pharmacies, and vendors, including disclosure of any amounts not passed on to the plan. While PBMs are required to provide data for the reports, when applicable, the fully insured plan or self-funded employer group are responsible for ensuring that the data is accurate and submitted. They may contract with their PBM, third-party administrator (TPA), or other third party to report on their behalf. CMS is collecting this data on behalf of the Departments of Health and Human Services, the Department of Labor, the Department of Treasury, and the Office of Personnel Management. Additionally, PBMs are required to provide the amount paid on the top

[136] N.Y. Pub. Health Law § 280-a(5)(b)

[137] https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2023R%2FPublic%2FACT333.pdf

[138] https://legiscan.com/NH/text/SB555/id/2956542

[139] https://avalere.com/insights/state-copay-accumulator-bans-impact-11-of-us-commercial-lives

[140] https://cga.ct.gov/current/pub/chap_700c.htm#sec_38a-477gg

[141] https://www.cga.ct.gov/2024/rpt/pdf/2024-R-0027.pdf

[142] https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc

[143] https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa

25 highest yield rebated drugs.[144] These disclosures are designed to provide plan sponsors and beneficiaries with a clearer understanding of the true costs and savings associated with their prescription drug plans. Plan sponsors must report how these rebates, fees, and any other remuneration paid by drug manufacturers reduce premiums and out-of-pocket costs for enrollees. While insurers, third party administrators (TPAs) and PBMs provide much of the reporting, group health plans are ultimately responsible for ensuring that information is submitted on their behalf.

The CAA also requires disclosure of broker compensation, to monitor potential conflicts of interest with compensation or incentives from PBMs. Brokers earn revenues in several ways that may not be apparent to the plan sponsor, such as commissions, bonuses, fees, TPA fees paid by PBMs, per prescription fees, etc.

Many argue the requirements of the CAA represent a step toward greater transparency in the PBM industry for commercial plan sponsors, especially self-insured plan sponsors, where state regulations generally are not applicable. CMS is collecting the RxDC report on behalf of the Departments of Health and Human Services, the Department of Labor, the Department of Treasury, and the Office of Personnel Management. CMS has stated that they will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs, but this has yet to occur as of the date of this report.

Pending Legislation

While there is no overarching federal agency that regulates PBMs, many House and Senate committees continue to focus on legislation that may have a material impact on PBMs. A summary of this activity is provided in Table 8 below.

[144] https://regtap.cms.gov/reg_librarye.php?i=3860

TABLE 8: FEDERAL LEGISLATIVE ACTIVITY AS OF JUNE 2023 [145]

BILL	STATUS	TRANSPARENCY REQUIREMENTS	BANNING SPREAD PRICING	REBATE PASS THROUGH TO PLAN	IMPROVED MEMBER OOP COSTS	PBM DELINKING
S. 1339, The Pharmacy Benefit Manager Reform Act	Advanced by Committee	X	X	X		
H.R. 3561, the PATIENT Act of 2023	Advanced by Committee	X	X		X	
S. 127, the PBM Transparency Act of 2023	Advanced by Committee	X	X	X		
The Senate Finance Committee PBM Legislative Framework	Legislative text has not been introduced	X	X	X		X
The Patients Before Middlemen (PBM) Act	Introduced					X
H.R. 2816, the PBM Sunshine and Accountability Act	Introduced	X				
H.R. 830 and S. 1375, the Help Ensure Lower Patient (HELP) Copays Act	Introduced				X	
H.R. 2880, Protecting Patients Against PBM Abuses Act	Introduced	X	X			X

De-linking PBM Revenue from Drug Cost

The concept of de-linking involves prohibiting PBM compensation from being tied to prescription drug list prices, by shifting to an administrative fee only model. Several de-linking bills have been introduced in Congress, but none have passed to date.[146] The Congressional Budget Office (CBO) estimated that delinking could save $700 million in Part D and $650 million in the commercial market when paired with transparency initiatives (both included in the bills that were

[145] https://www.commonwealthfund.org/blog/2023/bipartisan-congressional-support-pbm-reform-grows
[146] https://mypolicyhub.com/wp-content/uploads/2024/08/Impact-Chart-of-PBM-Legislation_8.5.24.pdf

scored). Proponents argue that de-linking would enhance transparency and reduce incentives that may encourage PBMs to favor higher-priced drugs due to rebate structures tied to list prices. The PBM industry has countered this argument, stating that de-linking would have numerous negative impacts, including increased premiums, increased revenue for manufacturers, and reduced PBM competition.[147,148] This concept, and the current legislative initiatives related to it, warrant further monitoring and study by the state.

Federal Trade Commission (FTC) Investigation

In addition to increased legislative oversight, PBMs are also under heightened scrutiny from the Federal Trade Commission (FTC). The FTC has an ongoing study focused on the six largest PBMs and how their practices impact prescription drug pricing, as well as patients' general access to prescription drugs. As part of this ongoing study, in July of 2024, the FTC released an interim report outlining their concerns with PBMs' influence on drug pricing.[149] Both sides have filed lawsuits against each other. One outcome of the FTC investigation is a lawsuit against Caremark, Express Scripts, and Optum Rx, the three largest PBMs, along with their affiliated rebate GPOs. The lawsuit seeks broad relief from PBMs in several areas, including disadvantaging low-cost versions of a drug in favor of high-cost versions, delinking PBM compensation from a drug's list price, and requiring patient deductibles or coinsurance to be based on the net cost after rebates instead of list price.[150]

PBMs responded to the interim report and lawsuit by defending their current business model. Express Scripts filed a lawsuit against the FTC over the interim staff report, claiming that the report was unfair, biased, erroneous, and defamatory.[151] All three PBMs also filed motions to dismiss the three filing FTC commissioners from the lawsuit.[152] They also sponsored an economic study, published in October of 2024, which countered many of the FTC findings from the interim report.[153]

ERISA LITIGATION RISK

As noted earlier in this report, ERISA is a U.S. federal statute that establishes baseline requirements for the administration and management of employee benefit plans, including health and welfare plans, which aims to safeguard the interests of individuals enrolled in these plans. It mandates fiduciary duties, establishing standards of conduct for those who oversee and manage employee benefit plans, with the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan.[154,155]

Increased traction of transparency laws and regulations has heightened the scrutiny of ERISA health benefits in recent years.[156] In February 2024, Johnson & Johnson (J&J) health plan fiduciaries received a class action suit alleging that the organization breached its fiduciary duties. The plaintiffs claimed that the organization cost plans and employees millions of dollars due to

[147] https://www.pcmanet.org/pcma-blog/delinking-proposal-increases-drug-costs-for-medicare-beneficiaries-and-taxpayers-hands-10-billion-giveaway-to-big-pharma/05/07/2024/

[148] https://bfi.uchicago.edu/wp-content/uploads/2023/09/BFI_WP_2023-124.pdf

[149] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[150] https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

[151] https://www.documentcloud.org/documents/25147237-cigna_lawsuit_ftc_report

[152] https://thehill.com/policy/healthcare/4924741-unitedhealth-cvs-caremark-ftc-lawsuit/

[153] https://carltonreport.org/wp-content/uploads/2024/10/Summary-PBMs-and-Prescription-Drug-Distribution.pdf

[154] https://www.dol.gov/general/topic/retirement/erisa

[155] https://www.dol.gov/general/topic/retirement/fiduciaryresp

[156] https://global.lockton.com/us/en/news-insights/employer-j-and-j-sued-for-breach-of-fiduciary-duties-and-mismanagement-of

high payments for prescription drugs, high premiums, high deductibles, high coinsurance, high copays, and low wages.[157] For instance, the complaint highlights that J&J members were charged over $10,000 for a specific drug (90-day supply teriflunomide) that was concurrently available at some pharmacies for less than $30. The complaint further alleges that all generic specialty drugs managed by J&J's PBM were on average 498% more expensive than what it costs the pharmacy to acquire the same drugs. It is important to note that the complaint does not provide insight into the total cost differential of the contract, but rather focuses on select medications. Ultimately, the plaintiffs contend that J&J did not demonstrate careful judgement when selecting its PBM and agreeing to uncompetitive contract terms. A very similar lawsuit was filed against Wells Fargo in July of 2024.[158] Additional class action lawsuits against employers for breaches of health plan fiduciary duties may emerge as members gain increased visibility into drug pricing through evolving PBM legislation.[159]

This litigation raises questions on employers' obligations regarding PBM selection and oversight. As a result of ERISA litigation risk, employers may employ increased monitoring of their PBM and may push for increased transparency. Ultimately, this litigation, combined with the FTC litigation, adds pressure on the high WAC / high rebate model.

[157] https://www.millerchevalier.com/publication/erisa-edit-jj-suit-adds-growing-wave-health-plan-litigation-over-costs-and-fees

[158] https://www.frierlevitt.com/articles/wells-fargo-hit-with-erisa-class-action-lawsuit-for-failing-to-monitor-and-audit-express-scripts/

[159] https://global.lockton.com/us/en/news-insights/employer-j-and-j-sued-for-breach-of-fiduciary-duties-and-mismanagement-of

Discussion and Considerations

DISCUSSION

Potential Misaligned Incentives in the Pharmacy Supply Chain

This section of the report discusses potential misaligned incentives and inefficiencies in the pharmacy supply chain and the impact of those dynamics on stakeholders, including PBMs, plan sponsors, pharmacies, and consumers in Connecticut.

High list price / high rebate strategies

There are several dynamics in the pharmacy supply chain that perpetuate high list price / high rebate strategies. From the plan sponsor's perspective, rebates are a valuable tool in keeping plan premiums low as most plans use rebate value to directly offset plan liability and do not share rebate value with members at the point of sale. Table 9 demonstrates how rebates can be more favorable to a plan sponsor than a lower net cost option, while resulting in higher out-of-pocket expenses for the member.

TABLE 9: EXAMPLE COMPARING VALUE OF REBATES V. LOW NET COST DRUG

		DRUG A	DRUG B
Gross Drug Cost (WAC)	A	$1,000	$500
Rebate	B	$500	$0
Net Drug Cost	C = A - B	$500	$500
Patient Cost Share (20% Coinsurance)	D = A * 20%	$200	$100
Overall Cost to Plan Sponsor	**E = C - D**	**$300**	**$400**

In the example above, Drug A has a 50% rebate, lowering the net cost of the drug to $500 – the same net cost as Drug B, which has a lower gross cost but no rebate. However, because the patient cost share is based on the gross cost of the drug, after accounting for rebates and patient cost share, Drug A provides a lower overall cost to the plan sponsor. The plan sponsor can use this lower overall cost to keep premiums low for all plan members. However, the member who utilized Drug A experiences higher patient out-of-pocket expenses (e.g., deductible, coinsurance), as their cost share is based on the gross cost of the drug.

Many participants in the pharmacy supply chain, including manufacturers, wholesalers, PBMs, rebate GPOs, and pharmacies, have the potential to benefit from higher costs of drugs. Whenever a stakeholder's profitability is tied to a percentage of the list cost of a product (e.g., AWP, WAC), higher prices can lead to higher profitability. From a PBM and wholesaler perspective, there is also an aspect of timing, where drugs can potentially be bought at a lower price prior to a price increase and sold for a higher price after a price increase.[160]

[160] https://www.commonwealthfund.org/publications/issue-briefs/2022/jul/impact-pharmaceutical-wholesalers-drug-spending

There are several dynamics that may work to perpetuate high list price / high rebate strategies. For example, PBMs have historically retained a portion of manufacturer revenue (including rebates), particularly in the commercial market. This offers an incentive for PBMs to prefer products with higher list prices and higher rebates over lower rebate options with lower list price, all else being equal. While rebate retention is a declining source of profit for PBMs, as more rebate value is passed through to plan sponsors, PBMs may still retain a portion of manufacturer value as PBMs and PBM-affiliate businesses (e.g., rebate GPOs) collect fees from manufacturers that are tied to the list price of the drug (e.g., as a percentage of WAC). While the rebate GPO does not make formulary decisions, the Big 3 rebate GPOs are under the same parent organization as PBMs who make formulary decisions. This could create an incentive for PBMs to prefer higher list price products on their formularies, allowing their affiliate rebate GPOs to capture increased GPO fees, rather than products that are most cost-effective overall.

While PBMs are increasingly passing through rebate value to plan sponsors, these GPO fees are expected to be retained by the rebate GPO and generally not shared with downstream entities. These GPO fees have increased in recent years as more of the rebate value is passed through to plan sponsors.[161] PBMs have disputed the claims that they prefer more highly rebated products, claiming that they prefer the lowest net cost option regardless of rebates and pointing out role of independent pharmacy and therapeutics (P&T) committees in ensuring clinical appropriateness.[162] However, we also note that most commercial plans, Medicare plans, and regulatory agencies do not have access to drug level rebate data to understand if or how rebates and net costs drive formulary decisions.

PBMs compete for plan sponsor business and one key component of their competitiveness is their financial guarantees, including rebate guarantees. Due to this competition, all else being equal, PBMs generally aim to offer the highest possible rebate guarantee to plan sponsors. The desire of competitive rebate guarantees can incent PBMs to prefer drugs that maximize their rebate guarantees.

A high list price / high rebate strategy can generally disadvantage biosimilars and generics, which typically have lower list prices and often do not offer comparable rebates. Without the high rebates, biosimilars and generics may struggle to gain preferred status on PBM formularies. This strategy ultimately impacts members who utilize these drugs, as their cost sharing is often based on the gross drug cost. While it is possible to base a patient's cost sharing obligation on the net cost of the drug (through point-of-sale rebates), this increases the plan sponsor's liability which may ultimately increase premiums for all plan sponsor members.[163] This may create hesitancy for plan sponsors in implementing point-of-sale rebates; however, plan sponsors can mitigate premium increases through plan design changes. These changes may increase costs or reduce coverage for members in other areas of the benefit. Point-of-sale rebates are discussed in greater detail in the Considerations section of the report.

One additional challenge to moving away from a high list / high rebate strategy is what is known as the "rebate wall." In a given therapeutic class, if a brand has significant market share and offers a deep rebate, a PBM or plan sponsor needs to be able to move a significant portion of the market share to the generic / biosimilar if they do not cover the high rebate brand. Without shifting a

[161] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[162] https://www.ftc.gov/system/files/ftc_gov/pdf/611920.2024.10.09_esi_respondents_answer_and_defenses_0.pdf

[163] https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/

significant amount of market share to the generic / biosimilar, PBMs or plans risk paying more in that therapeutic class, as they lose rebates on any brand utilization that remains. Table 10 demonstrates how rebate walls can create an added hurdle necessary to ensure formulary changes to lower net cost products are cost effective.

In Table 10, Scenario 1 represents a brand preferred strategy where Drug A is a brand that offers a 75% rebate in exchange for preferred formulary status; however, in Scenario 2 the plan sponsor decides to non-prefer Drug A in preference of Drug B, a lower WAC option that is lower net cost. As such, Drug A no longer offers rebates to the PBM. Despite a formulary change to a lower net cost option, the plan sponsor is only able to shift 80% of utilization from Drug A to Drug B. Because there is still utilization of Drug A (which no longer offers a rebate as it has lost preferred status), the overall net cost to the plan sponsor increases in Scenario 2 (brand non-preferred) compared to Scenario 1 (brand preferred). In Scenario 2, the PBM needs to shift a material percent of brand market share to the lower WAC alternative, approximately 95%, to have a lower plan sponsor net cost than Scenario 1.

TABLE 10: EXAMPLE DEMONSTRATING THE IMPORTANCE OF SHIFTING BRAND MARKET SHARE WHEN MOVING FROM A BRAND PREFERRED TO A BRAND NON-PREFERRED STRATEGY

		Scenario 1: brand preferred	scenario 2: brand non-preferred
Drug A Gross Cost (WAC)	A	$1,000	$1,000
Drug A Rebate	B	75%	0%
Drug A Script Volume	C	10,000	2,000
Drug A Total Net Cost	D = A * (1-B) * C	$2,500,000	$2,000,000
Drug B Gross Cost (WAC)	E	$500	$200
Drug B Rebate	F	0%	0%
Drug B Script Volume	G	0	8,000
Drug B Total Net Cost	H = E * (1-F) * G	$0	$1,600,000
Total Plan Sponsor Net Cost	**I = D + H**	**$2,500,000**	**$3,600,000**

Drug A is a higher WAC brand that offers rebates, Drug B is a lower WAC option that is lower net cost. Scenario 2 assumes 80% of Drug A market share shifts to Drug B.

PBM-affiliated specialty pharmacies

As previously discussed in the Evolving PBM Profit Pools section of the report, spend on specialty drugs is a significant and growing contributor to overall drug spend. PBM-affiliate specialty pharmacies make up the largest portion of PBM profits.[164] In a recent report by the FTC, they

[164] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

noted that specialty dispensing revenue across all U.S. pharmacies increased at a compound annual growth rate of 11.2% between 2016 and 2023, which was approximately three times faster than the dispensing revenue for non-specialty drugs. During this same period, the report notes that the Big 3 PBM's affiliated pharmacies increased their share of specialty dispensing revenue by 25%.[165]

The FTC report argues that the ownership structure can create conflicts of interest, as PBMs may have financial incentives to steer patients toward their own specialty pharmacies, potentially limiting patient choice and competition.[166] Additionally, the report expresses concerns about transparency in pricing and the potential for higher overall costs. The FTC report evaluated the reimbursement rates and pharmacy dispensing revenue for two generic specialty drugs (generic Zytiga used to treat prostate cancers and generic Gleevec used to treat leukemia). The FTC study found that for these two drugs the Big 3 PBMs often paid their affiliate pharmacies significantly more than the pharmacy acquisition cost of the drug, often 20 to 40-times the pharmacy acquisition cost. For example, commercial health plans reimbursed affiliated pharmacies an average of $2,700 per month for generic Gleevec in 2022, which was more than 40-times higher than the acquisition cost[167] of the drug at $66 per month. From the patient perspective, commercial reimbursement is reflective of the point-of-sale price which often determines patient cost-share (e.g., 20% coinsurance). For specialty drugs with inflated reimbursement, and thus, inflated
point-of-sale prices, this often results in higher cost share obligations for patients. From the pharmacy perspective, high reimbursement rates paid to PBM-affiliated pharmacies results in increased revenue for PBM-affiliated pharmacies for these particular drugs or claims.

However, it is not uncommon within current PBM pricing structures and arrangements to make disproportionate margins on select claims, channels, or services, and to have those positive margins offset by negative margins within other claims, channels or services within the contracted rates and fees (i.e., offsetting or cross-subsidizing). Historically, PBMs and their affiliated pharmacies have been more competitive on pricing for brand products, often losing money on that channel, and less competitive in the generic space, where they make up the lost margin on brands. These pricing structures have recently been put under pressure with alternative pricing sources, such as GoodRx drug discount cards and Mark Cuban Cost Plus Drugs, which offer additional discounts and transparency in pricing, mostly for generic products. PBMs have had to respond in some channels by lowering their standard pricing or offering integrated discount cards, such as GoodRx within their commercial benefits. [168,169,170]

The FTC report also found that the Big 3 PBMs often paid their affiliate pharmacies significantly more than unaffiliated pharmacies for the two specialty generic case study drugs. It is worth noting that the FTC did not present a study comparing overall reimbursement rates between these two groups. They also did not evaluate the overall cost impact of limited networks or steering strategies to payers or members.

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[165] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[166] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[167] Defined by National Average Drug Acquisition Cost

[168] https://www.evernorth.com/articles/increased-pharmacy-savings-and-affordable-prescription-medication

[169] https://investors.goodrx.com/news-releases/news-release-details/cvs-caremark-and-goodrx-launch-caremarkr-cost-savertm-help-lower?mobile=1&mobile=1&mobile=1

[170] https://investors.goodrx.com/news-releases/news-release-details/goodrx-and-medimpact-announce-program-ensure-seamless-access/?mobile=1&mobile=1&mobile=1

PBMs also own pharmacy network pricing contracts, where PBMs negotiate minimum overall reimbursement rates for their drug claims with a pharmacy or group of pharmacies. PBMs reimburse network pharmacies in a variable nature. Reimbursement is not necessarily tied to the contracted rate on any given client or claim, as long as the PBM meets the agreed upon minimum reimbursement amount in aggregate over the defined time period. PBMs may also own dispensing pharmacies in specific channels (e.g., their affiliate specialty pharmacies) and have an incentive to make revenue from specialty dispensing, which is a growing source of profit for PBMs.[171] Due to their vertical integration and ownership of network contracts, PBMs can guarantee rates that incentivize the use of PBM-affiliate pharmacies.

Pharmacy reimbursement

Pharmacy reimbursement is typically based on contractual agreements between the pharmacy, or a collection of pharmacies, as with pharmacy services administrative organizations (PSAOs), and PBMs. Pharmacy reimbursement contract terms typically use pricing benchmarks, such as AWP, WAC, and MAC (which is mostly for generic reimbursement). These benchmarks do not necessarily reflect the drug's acquisition cost. At the point-of-sale, pharmacies will typically receive reimbursement for the ingredient cost of the drug (based on one of the pricing benchmarks above), a dispensing fee, and taxes. The pharmacy will also generally be charged an administration or transaction fee by PBMs. Pharmacy claims may then be subject to post-sale adjustments based on their PBM contracts. As previously discussed in the PBM Market Dynamics section, pharmacies and PBMs typically have effective rate guarantees (both brand effective rates and generic effective rates) in their contracts where PBMs are required to meet a certain minimum overall reimbursement rate (maximum discount rate) for their drug claims with that pharmacy or group of pharmacies. Because these effective rate guarantees are reconciled in aggregate over a defined period, they may result in the pharmacy owing PBMs a remittance (if the PBM exceeded the effective rate guarantee, in aggregate) or PBMs may use the overage to offset underpayments with that pharmacy in separate networks or lines of business.

While the effective rate guarantee offers some reimbursement predictability, the terms are often nebulous and they can also be difficult to anticipate and monitor, creating financial insecurity for pharmacies.[172] The FTC report highlights that the Big 3 PBMs have considerable market power and are vertically integrated with mail and specialty pharmacies (and retail pharmacies in the case of CVS Caremark). The FTC argues that vertical integration may increase a PBM's ability to disadvantage non-affiliate and / or independent pharmacies by setting unsustainable reimbursement rates. The FTC report highlights that pharmacies must often accept PBMs' contract terms or drop out of the pharmacy network, thereby losing patient and prescription volume. The report also notes that this ability to put downward pressure on reimbursement rates for unaffiliated pharmacies could potentially harm competition.[173] These points have been disputed by the PBMs in a recent study done by Compass-Lexecon (commissioned by the Big 3 PBMs). The report showed that independent retail pharmacy reimbursement rates overall were higher than unaffiliated chain pharmacies.[174]

[171] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[172] https://www.pharmacyfirst.com/wp-content/uploads/2021/02/Pharmacy-First_Effective-Rate-User-Guide_CEO.pdf

[173] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[174] https://compass-lexecon.files.svdcdn.com/production/files/documents/PBMs-and-Prescription-Drug-Distribution-An-Economic-Consideration-of-Criticisms-Levied-Against-Pharmacy-Benefit-Managers.pdf?dm=1728503869

Several states have enacted legislation aimed at ensuring that pharmacies are reimbursed sufficiently. This type of legislation often falls into one of the following categories:[175,176]

- Requiring pharmacy reimbursement at or above certain benchmarks (e.g., NADAC)
- Regulating PBM MAC list processes (for example requiring PBMs to have an appeal process for MAC lists, outlining which drugs may be subject to MAC pricing, requiring that PBM's make their MAC lists available to pharmacies, and / or requiring transparency around the data sources used to determine MAC pricing)
- Pharmacy reimbursement that is at or above what a PBM reimburses its affiliated pharmacies
- Limitations to PBM effective rate methodologies

Arkansas and Delaware require a minimum reimbursement for pharmacies – both prohibiting reimbursing pharmacies less than NADAC for the ingredient cost component, and if no NADAC is available then reimbursement at the WAC. However, PBMs argue that this type of legislation may remove incentives for pharmacies to shop for the best price and could result in pharmacies purchasing drugs above market price, ultimately increasing plan sponsor costs.[177]

Louisiana prohibits PBMs from reimbursing local pharmacies (defined as independent, non-chain pharmacies) "less than the amount it reimburses chain pharmacies, mail order pharmacies, specialty pharmacies, or affiliates of the PBM for the same drug or device or the same pharmacy service."[178] Similarly, Arkansas law prohibits a PBM from reimbursing "a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a PBM affiliate for providing the same pharmacist services."[179] New York also recently put rules into place that require reimbursement to non-affiliated pharmacies at least equal to the reimbursement to an affiliate pharmacy when in the same network.[180]

Arkansas law also prohibits PBMs from making or permitting "any reduction of payment for pharmacist services by a pharmacy benefits manager or a healthcare payor directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including without limitation, generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment."[181]

While these types of legislation aim to ensure fair pricing, they can be difficult to enforce.[182] However, in August 2024 the Arkansas governor and the Arkansas Insurance Department Commissioner announced penalties and hearings against four PBMs (CVS Caremark, Magellan, Express Scripts, and MedImpact) for failure to comply with State law requiring pharmacy reimbursement at or above NADAC. The Arkansas Insurance Department is seeking a $5,000

[175] https://www.frierlevitt.com/articles/provider-enforcement-of-state-fair-pricing-laws-as-a-means-to-secure-reasonable-and-sustainable-reimbursement-rates/

[176] https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

[177] https://www.mymatrixx.com/news/2024-louisiana-legislature-pushes-higher-drug-costs

[178] https://legis.la.gov/Legis/law.aspx?d=1147622

[179] https://law.justia.com/codes/arkansas/title-23/subtitle-3/chapter-92/subchapter-5/section-23-92-506/

[180] https://www.dfs.ny.gov/system/files/documents/2024/11/rf-ins-a3reg219-text.pdf

[181] https://law.justia.com/codes/arkansas/title-23/subtitle-3/chapter-92/subchapter-5/section-23-92-506/

[182] https://www.frierlevitt.com/articles/provider-enforcement-of-state-fair-pricing-laws-as-a-means-to-secure-reasonable-and-sustainable-reimbursement-rates/

per claim penalty totaling $1.47 million in possible penalties.[183] Even when states have mandated reimbursement rules, PBMs can have aggregate contracts that may allow them to offset overpayment from state mandated reimbursement against other contracted rates they have with a pharmacy chain or PSAO that operates in multiple states. This effectively negates state mandated reimbursement rules. For example, if a state mandates a $10 dispensing fee, but the PBM is contracted, in aggregate across the U.S. with that pharmacy chain or PSAO at a $0.25 per claim dispensing fee, then at the end of the year they reconcile to $0.25, even if the pharmacy was paid $10 at point of sale in that particular state. The financial impact of these state regulations are typically passed on to the payer by PBMs in the form of contract addendums and pricing adjustments.

CONSIDERATIONS

Improving PBM Oversight in Connecticut

While PBMs operating in Connecticut are required to register with and provide annual rebate reports to the Connecticut Insurance Department, rebate retention is a shrinking profit pool for PBMs, and this level of reporting may not be sufficient to understand PBM profitability in the state. PBM affiliated businesses (e.g., PBM-owned specialty pharmacies, rebate GPOs, and biosimilar distributors) are a growing source of PBM revenue that provide additional layers of revenue retention for vertically integrated organizations. The State may consider requiring additional reporting from PBMs, such as:

- **Pharmacy Reimbursement Reporting (**Reporting on pharmacy claim volume, spread, and average generic effective rate, brand effective rate, and dispensing fees by pharmacy, network, and line of business)**:** Typically, larger pharmacies and PSAOs will have a generic effective rate agreement in place with a PBM. However, for pharmacies that do not have a generic effective rate, they have to accept a PBM's reimbursement if they want to be included in the network. The reimbursement should be separated into dispensing fees, ingredient costs, and all other fees by line of business (e.g., commercial, Medicare). This level of reporting would provide insight into appropriateness of drug reimbursement and dispensing fees, along with fees charged to pharmacies by PBM, and any differential in reimbursement between affiliate and nonaffiliate pharmacies, along with chain versus independent pharmacies.) As the Connecticut Medicaid program is managed under FFS, which requires specific reimbursement logic, this level of reporting would not be applicable to the Medicaid program in Connecticut.

- **Affiliate Revenue Reporting:**

  - Reporting retained manufacturer revenue, in aggregate, both directly and through affiliates - While more rebates are passed through to plan sponsors, PBMs and GPOs are collecting an increasing amount and number of fees that may not be passed through to plan sponsors. As such, Connecticut may consider more clearly defining "rebates" and require more granular reporting from PBMs on what percentage of each component of rebates (e.g., base rebate, price protection, manufacturer administration fee) is retained by them and any upstream parties (other PBMs, affiliates, GPOs). The State may also require

[183] https://governor.arkansas.gov/news_post/governor-sanders-arkansas-insurance-department-enforce-arkansas-law-against-pbms/

reporting on collected and retained fees from affiliated rebate GPOs, including data fees, clinical fees, value-GPO fees, portal access fees, and formulary compliance fees (outlined in Table 3).

- Reporting on other PBM sources of profit, such as administrative fees, spread pricing, clinical fees, etc.

- Reporting on revenue and profit for affiliate pharmacies (by retail, mail, and specialty) for Connecticut pharmacy claims

- Reporting on profit from biosimilar distributors -While the expansion of the Big 3 PBMs into biosimilar manufacturing and distribution may increase access to biosimilars, drive competition, and reduce out-of-pocket costs for members, these new supply chain stakeholders also provide new layers of revenue retention and profit for the parent organization.

Stakeholders interviewed by the U.S. Government Accountability Office (GAO) expressed support for laws related to PBM transparency. They noted shortcomings of some existing state laws that do not allow state regulatory agencies to capture information on the full scope of PBM revenue and expenses. They also observed that additional information is needed to gain a better understanding of prescription drug cost drivers. As for the challenges related to transparency reporting requirements, some expressed concern that these reporting requirements may pose an administrative burden to PBMs without necessarily lowering drug costs.[184]

The State may also consider alternative routes for obtaining information that PBMs may be reluctant to provide. For example, the State may request pharmaceutical manufacturers report what they paid to PBMs for every pharmacy in Connecticut. This information should be used for internal analysis purposes only, as information on drug rebates is highly confidential. While manufacturers may be hesitant to provide such sensitive information, the State can mitigate this risk by clearly communicating its data use intent and putting limitations on what can be shared, similar to CID restrictions on rebate data currently collected for the fully insured commercial market. Some states (e.g., Florida, Louisiana, New Jersey, and Utah)[185] have enacted legislation requiring manufacturers to report WAC increases over a specified threshold, which is intended to measure the impact of manufacturer price increases.

To gain a more holistic view of the complex pharmaceutical supply chain in Connecticut, the State may also consider requiring more comprehensive data submission from stakeholders across the supply chain, including manufacturers, pharmacies, wholesalers, and PBMs. The State of Maine has taken this approach to provide a more complete view of trends in the cost of prescription drugs, analysis of manufacturer prices and price increases, major components of prescription drug pricing along the supply chain, and impacts on insurance premiums and cost sharing.[186] Having a more complete view of the supply chain would allow the State to better identify what is

[184] https://www.gao.gov/assets/d24106898.pdf

[185] https://www.goodwinlaw.com/en/insights/publications/2023/11/alerts-lifesciences-state-drug-transparency-law-development-update

[186] https://mhdo.maine.gov/RxDrugPricingTransparency.htm

driving cost increases for consumers and payers in Connecticut and help clarify where future action may be warranted.

> The pharmacy supply chain is exceedingly complicated and nuanced. The State can benefit from partnering with an independent consulting firm with comprehensive subject matter knowledge on pharmacy contracts and the pharmacy supply chain. This type of partnership can aid the State in designing PBM oversight language that aligns with the State's intended goals and provides little room for misinterpretation by reporting entities. In the face of increased regulatory pressures, PBM business practices are evolving, and it is important to partner with an expert who understands these evolving business practices.

Reducing Drug Prices for Connecticut Consumers

Options related to reducing drug prices for consumers in Connecticut focus on the commercial market, as existing legislation limits drug cost sharing in Medicaid and Medicare. For example, Medicaid enrollees in Connecticut generally do not pay a deductible or copay.[187,188] For Medicare, the Inflation Reduction Act (IRA) made changes to the Medicare Part D benefit that limits the amount that beneficiaries pay out-of-pocket for their prescription drugs.[189,190,191]

In the commercial market, there are a number of strategies to lower prescription drug prices for consumers, including:

1. Increasing biosimilar adoption
2. Assessing the potential impact of point-of-sale rebates
3. Lowering patient cost share for brand-over-generic strategies
4. Promoting cost-plus pricing models and reducing cross-subsidization
5. De-linking PBM revenue from drug cost
6. Expanding the use of preventive drug lists

Each of these items is discussed in greater detail below.

1. Increasing Biosimilar Adoption

A biologic drug is a medicine developed from a living organism or its products (e.g., cells, blood, plasma, proteins, etc.) and is typically more complex than other drugs. A biosimilar is highly similar to a biologic (or reference) medication already approved by the U.S. Food and Drug Administration (FDA), with no clinically meaningful difference in terms of safety and effectiveness from the reference product.[192] Similar to generic launches of small-molecule drugs, biosimilars may launch following the loss of exclusivity offered to the reference product, which can create

[187] https://cga.ct.gov/2015/rpt/2015-R-0160.htm

[188] There are also maximum out-of-pocket costs for Medicaid set at the federal level that vary by family income but are generally $4 for preferred drugs and $8 for nonpreferred drugs.

[189] https://www.congress.gov/bill/117th-congress/house-bill/5376/text

[190] Starting in 2025, the Medicare part D benefit includes a maximum out-of-pocket limit of $2,000 for beneficiaries

[191] Medicare Part D plans commonly offer generics at no or low cost sharing, as most Part D plans use a tiered formulary structure where generic drugs are place in lower tiers with lower copays.

[192] https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients

price competition in the market. Biosimilars are often available at a lower cost than the reference biologics, often 15% to 35% lower than the reference biologic.[193]

Humira® (adalimumab) is a biologic drug used to treat a variety of inflammatory conditions and was the highest grossing drug in the world through 2023.[194] In fact, according to the Connecticut Insurance Department's 2024 Outpatient Prescription Drug Cost Report, Humira was the top drug contributing to gross drug costs in the state, accounting for $26.6 million in spend in 2022. In 2023, ten Humira biosimilars entered the market at various price points, with discounts off the Humira list price ranging from five percent (5%) to 86%.[195] Despite the launch of multiple lower cost Humira biosimilars, biosimilar market share was at four percent (4%) as of February 2024.[196]

Since then, CVS Caremark announced the exclusion of brand Humira from its major commercial formulary effective April 1, 2024 in place of Humira biosimilars, including a low-list-price Humira biosimilar from Cordavis (CVS Health's affiliate pharmaceutical distributor). This significantly shifted market share towards biosimilars for new Humira prescriptions, resulting in a 22% market share for Humira biosimilars as of August 2024.[197,198,199] Following CVS Caremark's major formulary change, Express Scripts announced they will remove brand Humira from its major national formulary effective January 1, 2025. Express Scripts' 2024 National Preferred Formulary (as of July 2024) lists multiple low-list-price Humira biosimilars, as well as two biosimilars from Quallent Pharmaceuticals (Cigna Group's affiliate pharmaceutical distributor) available at a 46% discount to brand Humira.[200] Similarly, in September 2024, UnitedHealth Group announced Humira will be removed from its major national formulary effective January 1, 2025 in place of biosimilars.[201]

As patient cost share is often based on the gross cost of the drug (i.e., the cost of the drug before rebates), lower cost biosimilars offer the potential to lower patient out-of-pocket costs. The State may consider the following ways to increase biosimilar adoption in Connecticut:

- Require that PBMs and payers provide lower patient cost share for preferred products when a less-expensive biosimilar is available in the market. Due to formulary strategies that may prefer originator products or higher list price products over lower list price products, patients may not be able to benefit from these lower cost products in the form of lower cost share (coinsurance, lower-tier copays, deductibles, maximum out-of-pocket, etc.). Strategies such as requiring a lower patient cost share or applying point-of-sale rebates when these lower priced alternatives are available on the market, can help ensure that the patient receives the benefit of a lower cost alternative, regardless of formulary.

[193] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2816952

[194] https://www.ajmc.com/view/humira-the-first-20-billion-drug

[195] https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html

[196] Samsung Bioepis Biosimilar Market Report 5th Edition, Q2 2024 available for download here: https://www.samsungbioepis.com/en/etc/gadown.do?filename=SB+Biosimilar+Market+Report+Q4+2024.pdf&utm_source=pdfClick&utm_medium=filedown&utm_campaign=marketReport

[197] https://www.cvshealth.com/news/pbm/cvs-caremark-accelerates-biosimilars-adoption-through-formulary-changes.html

[198] https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html

[199] Samsung Bioepis Biosimilar Market Dynamics 7th Edition, Q4 2024 available for download here: https://www.samsungbioepis.com/en/etc/gadown.do?filename=SB+Biosimilar+Market+Report+Q4+2024.pdf&utm_source=pdfClick&utm_medium=filedown&utm_campaign=marketReport

[200] https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html

[201] https://www.reuters.com/business/healthcare-pharmaceuticals/unitedhealth-remove-abbvies-humira-some-us-drug-reimbursement-lists-next-year-2024-09-10/

- Ensure that plan and member costs for preferred biosimilars are not greater when members are required to utilize affiliate pharmacies. Require documentation that the net cost to payers and the member cost share are not higher at the affiliate pharmacy when lower-priced alternatives are available in the market that could result in lower plan pay or member pay elsewhere.

- Require PBMs to provide net price justification (including transparency into net cost after rebates) when preferring higher list price products over lower list price alternatives (generics or biosimilars). To ensure payers and members are benefiting from formulary strategies that favor high list priced products over lower list price products, the State could require transparent net cost reporting to show how the strategy is benefiting both payers and members in the state. This may require drug level rebates which are considered confidential. The State can mitigate this risk of exposure by applying confidentiality rules similar to CID restrictions on rebate data for the fully insured commercial market.

2. Assessing the Potential Impact of Point-of-Sale Rebates in the Commercial Market

A POS rebate occurs when the value of the manufacturer rebates goes to reduced patient cost-sharing at the pharmacy counter (i.e., at the POS) rather than to the plan, where it is often used to reduce premiums for all members. A survey of large employers by the National Business Group on Health found that approximately 20% of large employers use POS rebates for their pharmacy benefit and that more employers were considering POS rebates in future years.[202] The impact of POS rebates on patient out-of-pocket costs (for members with a coinsurance who have met their deductible) is illustrated in Table 11 below.

TABLE 11: EXAMPLE COMPARING PATIENT AND PLAN SPONSOR COSTS WITH AND WITHOUT REBATES AT POS

	Scenario a: rebate at pos	scenario b: no rebate at pos
Gross Drug Cost (WAC)	$1,000	$1,000
Rebate (50%)	$500	$500
Net Drug Cost	$500	$500
Patient Cost Share (20% Coinsurance)	$500 * 20% = **$100** Patient cost share is based on the net cost of the drug	$1,000 * 20% = **$200** Patient cost share is based on the gross cost of the drug
Overall Cost to Plan Sponsor	**$400**	**$300**

Assumes a 20% coinsurance for a patient who has met their deductible.

[202] https://www.drugchannels.net/2019/09/employers-slowly-warm-to-point-of-sale.html

In the example above, the patient cost share is lower in scenario A (rebate at POS) because the cost share is based on the net cost of the drug (i.e., the gross cost minus the drug rebate); however, the plan liability is higher in scenario A which could potentially result in higher premiums for all members, all else being equal (i.e., no changes in benefit design).[203] POS rebates are most impactful for patients who have higher costs share obligations (e.g., high deductible and / or high coinsurance) who utilize expensive brand medications.

Additionally, POS rebates, particularly for patients with high deductibles and / or high coinsurance who utilize expensive medications to treat chronic conditions, may result in increased adherence due to the lower patient out-of-pocket expense.[204] According to a 2018 report from CVS, POS rebates improved patient adherence by four to six percent (4 to 6%).[205]

While applying rebates at the POS is generally expected to result in higher premiums for all members, the magnitude of premium impact depends on the plan design. In a previous analysis measuring the impact of POS rebates on the commercial health insurance market, Milliman found that nationwide payer costs would increase an average of 0.6% or less, depending on the plan design. Payer costs would not be impacted for preferred provider organization plans (PPOs) with brand pharmacy benefits subject to copays (copay PPO). For PPO plans with brand pharmacy benefits subject to a set coinsurance percentage (coinsurance PPO) and HDHPs with a brand pharmacy benefit subject to a copay after a member satisfies their deductible (copay HDHP), payer costs would increase by 0.4%. The largest increase in payer costs would be experienced by a HDHP with brands subject to coinsurance after a member satisfies their deductible (coinsurance HDHP) at 0.6%.[206]

Some have expressed concern that POS rebates would result in a level of rebate transparency that may enable manufacturers to understand the rebates offered by their competitors which could lead to reduced competition and a decline in manufacturer rebates.[207,208] Various analyses have estimated that policies resulting in the disclosure of rebates could result in a two to three percent (2 to 3%) decrease in manufacturer rebates from today's average rebate value.[209]

The Connecticut State employee prescription plan, managed by CVS Caremark, currently provides rebates at POS with 100% pass through of rebates to members[210] This model could be assessed further to determine how it may impact the overall commercial market if applied.

The State may consider assessing commercial member cost share data to determine if member cost share is a barrier to accessing high-cost brand medications. The State may also consider encouraging plan sponsors to adopt POS rebates, either applying 100% or a portion of the rebate at POS, for all drug classes or select drug classes (e.g., specialty drugs or targeted therapeutic classes).

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[203] https://www.theactuarymagazine.org/rebates-at-the-point-of-sale/

[204] https://icer.org/wp-content/uploads/2018/12/March-2019-ICER-OHE-White-Paper-on-Rebates-Final.pdf

[205] https://icer.org/wp-content/uploads/2018/12/March-2019-ICER-OHE-White-Paper-on-Rebates-Final.pdf

[206] https://www.milliman.com/-/media/milliman/pdfs/2022-articles/1-19-22-measuring-impact-point-of-sale-rebates-commercial-health-insurance-market.ashx

[207] https://www.pcmanet.org/wp-content/uploads/2023/01/Increased-Costs-Associated-With-Proposed-State-Legislation-Impacting-PBM-Tools-January-2023.pdf

[208] https://www.pcmanet.org/wp-content/uploads/2024/04/POS-Rebates-Legislation-Would-Increase-Costs-for-the-States.pdf

[209] https://www.pcmanet.org/wp-content/uploads/2023/01/Increased-Costs-Associated-With-Proposed-State-Legislation-Impacting-PBM-Tools-January-2023.pdf

[210] https://osc.ct.gov/vendor/rfps/2023/PBM%20RFP%20QnA%202.pdf

Currently, there are a few examples where states mandate that rebates be applied at POS. Arkansas requires that cost sharing be based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the drug.[211] New Hampshire enacted legislation on July 26, 2024 that requires at least 50% of all rebates be "remitted directly to the covered person at the point of sale", with the remainder being required to be remitted to the insurer and used to offset premiums.[212] Also, in 2019, Maine passed legislation that requires PBMs to pass rebates on to consumers at POS, or for carriers to use retained rebates to lower premium costs.[213]

3. Lowering Cost Share for Brand-Over-Generic Strategy

PBMs and / or plan sponsors may implement a brand-over-generic strategy where the higher list price brand product is preferred over lower list price generics. Due to rebate and formulary dynamics, plan liability may be lower for certain brands compared to generic counterparts. However, as patient cost share is often based on the gross drug cost, this strategy often results in higher out-of-pocket expenses for patients. To mitigate this, the State may consider working with major PBMs and plan sponsors who have significant commercially insured lives to recommend lower cost share (e.g., generic equivalent copays) where there is a brand-over-generic strategy in place or require the POS rebates described above to mitigate this issue.

Alaska now has a law in place that requires PBMs to disclose and provide any benefit or payment received as the result of a drug substitution where the dispensed drug costs more than the prescribed drug to the plan sponsor.[214] While this may not directly benefit the member, it does mandate that the benefit is provided to the payer. The same bill also requires full disclosure of all financial terms and arrangements for remuneration between a PBM and a manufacturer to the plan sponsor.

4. Promoting Cost-Plus Pricing Models and Reducing Cross-Subsidization

As described in the PBM Market Dynamics section of this report, current pricing models are often based on confidential reimbursement and discount contracts, arbitrary list pricing, and unknown actual acquisition costs. This creates the potential for highly variable and inconsistent pricing at a claim and drug level for both payers and members and may result in significantly higher out-of-pocket costs for members. Recently, some PBMs have begun offering new pricing models based on pricing benchmarks that are more closely related to actual acquisition cost of the drug.[215,216,217] The State may collaborate with PBMs and plan sponsors to promote education and adoption of these cost-plus pricing models to bring more predictability in pricing to members. While some of the larger PBMs have begun offering these pricing models to payers, they may start gaining favor due to trends or pressures such as ERISA litigation mentioned earlier in this report.

[211] https://law.justia.com/codes/arkansas/title-23/subtitle-3/chapter-92/subchapter-7/section-23-92-704/

[212] https://legiscan.com/NH/text/SB555/id/2956542

[213] https://legislature.maine.gov/bills/getPDF.asp?paper=SP0466&item=4&snum=129

[214] https://www.akleg.gov/PDF/33/Bills/HB0226Z.PDF

[215] https://www.cvshealth.com/news/company-news/our-path-to-accelerating-long-term-growth.html

[216] https://www.evernorth.com/article/pharmacy-benefits-management-pbm-affordability-transparency

[217] https://www.unitedhealthgroup.com/newsroom/posts/2023/2023-04-24-optum-rx-enhancements-preserving-choice.html

Another option would be to promote adjustments in pricing models to reduce cross-subsidization in today's market. This would involve adjusting reimbursements to ensure one type of drug (e.g., brands) is not reimbursed below cost, which results in other channels or drug types (e.g., generics) being significantly over-reimbursed to make up for the loss. Eliminating this pricing dynamic could also potentially reduce some pricing inconsistencies.

5. De-linking PBM Revenue from Drug Cost

Historically, PBMs have been compensated through a variety of mechanisms, many of which are tied to the list price of a drug. Spread pricing, rebate retention, and fees based on WAC are all based on the price of a drug. While manufacturers set drug prices, some have argued that drug prices remain high due to profit incentives for PBMs, where PBMs can earn more profit on drugs with higher prices.[218] The concept of de-linking involves prohibiting PBMs from earning compensation based on the price of a drug. This generally requires PBMs to shift their compensation to flat fees from stakeholders (e.g., aggregate dollar amounts, PMPM fees) and administrative-fee-only models. De-linking has the potential to reduce incentives that may encourage PBMs to favor higher-priced drugs. To address this issue, the State may evaluate strategies that limit PBM compensation and fee structures that are based on the price of drugs. Several de-linking bills have been introduced in Congress, but none have passed to date.[219]

Another strategy that the State may consider is limiting the absolute magnitude of fees that a PBM may charge to and/or retain from industry stakeholders (e.g., manufacturers). Bona-fide service fees have a statutory definition and are required to represent fair market value.[220] However, other PBM fees that are not considered bona-fide service fees generally do not have to be based on fair market value or otherwise have any statutory limits. The State may consider capping fees assessed by PBMs and / or retained by PBMs, potentially limiting their absolute magnitude (e.g., fees cannot exceed a certain percentage of WAC), ensuring that fees cannot exceed a predefined limit. If the State pursues this avenue, the State should consider the absolute magnitude of all fees assessed by a PBM in totality, and carefully define in statute what constitutes a fee and / or other forms of manufacturer remuneration.

6. Expanding the Use of Preventive Drug Lists

Preventive drug lists typically include medications that are covered by health plans without requiring the patient to meet their deductible first. These lists are designated to support preventive care and manage chronic conditions by providing essential medications at no or low cost to the patient. The Affordable Care Act (ACA) mandates that certain preventive services, including specific medications, must be available without cost-sharing to members. These requirements apply to all commercial plans – fully-insured and self-insured – in the individual, small group, and large group markets. The ACA mandated preventive drug list covers medications for cardiovascular protection (e.g., Aspirin and statins), prenatal vitamins, contraceptive medications, prescriptions for tobacco cessation, among others.

With the exception of the ACA mandated preventive drug lists, high deductible health plans are generally not allowed to cover medications before a patient meets their deductible. However, the IRS (under IRS Notice 2019-45) allows pre-deductible coverage of certain drugs in addition to the

[218] https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

[219] https://mypolicyhub.com/wp-content/uploads/2024/08/Impact-Chart-of-PBM-Legislation_8.5.24.pdf

[220] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-J/section-414.802

ACA preventive drug list. This list includes additional drugs that are not on the ACA mandated preventive drug list such as inhaled corticosteroids to treat asthma, insulin for individuals with diabetes, selective serotonin reuptake inhibitors (SSRIs) for depression, and others.[221] According to findings from a 2021 Employe Benefit Research Institute (EBRI) survey of employers, 76% of employers added some pre-deductible coverage as a result of IRS Notice 2019-45, although only 8% added coverage of all 14 health care services. Some of the most common pre-deductible medications added by employers included insulin and glucose lowering agents, and beta blockers. Employers cited several reasons for adding pre-deductible coverage, including the well-being of their employees, enhancing employee retention and attraction, and achieving long-term cost savings.[222] According to data from the U.S. Bureau of Labor Statistics, 51% of private industry workers participated in a HDHP in 2023, with a median annual individual deductible of $2,500.[223] According to a study of employer sponsored insurance in 2018, Connecticut had 55.3% of employees enrolled in a high-deductible health plans, which was higher than the national average (49.1%) and had average individual deductibles that were higher than the national average.[224]

The State may consider the following:

- Assessing commercial plan sponsors' plan design for adoption of pre-deductible coverage of drugs in key chronic disease classes. This assessment can be accompanied by an analysis of patient cost share and medication adherence to understand the degree to which additional pre-deductible coverage of medications to treat chronic diseases may impact patient out-of-pocket expenses and medication adherence.

- Encouraging plan sponsors with HDHPs to adopt pre-deductible coverage (with no or low copay) for those who have not adopted this pre-deductible coverage or who have a limited list of medication categories that they added for pre-deductible coverage. OHS may consider communicating information related to IRS Notice 2019-45 to the largest employers in the State and encourage uptake of pre-deductible coverage. Connecticut previously formed a HDHP Task Force to study the structure of HDHPs and the impact of such plans on enrollees in the State. The HDHP Task Force produced a report on February 1, 2020 where task force members noted that individuals with high deductibles will often delay or forgo care because they do not have the resources to meet their high deductibles and other out-of-pocket expenses. Adopting pre-deductible preventive services was a recommendation by at least one task force member. However, another task force member noted that requiring pre-deductible coverage of certain services may raise cost sharing elsewhere due to actuarial value (AV) ratings.[225] One of the key recommendations (recommendation 1.5) in the report was increasing public awareness of the availability of pre-deductible preventive services, as high deductibles may serve as an obstacle to consumers seeking preventative care.

[221] https://www.irs.gov/pub/irs-drop/n-19-45.pdf

[222] https://www.ebri.org/docs/default-source/pbriefs/ebri_ib_542_hsaemployersur-14oct21.pdf?sfvrsn=73563b2f_6

[223] https://www.bls.gov/opub/ted/2024/51-percent-of-private-industry-workers-participated-in-high-deductible-health-plans-in-2023.htm

[224] https://www.shadac.org/sites/default/files/ESIReport2019/CT_infographic_9.19.pdf

[225] https://www.cga.ct.gov/ins/tfs/20190822_High%20Deductible%20Health%20Plan%20Task%20Force/HDHP%20Final%20Report%20212020/High%20Deductible%20Health%20Plan%20Task%20Force%20Final%20Report%20DRAFT%201-27-20.pdf

- Encouraging plan sponsors with non-HDHPs (e.g., PPOs and HMOs) to adopt pre-deductible coverage for chronic disease preventive drugs and telehealth services beyond what is mandated by the ACA. The preventive drugs could be aligned to those in IRS Notice 2019-45, or a slimmed down version, and could be limited to generic drugs. This would reduce patient out-of-pocket expenses for certain preventive drugs, while potentially increasing patient adherence to these drugs.

According to a study by EBRI using claims data and assumptions about behavioral responses, the impact on premiums of expanding pre-deductible coverage per IRS Notice 2019-45 (which includes more than preventive drug coverage) is modest (0.87%). These results aligned with results from similar studies. A 2021 America's Health Insurance Plans (AHIP) survey of health insurers found that most reported either no premium increase or a premium increase of less than one percent (1%). Another study that was limited to expanded pre-deductible drug coverage (with a combination of copay and coinsurance) of 57 drugs classes used to treat 11 chronic conditions would increase premiums by 1.7%.[226]

[226] https://www.ebri.org/docs/default-source/pbriefs/ebri_ib_588_pdc2-17aug23.pdf?sfvrsn=6215062f_4

Caveats and Limitations

This report was commissioned by the State of Connecticut Office of Health Strategy. We do not intend this information to benefit any third party, even if we permit the distribution of our work to such third party. This information is intended to assist the State of Connecticut Office of Health Strategy with:

(1) understanding the impact of PBM practices on providers and consumers in the state,

(2) comparing these practices to those of PBMs operating in other states, and

(3) providing policy options that may lower the cost of prescription drugs for consumers and increase transparency with PBM practices. This information may not be appropriate and should not be used for other purposes.

In preparing this information, we relied on market knowledge, data from MMIT, Connecticut's APCD, and publicly available information. To the extent that any of the data or information publicly sourced is inaccurate or incorrect, the results could be materially affected.

This report outlines the review and opinions of the authors and not necessarily those of Milliman. Milliman does not endorse any public policy, legislative proposal, or advocacy position on matters discussed in this report. Milliman does not provide legal advice and recommends that the State of Connecticut Office of Health Strategy consult with its advisors regarding legal matter.

Glossary

Actuarial Value (AV)	The percentage of total average costs for covered benefits that a plan will cover.
Affiliate	A business relationship wherein one organization has a stake in another organization (e.g., both organizations are subsidiaries of the same larger parent company).
Affordable Care Act (ACA)	A comprehensive health care reform law enacted in 2010 with the goals of making affordable health insurance available to more people, expanding Medicaid to cover more individuals, and supporting innovative medical care delivery methods designed to lower the costs of health care generally.
All-Payer Claims Database (APCD)	Database that receives and stores data from a reporting entity (e.g., insurer, health center, PBM, TPA, etc.) relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.
“Any-willing provider” network	Network where the health plan must contract with any interested pharmacy that meets the plan’s standard terms and conditions for network participation.
Average Wholesale Price (AWP)	A benchmark figure used in the pharmaceutical industry that represents the average price paid by retail pharmacies, hospitals, and clinics to buy a drug from a wholesale distributor.
“Big 3” PBMs	The "Big 3" refers to the three largest PBMs in the United States: CVS Caremark, Express Scripts, and OptumRx.
Biologic drugs	Complex, large molecule medications derived from living cells or organisms, used in the treatment and management of various diseases and medical conditions, and are often specialty medications.
Biosimilar drugs	An FDA-approved biologic product that is highly similar to and has no clinically meaningful differences from an existing approved reference biologic drug.
Bona fide service fees	Legitimate fees paid for actual services rendered and are not passed through as discounts or price concessions from PBMs to plan sponsors.
Single source brand drug	Branded pharmaceutical product that is available from one manufacturer and does not face competition from equivalent generics.
Multi-source brand drug	Branded pharmaceutical product available from multiple manufacturers, and typically occurs when the drug’s patent exclusivity expires allowing other manufacturers to produce and sell generic versions of the drug.
Centers for Medicare and Medicaid Services (CMS)	The federal agency that provides health coverage through Medicare, Medicaid, the Children’s Health Insurance Programs, and the Health Insurance Marketplace.
Claw back	Occurs when a PBM requires a pharmacy to return a portion of payment received for a prescription drug and generally occurs

	when the patient pay amount exceeds the reimbursement rate the PBM negotiated with the pharmacy.
Commercial insurance	Commercial health insurance is health insurance that is sold and administered by a private company rather than provided by the government.
Congressional Budget Office (CBO)	Office that intends to produce independent, nonpartisan, analysis of economic and budgetary issues to support the Congressional budget process.
Connecticut Insurance Department (CID)	Responsible for regulating the insurance industry in Connecticut.
Copay accumulators	A benefit design feature that ensures manufacturer copay assistance used by a member does not count towards the patients' deductibles or out-of-pocket maximums.
Cost-plus pricing	Pharmacy reimbursement is based on the actual acquisition cost plus a markup and / or fixed per claim dispensing fee. This approach ensures that pharmacies are reimbursed for the actual cost of the drug along with an additional amount to cover dispensing and other related costs.
Dispensing fee	The amount reimbursed to a pharmacy to cover the charge for professional services and overhead costs.
Effective rate guarantees	Guarantees that are designed to ensure that PBMs meet a certain minimum overall reimbursement rate for their drug claims with a given pharmacy or group of pharmacies. These agreements often use industry pricing benchmarks, such as the AWP to set reimbursement rate guarantees.
Employee Retirement Income Security Act (ERISA)	A U.S. federal statute that establishes baseline requirements for the administration and management of employee benefit plans, including health and welfare plans, which aims to safeguard the interests of individuals enrolled in these plans. It mandates fiduciary duties, establishing standards of conduct for those who oversee and manage employee benefit plans, with the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan.
Federal Trade Commission (FTC)	An independent, bipartisan agency of the U.S. government tasked with protecting consumers and ensuring a strong competitive market by enforcing non-criminal antitrust laws, investigating fraud or false advertising, and performing congressional inquiries.
Federal Upper Limit (FUL)	The maximum amount that can be reimbursed for certain drugs with the purpose of ensuring that Medicaid is a prudent buyer.
Fee-for-service (FFS)	A reimbursement model where healthcare providers are paid separately for each service they provide, such as tests, procedures, or other treatments. The "fee" represents the cost of each service, which is often based on a fee schedule or discount off billed charges basis.
Fiduciary	A person or organization that acts on behalf of others and is required to put the clients’ interests ahead of their own, with a duty to preserve good will and trust.
Formulary	A dynamic list of medications that a plan sponsor covers to promote the use of effective, cost-efficient medicines. The list is made based on clinical and financial considerations.

Fully-insured plan	A fully insured funding arrangement includes paying a fixed premium to an insurance carrier, which then assumes the risk for health claims. The carrier is at risk for the overall financial performance of the plan.
Gag clauses	Clauses that restrict pharmacists from informing patients about more affordable medication alternatives.
Generic drug	A generic drug contains the same chemical substance (dosage form, safety, strength, administration, quality, and intended use) as a drug that was originally protected by the chemical patent.
Generic dispensing rate (GDR)	The ratio of generic medications dispensed to total prescriptions filled used to measure the proportion of prescriptions dispensed as generic drugs compared to the total number of prescriptions dispensed. A higher GDR indicates a greater use of generic medications.
Gross drug cost	The cost of the drug before rebates.
Health Exchange	A marketplace created by the ACA to help individuals and small employers find and enroll in health insurance plans that meet certain standards.
Health Maintenance Organization (HMO)	Provides healthcare coverage through a relatively more limited network of healthcare providers. Participants usually select a primary care physician (PCP) from within the network that coordinates their healthcare services, including referrals to specialists when needed.
High Deductible Health Plan (HDHP)	A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but members pay more health care costs before the insurance company starts to pay its share.
HUSKY Health	The Medicaid program in Connecticut, which serves as the primary source of health coverage for low-income individuals and operates under a fee-for-serve model with administrative services only contracts.
Inflation Reduction Act (IRA)	The Inflation Reduction Act, signed into law on August 16, 2022aims to address various economic issues, including lowering prescription drug costs. This included key healthcare provisions for Medicare, such as Medicare Part D benefit redesign.
Managed Market Insight & Technology (MMIT)	A provider of market access data, analytics and insights in the pharmaceutical industry.
MAC (Maximum Allowable Cost)	MAC is a pricing benchmark used by insurers and PBMs to determine the maximum amount they will reimburse for generic drugs and brand-name drugs with generic equivalents. It helps control drug costs by encouraging the use of lower-cost alternatives.
Medicaid Drug Rebate Program (MDRP)	A program that includes CMS, state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.
Medicare Advantage Prescription Drug Plan (MA-PD)	Medicare Advantage plans that provide integrated medical (Part C) and drug coverage (Part D) under one plan.

Medicare Prescription Drug Plan (PDP)	Standalone plans that provide prescription drug coverage only and are designed to complement original Medicare (Part A and Part B).
National Average Drug Acquisition Cost (NADAC)	A survey-based pharmacy actual acquisition cost benchmark maintained by CMS.
Net drug cost	The gross drug cost minus the drug rebate.
Network discount guarantees	Guarantees where the PBM commits to achieving specific discount rates on prescription drug prices within a pharmacy network over a defined period. These guarantees are designed to ensure that the plan sponsor receives a certain level of cost savings on medications dispensed through the PBM's network.
Office of Health Strategy (OHS)	A state agency in Connecticut responsible for developing health policy that improves health outcomes and limits health care cost growth across all sectors.
Pass-through pricing	A pricing arrangement where the PBM passes their actual drug costs directly to the plan sponsor without marking up the price.
Payer	A payer is an entity that pays for the healthcare services provided by a healthcare provider. Generally, these include healthcare insurance companies, self-insured employers, or government programs.
Pharmacy Services Administrative Organization (PSAO)	A third-party organization that provides administrative and support services to independent pharmacies, such as contract neogiation support with PBMs.
Pharmacy and Therapeutics (P&T) Committee	A group of healthcare professionals that evaluates and manages the formulary of medications for a health plan or healthcare institution. They review clinical efficacy, safety, and cost-effectiveness of drugs.
Pharmacy Benefit Manager (PBM)	Third-party organizations that administer pharmacy benefits on behalf of plan sponsors and serve as an intermediary between plan sponsors, pharmaceutical manufacturers, and pharmacies. Services include pharmacy claims processing and payment, prescription drug formulary design and maintenance, rebate contracting management, pharmacy network contracting management, and clinical program management.
Pharmacy network	A pharmacy network is a group of pharmacies that have contracted with an insurance company or PBM to provide prescription medications to plan sponsors at agreed-upon prices and terms.
Plan sponsor	A plan sponsor is an entity that establishes and maintains a health insurance plan, retirement plan, or other employee benefit plan. This can be an employer, a union, or another type of organization.
PMPM (Per Member Per Month)	PMPM is a metric used in the healthcare industry to describe the average cost or revenue generated per member for each month. It is commonly used in capitation payment models.
Point-of-sale rebates	An arrangement where the estimated value of the manufacturer rebates is passed through to reduce patient cost-sharing at the pharmacy counter rather than to the plan where it is often used to reduce premiums for all members.

Preferred Provider Organization (PPO)	A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Members pay less to use providers that belong to the plan's network. Members can use doctors, hospitals, and providers outside of the network for an additional cost.
Prior authorization	A review process used by health insurance companies or PBMs to determine if a service or product will be covered based on medical necessity and clinical appropriateness to help ensure appropriate care and manage costs.
Rebate	Payments from drug manufacturers to PBMs in negotiating favorable drug pricing based on PBM formulary and tier placement. Primarily applies to high-cost brand-name prescription drugs in competitive therapeutic classes.
Rebate group purchasing organizations (GPOs)	A specific entity that works to offer savings through cost-effective solutions by purchasing large quantities of medications to share within the group, enabling them to achieve greater discounts than if they were to operate independently. The goal is to lower prices and reduce transaction costs by increasing the purchasing power of a larger group.
Rebate guarantees	A commitment made by a PBM to a health plan or plan sponsor to provide a minimum amount of rebate savings from pharmaceutical manufacturers over a specified period.
Rebate retention	Refers to the difference between the amount the PBM receives as a rebate from the manufacturer and the amount the PBM passes through to the plan sponsor or payer.
Self-insured plan	The employer assumes the risk of paying medical and pharmacy claims directly, and shares cost with the employees. The employer may partner with a third-party administrator (TPA) to manage claims processing and administrative tasks for a fee.
Specialty drugs	Typically, high-cost drugs that treat rare or complex health conditions.
Spread pricing	Refers to the difference between what the PBM charges a patient's health insurance and what the PBM pays the pharmacy for dispensing the medication.
Step therapy	A form of utilization management which typically requires trial and failure of a specific drug therapy prior to progressing to other more costly or risky therapies only if necessary. The goal is to utilize the least expensive—but still effective—medications available.
Third-Party Administrator (TPA)	Entity that manages claims processing and administrative tasks in exchange for a fee.
U.S. Government Accountability Office (GAO)	An independent and legislative agency that monitors and audits government spending and operations. The agency examines how taxpayer dollars are spent and provides recommendations on how to save the government money or operate more fiscally responsibly.
U.S. Food and Drug Administration (FDA)	The administration responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.

Usual & Customary (U&C) Price	Prices reflect the costs of the drugs to the consumer at the retail level without the use of insurance. Often referred to as the “cash price” for patients.
Utilization Management (UM)	Encompasses programs / program features that are designed to manage plan spend while delivering effective care. These include, but are not limited to: ▪ Prior authorization ▪ Quantity limits ▪ Step therapy ▪ Opioid management edits
Vertically integrated organizations	Organizations that often include a health insurer, PBM, group purchasing organization (GPO), pharmacies (retail, mail, and / or specialty), provider services, and drug distribution.
Wholesale Acquisition Cost (WAC)	Denotes the price set by the drug manufacturerfor a drug when sold to to wholesalers or other direct purchasers, not including discounts or rebates, or other price concessions.
340B entities	Healthcare organizations that participate in the federal 340B Drug Pricing Program which is intended to provide financial assistance to entities serving vulnerable populations.

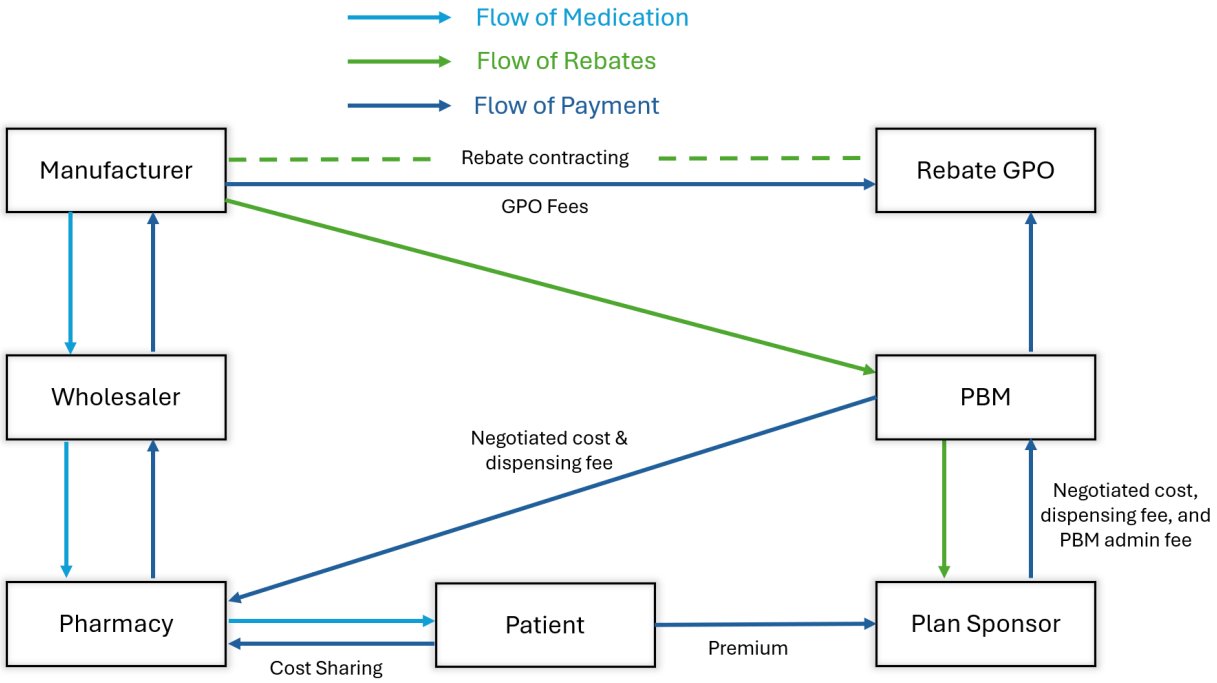
Appendix A: Overview of the Pharmacy Supply Chain

The figure below shows the flow of medication, rebates and payment through the pharmacy supply chain for a commercial pharmacy claim. This is high-level overview that does not reflect the experience of every commercial pharmacy claim.

- Flow of Medication: Medications are produced by manufacturers. A drug wholesaler purchases medications directly from manufacturers and distributes them to various healthcare providers, including pharmacies, hospitals, clinics, and other medical facilities. Pharmacies receive medications from wholesalers and dispense medications to patients based on prescriptions from healthcare providers.

- Flow of Rebates: In the commercial market, manufacturers often negotiate rebates and other fees and discounts with rebate GPOs. These rebate GPOs allow for increased scale and negotiation power with the drug manufacturer. PBMs often access rebate rates through a GPO and typically pass through rebates, or a portion of rebates, to the plan sponsor.

- Flow of Payment: As described above, pharmacies typically purchase drugs through a wholesaler who purchases larger quantities of drugs directly from the manufacturer. Pharmacies receive reimbursement from both PBMs and patients. PBMs negotiate pharmacy reimbursement and dispensing fees with pharmacies. At the same time, patients may pay a portion of the cost of the prescription (i.e., cost sharing) as part of their benefit design. In addition to paying a portion of the cost of the drug, patients also pay a premium to their plan sponsor to help cover the cost of the benefit., The plan sponsor pays a PBM to administer the pharmacy benefit portion of their healthcare offering, covering the negotiated cost of the drug, dispensing fees, and the PBM administration fee (which may be in the form of a flat fee, or included within spread pricing, share of rebates, or other arrangements). In turn, PBMs pay fees to rebate GPOs to process rebates and access rebate contracts that are negotiated between the manufacturer and the GPO.


Flow of Medication
Flow of Rebates
Flow of Payment
Manufacturer
Rebate contracting
Rebate GPO
GPO Fees
Wholesaler
PBM
Negotiated cost &
dispensing fee
Negotiated cost,
dispensing fee, and
PBM admin fee
Pharmacy
Patient
Plan Sponsor
Premium
Cost Sharing

Appendix B: Pharmacy Benefit Manager Practice Report Supplement - Estimated Connecticut PBM Revenue, Rebates, Pricing Spread, and Profit

Appendix B Table of Contents

Pharmacy Benefit Manager Revenue and Profit Overview

This supplement to the Report of Pharmacy Benefit Manager Practices provides estimates of PBM revenue and profitability in the state of Connecticut, including a breakout of key revenue sources described in the main report.

Drug spending in the state of Connecticut in 2023 was approximately $10.1 billion, creating almost $380 million in net profit to Pharmacy Benefit Managers. These profits are derived from a combination of rebate retention, spread pricing revenue, affiliated pharmacy revenue, group purchasing organization (GPO) fees, and other fees.

This section provides an estimate of PBM profit and revenue in Connecticut by market. The majority of PBM revenue in the state is concentrated in the commercial market, where there are a broader array of revenue opportunities. In the commercial market, net profit was approximately $228 million in 2023, with a net profit margin of 5.2%. In contrast, estimated PBM revenue in Medicare is significantly lower, reflecting fewer revenue sources, where PBM net profits are approximately $150 million with a net profit margin of 3.8%. PBM revenue is very minimal for the Medicaid line of business because of the unique features of Connecticut's Medicaid market, including limited PBM involvement in managing the Medicaid pharmacy benefit for the state. This supplement provides the methodology for these estimates, the overall results as described in Table 7, as well as the calculations leading to these results.

Methodology and Data Sources

This supplement summarizes and combines enrollment, utilization, and cost data from Connecticut's All Payer Claims Database (APCD) and the Centers for Medicare and Medicaid Services' (CMS's) Virtual Research Data Center (VRDC). The methodology and data sources are discussed in greater detail below.

PHARMACY BENEFIT MANAGER DATA REQUEST

On October 5, 2024, OHS requested utilization data summaries and other key financial information from the top utilized PBMs in Connecticut. The majority of PBMs did not provide all the data requested in time for inclusion in the original report or this supplement. OHS lacks the regulatory authority to collect the additional data required for this analysis. The efforts from the PBMs that attempted to provide portions of the requested data were appreciated. Ultimately, the data provided by those PBMS could not be utilized due to incomplete or partial submissions and timing requirements of the analysis. Both data sources specific to, and sources and assumptions not specific to Connecticut as described below, were used to create estimates for the state, in place of data directly from PBMs.

SPENDING AND UTILIZATION DATA

Connecticut All-Payer Claims Database (APCD): The data source for this report is Extract 6012 from the Connecticut APCD, which includes claims paid from January 1, 2023, through December 31, 2023, with six additional months of runout for those dates of service. The APCD receives claims from the Medicaid, Medicare Advantage, and commercial markets. The commercial market includes fully insured commercial plans, state employee plans, the Connecticut Partnership Plan

(self-insured non-state public employers that participate in this group) and some voluntarily submitted self-insured data. Other self-insured plans do not submit data to the APCD, per the Gobeille v. Liberty Mutual decision.[227] Commercial market data presented in the report cover about 60% of the market.

CMS's Virtual Research Data Center (VRDC): CMS's 100% Research Identifiable Files (RIF) covering Connecticut's entire Medicare Part D market were utilized, with claims incurred from January 1, 2023, through December 31, 2023. This data reflects the pharmacy claims of approximately 600,000 members and represents all actively enrolled beneficiaries of individual Medicare Part D plans.

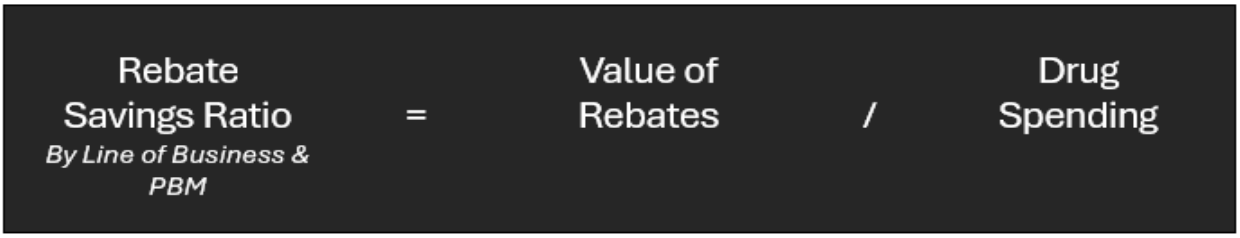
ENROLLMENT MEMBERSHIP COUNTS

Unique records were counted from an eligibility table within the APCD to determine the number of commercial lives in the APCD data.

Managed Markets Insight & Technology's (MMIT) Payer Landscape Files: Managed Markets Insight & Technology's (MMIT's) 2023 Payer Landscape Files were used for membership counts by line of business. MMIT leverages multiple sources of data and uses a rigorous process of checks and balances to ensure there is no double counting of insured member lives in the US. We used MMIT to estimate how many members were missing from the APCD in the commercial line of business. These counts were applied to commercial averages from the APCD data to estimate the complete commercial market in Connecticut. Note that this estimate may be impacted by the different mix of payer type (weighting of fully insured versus self-insured) between the APCD data and the payers not reporting to the APCD.

REBATE ESTIMATES

Preliminary Information for the 2025 Connecticut's Cost Growth Benchmark Target Reporting: This includes calendar year 2023 data as provided by payers annually as part of OHS's Cost Growth Benchmark Initiative. OHS provided total rebates and total prescription drug spend by payer and line of business (commercial, Medicare, and Medicaid). The ratio of rebates and total prescription drug spend reported by payers to the State was applied to the estimated drug spend by line of business and PBM (which was calculated for Connecticut as just described above in the Utilization Data and Enrollment Membership sections).



[227] https://www.scotusblog.com/case-files/cases/gobeille-v-liberty-mutual-insurance-company/

REBATE RETENTION

Connecticut Insurance Department (CID) Pharmacy Benefit Manager Rebate Report: CID produces an annual report of the aggregate dollar amount of all rebates and rebates retained by the PBM. This CID report provides information for the commercial fully insured market. The percentages retained by the PBM for fully insured commercial claims were applied to rebate estimates calculated from the data sources above. For the paid claims in calendar year 2023, $1,392,681 or 0.3% was reported to be retained by PBMs for those that provided data. For commercial claims not reported to the CID (mostly self-insured commercial claims), rebate retention was calculated as described below in the Estimated PBM Rebate Retention in Connecticut section of the report.

POINT-OF-SALE REBATES

SSR Health Data: The APCD data included claims for which point-of-sale rebates were applied and so the total spend amount was understated. SSR Health data was used to estimate the point-of-sale rebate value deployed for groups that were known to have implemented this plan design within the APCD data. Actual client rates and rebate eligibility may differ from these estimates as it was not possible to identify all plans that deployed point-of-sale rebates. The estimated point-of-sale rebate amounts were added to the total spend amount to have the spending reflect pre-rebate amounts. This was done to minimize a double application of rebates when applying the aggregate rebate amounts (since the methodology applied rebates in aggregate).

PBM PROFIT INFORMATION

Financial Reports: Publicly available 10-K and 10-Q Securities and Exchange Commission (SEC) reports for CVS Health Corporation, Cigna Corporation, Anthem Inc., and UnitedHealth Group Incorporated were reviewed, with information from Q1-Q4 2023 used for this analysis to align with the claims data period being summarized.

The following assumptions were made:

- CVS includes CarelonRx script volume and any profit from processing CarelonRx script volume. CVS's 2023 experience was adjusted to remove CarelonRx.
- Anthem (CarelonRx) does not report script volume. CarelonRx's script volume was estimated using reported membership by line of business and segment.
- All other prescription counts were estimated using information from Statista. Statista does not include COVID vaccines. COVID-19 vaccines were added in using information from the Centers for Disease Control and Prevention (CDC).[228,229]
- Total percent gross profit and percent net profit (which was not specific to Connecticut) were calculated for each PBM. The percent of gross and net profit as calculated from the earnings reports was applied to total allowed amounts specific to each PBMs volume in Connecticut. An assumption weighting factor (60/40) was applied to the commercial line of business versus

[228] https://www.statista.com/statistics/238702/us-total-medical-prescriptions-issued/

[229] https://data.cdc.gov/Vaccinations/COVID-19-Vaccinations-in-the-United-States-Jurisdi/unsk-b7fc/about_data

the Medicare line of business based on additional revenue streams available in the commercial market.

For the small volume of Connecticut claims that were not affiliated with the four PBM's listed above, an average gross and net profit was applied using information from the larger PBMs. This approach could either overestimate or underestimate the profits for these smaller PBMs, depending on how actual profits vary from these averages.

PBM SPREAD ESTIMATES

PBM spread pricing refers to the difference between what the PBM charges a patient's health insurance and what the PBM reimburses the pharmacy for the medication. To calculate PBM spread, allowed cost from Connecticut generic claims was utilized, along with an estimated acquisition cost and pharmacy gross margin for generic drugs. The formula used to calculate PBM spread for generic drug claims is below, followed by a description of how each of these components were estimated for the analysis.

Acquisition Cost for Generic Drugs: Retail pharmacy acquisition cost for generic drugs was estimated at the claim level utilizing the lesser of two industry pricing benchmarks, the Centers for Medicare & Medicaid Services (CMS) National Average Drug Acquisition Cost (NADAC) and Glass Box Analytics' Predictive Acquisition Cost (PAC), based on the date the claim was incurred. [230] Allowed cost was used as a default when neither of these pricing sources were available for a particular product. The difference between allowed cost and this calculated acquisition cost, minus the pharmacy gross margin (referenced below), was used as the estimated PBM spread amount for generic drugs. PBM spread was only calculated for generic drug claims at retail and non-affiliate mail order/specialty pharmacies and no spread (0%) for brand drugs was assumed for this analysis, as brand drugs typically have very low spread margins.[231] It is recognized that this methodology may underestimate the calculated PBM spread for the State.

Pharmacy Gross Margin: The PBM spread calculation assumes the published retail pharmacy gross margin of 42.7% of allowed amount was utilized for the commercial line of business for generic drug claims. [232]

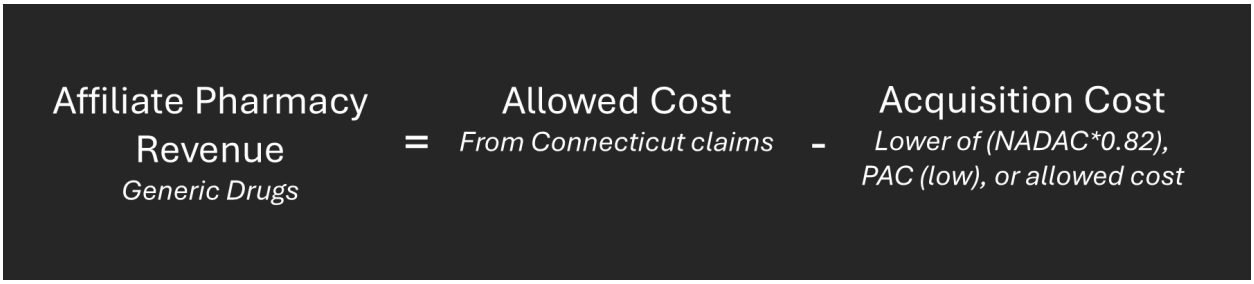
[230] https://www.predictiveacquisitioncost.com/

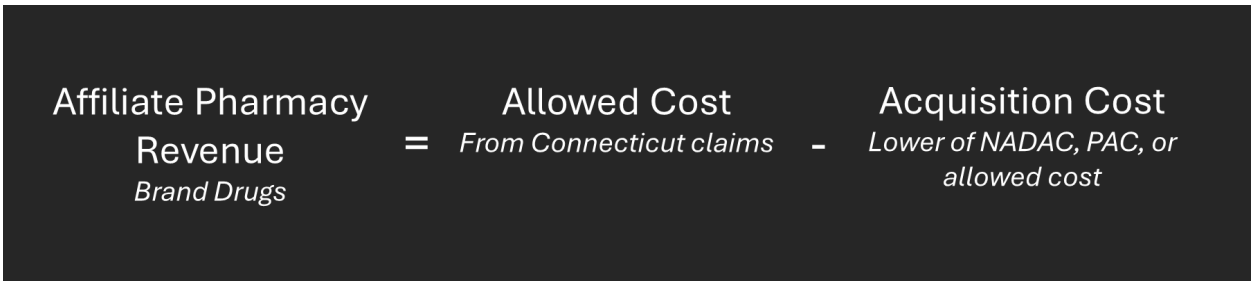
[231] https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

[232] https://aspe.hhs.gov/sites/default/files/documents/db1adf86053b1fda8ae9efd01c10ddc8/Pharma%20Supply%20Chains%20Margins%20Report_Final_2024.09.27_Clean_508.pdf

PBM AFFILIATE PHARMACY REVENUE ESTIMATES

To calculate PBM affiliate pharmacy revenue, allowed cost from Connecticut claims for both brand and generic drug claims was utilized, along with an estimated acquisition cost. The formulas used to calculate affiliate pharmacy revenue for both brand and generic drugs are below, followed by a description of how acquisition cost was estimated for the analysis.





Affiliate Pharmacy Acquisition Cost: Affiliate pharmacy (mail and specialty affiliates) acquisition cost was calculated at the claim level by selecting the lower of two industry pricing benchmarks, NADAC (minus 18%) and the low range of PAC pricing, based on the date the claim was incurred. A discount factor of 18% was applied to the NADAC price to account for the greater purchasing power of these entities for generic drug products. This discount factor is based on an analysis of generic NADAC prices in 2024 when NADAC prices decreased significantly due to a change in the pool of pharmacy contributors to the NADAC pricing survey. If the pricing benchmarks were not available for a particular drug code, the allowed cost was used as a default. The difference between allowed cost and this calculated acquisition cost was used as the affiliate pharmacy revenue amount, which includes PBM spread and pharmacy gross margin.

Brand drug claims were calculated in a similar manner to generic drug claims, however, acquisition prices for PAC and NADAC were not adjusted down for brand drugs in this analysis.

Results

ESTIMATED TOTAL GROSS SPEND (ALLOWED) IN CONNECTICUT

Table 1 provides estimated 2023 total gross spending on outpatient prescription drugs in Connecticut. It is based on enrollment, utilization, and cost data as described above from the Connecticut APCD and CMS's VRDC.

TABLE 1: ESTIMATED 2023 TOTAL GROSS OUTPATIENT DRUG SPEND IN CONNECTICUT (IN MILLIONS)

LINE OF BUSINESS	TOTAL ESTIMATED SPEND	TOTAL MEMBER COST SHARE	PERCENT MEMBER COST SHARE
Medicaid[1]	$1,829	≈$0	≈0.0%
Medicare	$3,965	$254	6.4%
Commercial[2]	$4,347	$448	10.3%
TOTAL	**$10,141**	**$702**	**6.9%**

[1]In Medicaid, total member cost share was less than $400,000.
[2]Approximately 60% of the commercial market population was represented in the APCD data. To account for the remaining population, averages from the existing commercial data were estimated and applied.

ESTIMATED PBM REBATE RETENTION IN CONNECTICUT

In this section PBM retention of manufacturer revenue and rebates in Connecticut is estimated by line of business. Table 2 shows the estimated rebate retention in 2023, by line of business.

TABLE 2: ESTIMATED 2023 TOTAL REBATES AND PBM RETAINED REBATES IN CONNECTICUT (IN MILLIONS)

LINE OF BUSINESS	TOTAL REBATES ($M)	RETAINED REBATES ($M)	RETAINED REBATES (% OF TOTAL REBATES)	RETAINED REBATES % OF TOTAL ALLOWED
Medicaid	$1,139	N/A	N/A	N/A
Medicare	$1,108	$4.0	0.4%	0.1%
Commercial	$1,296	$30.7	2.4%	0.7%

COMMERCIAL

PBMs that operate in Connecticut are required to provide annual rebate reports to the CID for the fully insured commercial market. CID uses this information to publish the annual *Pharmacy Benefit Manager Rebate Report*. According to the most recent annual rebate report $1,392,681, or 0.3%, was retained by PBMs in Connecticut in 2023 for the fully insured commercial market.

For the self-insured portion of the commercial market that was not reported to CID, rebate retention was estimated by applying percentages retained by PBMs based on recent public disclosures by the Big 3 PBMs on the total amount of rebates they currently pass through in the commercial market (disclosures reported on a national basis and not specific to Connecticut).[233] For self-insured commercial rebates not associated with these PBMs, a retention rate was estimated using an average of the Big 3 PBM public disclosures. These rebate retention percentages were applied to the estimated total rebates in Connecticut (calculated as described in the Methodology and Data Sources section of this report). Table 3 below displays how rebate retention rates were estimated for the fully insured and self-insured commercial populations.

TABLE 3: ESTIMATED 2023 COMMERCIAL TOTAL REBATES AND PBM RETAINED REBATES IN CONNECTICUT BY INSURED TYPE (IN MILLIONS)

INSURED TYPE	TOTAL REBATES ($M)	RETAINED REBATES ($M)	RETAINED REBATES (% OF TOTAL REBATES)[1]	RETAINED REBATES (% OF TOTAL ALLOWED
FULLY INSURED	$426.5	$1.3	0.3%	0.1%
SELF-INSURED	$869.9	$29.4	3.4%	1.0%
TOTAL COMMERCIAL	$1,296.4	$30.7	2.4%	0.7%

[1] Fully insured retention rate as reported by PBMs to Connecticut Insurance Department. Self-insured retention rate was based on recent public disclosures by Big 3 PBMs regarding the total amount of rebates they currently pass through in commercial (disclosures reported on a national basis and not specific to Connecticut).[7]

MEDICAID

For statutory rebates, as defined by the Medicaid Drug Rebate Program (MDRP), rebates are paid by drug manufacturers on a quarterly basis to states and are shared between the states and the federal government to offset the overall cost of prescription drugs in Medicaid.[234] PBMs do not retain any portion of Medicaid statutory rebates. States are also able to enter into supplemental rebate agreements where they may receive additional rebates above the statutory rebates, for preferred placement on the state's preferred drug list (PDL). In Medicaid fee-for-service (FFS), these supplemental rebates typically come from the manufacturer directly to the state Medicaid agency, with no PBM rebate retention. Under the Medicaid ASO model, Gainwell

[233] https://www.pcmanet.org/pcma-blog/big-pharma-highlights-how-pbms-secure-significant-savings-on-prescription-drugs/08/12/2024
[234] https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html

Technologies is reimbursed for services through an administration fee. Gainwell does not retain revenue through spread pricing, rebate retention, or other pricing models seen with managed care models. In Medicaid,100% of the rebates were assumed to be received by the state.

MEDICARE

While CMS regulation does not prohibit PBMs from retaining rebates, there are material financial disincentives to retaining rebates in Medicare Part D. [235] CMS shares in a portion of all rebate dollars earned for Part D business, including PBM retained rebates. Plans are responsible for paying CMS's share of any retained rebates. Due to this dynamic, rebate retention is typically very minimal in Medicare Part D. For Medicare, it was assumed that PBMs passed-through 99.6% based on a national average (not specific to Connecticut). [236]

ESTIMATED PBM SPREAD PRICING

In this section, PBM spread pricing in Connecticut is estimated by line of business. Detail on the calculation of spread may be found in the Methodology and Data Sources section. Table 4 shows the estimated PBM spread in 2023, by line of business.

TABLE 4: ESTIMATED 2023 PBM SPREAD PRICING AT RETAIL AND NON-AFFILIATE MAIL / SPECIALTY PHARMACIES IN CONNECTICUT

LINE OF BUSINESS	SPREAD (% OF TOTAL ALLOWED FOR RETAIL AND NON-AFFILIATED MAIL / SPECIALTY PHARMACIES)	RETAINED SPREAD ($M)
Medicaid	N/A	N/A
Medicare	N/A	N/A
Commercial	3.58%	$86.3

Commercial: Spread pricing was estimated at retail and non-affiliated mail / specialty pharmacies across the entire commercial market. While some payers may choose reimbursement models that do not include spread pricing arrangements, these costs are typically shifted to administrative fees (shifting this revenue to "Other PBM Revenue" in our calculations) to compensate for the revenue differential.

Medicaid: Medicaid regulations require covered outpatient drugs billed under the pharmacy benefit in Medicaid fee-for-service (FFS) to be reimbursed based on actual acquisition cost plus a professional dispensing fee.[237] Connecticut ingredient cost reimbursement is the lowest of usual and customary, NADAC, federal upper limit (FUL), or WAC plus a professional dispensing fee of

[235] https://www.gao.gov/assets/gao-19-498.pdf

[236] https://www.gao.gov/assets/gao-19-498.pdf

[237] 42 CFR 447.518(a)(2), CMS 2016a.

$10.75.[238] Due to this prescriptive reimbursement methodology, and the fact that HUSKY Health is entirely under FFS, spread pricing cannot be implemented in Connecticut's Medicaid program.

Medicare: While CMS regulation does not prohibit PBMs from retaining spread, there are material financial disincentives to retaining spread in Medicare Part D. CMS requires member cost-sharing and subsidies to be calculated on the actual reimbursement to the pharmacy. If a PBM charges a plan more than the pharmacy, the plan is subsidizing the drug costs for other stakeholders (e.g., member, government, and manufacturers). Due to this dynamic, network spread retention is uncommon in Medicare Part D.

AFFILIATE PHARMACY REVENUE

In this section mail order and specialty affiliate pharmacy revenue was estimated in Connecticut by line of business. Affiliate pharmacy revenue includes PBM spread and pharmacy gross margin. See Methodology and Data Sources section for detail on how affiliate pharmacy revenue was calculated. Table 5 shows the estimated affiliate pharmacy revenue, as a percentage of the total drug cost associated with those affiliate pharmacies, by line of business.

TABLE 5: ESTIMATED 2023 PBM MAIL AND SPECIALTY AFFILIATE PHARMACY REVENUE IN CONNECTICUT

LINE OF BUSINESS	AFFILIATE PHARMACY REVENUE (% OF TOTAL ALLOWED FOR AFFILIATE PHARMACIES)	AFFILIATE PHARMACY REVENUE ($M)
Medicaid	N/A	N/A
Medicare	14.61%	$94.6
Commercial	3.71%	$72.0

Commercial: Affiliate pharmacy revenue in the commercial market was calculated for mail and specialty pharmacies that were associated with the PBM that managed the pharmacy benefit. Commercial pharmacy benefits often have exclusive arrangements with these affiliate pharmacies, requiring members to fill their mail and/or specialty prescriptions at these pharmacies.

Medicaid: The PBM for HUSKY Health (Gainwell) does not own or operate an affiliated pharmacy. While some claims may be filled by pharmacies affiliated with other PBMs, this was not calculated as PBM revenue and would not be reported as PBM revenue in earnings.

Medicare: Affiliate pharmacy revenue in commercial was calculated for mail and specialty pharmacies that were associated with the PBM that managed the pharmacy benefit. Medicare has any willing provider requirements that do not allow exclusive pharmacy arrangements. However, these affiliate pharmacies can capture a significant portion of the mail and specialty volume within their respective PBMs as a result of convenience and existing member

[238] https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/medicaid-covered-outpatient-prescription-drug-reimbursement-information-state/index.html

relationships. This fact resulted in significant estimated revenue for affiliate pharmacies in Connecticut.

REBATE GROUP PURCHASING ORGANIZATION (GPO) FEES

In this section, rebate GPO revenue for claims in Connecticut was estimated by line of business. Details on the calculation of GPO fees may be found in the Methodology and Data Sources section. Table 6 shows the estimated PBM GPO revenue in 2023, by line of business.

TABLE 6: ESTIMATED 2023 PBM GPO FEES BASED ON BRAND DRUG COST IN CONNECTICUT

LINE OF BUSINESS	GPO FEES (% OF BRAND DRUG COST (WAC))	GPO FEES ($M)
Medicaid	N/A	N/A
Medicare	N/A	N/A
Commercial[1]	1.00%	$41.6

[1] GPO fees are estimated based on 1% of total brand wholesale acquisition costs (WAC) applied to estimated commercial brand claims incurred in Connecticut and is based on estimated manufacturer data fees and contracting entity vendor fees in 2023.[239] These fees are assumed to be outside the definition of rebates reported to the Connecticut Insurance Department.

Commercial: In addition to drug rebates, rebate GPOs typically collect additional fees from manufacturers for other services or access provided. The revenue from these additional fees is typically outside of the definition of rebates, and often not disclosed and is not necessarily passed through to downstream plan sponsors. The fees for the commercial market were estimated at 1% of brand drug cost (WAC), however this percentage is escalating at a rapid rate within the industry.[240]

Medicaid: There is currently no rebate GPO involved with the rebate agreements, invoicing, or payment in Medicaid.

Medicare: Rebate GPOs currently only operate in non-government business. PBMs contract directly (or aggregate through other PBMs) for Medicare business due to additional transparency and regulatory requirements in the government space, and do not assess the same level of manufacturer fees within these direct contracts.

ESTIMATED TOTAL PBM REVENUE AND PROFIT

The total PBM revenue, profit, and profit margin in Connecticut were estimated by line of business. Table 7 shows these metrics for 2023, by line of business. For commercial and Medicare, the gross and net profit margins applied to estimated Connecticut drug spend reflect each PBM's aggregate business and were not specific to the state of Connecticut.

[239] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

[240] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

TABLE 7: ESTIMATED 2023 PBM REVENUE AND PROFIT APPLIED TO CONNECTICUT DRUG SPEND (IN MILLIONS)

NOTES	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
LINE OF BUSINESS	PBM REBATE RETENTION	GPO FEES	PBM SPREAD	AFFILIATE PHARMACY REVENUE	OTHER PBM REVENUE	TOTAL GROSS PROFIT	GROSS PROFIT MARGIN	TOTAL NET PROFIT	NET PROFIT MARGIN
MEDICAID	$0.0	$0.0	$0.0	$0.0	$5.3	$5.3	0.29%	$1.4	0.1%
MEDICARE	$4.0	$0.0	$0.0	$94.6	$109.5	$208.2	5.25%	$150.1	3.8%
COMMERCIAL	$30.7	$41.6	$86.3	$72.0	$87.7	$318.3	7.32%	$227.9	5.2%

[1] PBM Rebate Retention for commercial fully insured was calculated based on reported retention by PBMs to the state of Connecticut. Commercial self-insured retention rate was based on recent public disclosures by Big 3 PBMs regarding the total amount of rebates they currently pass through in commercial (disclosures reported on a national basis and not specific to Connecticut). Medicare rebate retention was estimated based on national rebate retention as reported by the Government Accountability Office (GAO).[241] These retention rates were applied to reported and estimated rebates in Connecticut for each insured type, PBM, and line of business. (Table 2 & 3)

[2] GPO fees are estimated based on 1% of total brand wholesale acquisition costs (WAC) applied to estimated commercial brand claims incurred in Connecticut and is based on estimated manufacturer data fees and contracting entity vendor fees in 2023.[242] These fees are assumed to be outside the definition of rebates reported to the State of CT insurance department. (Table 6)

[3] PBM Spread was calculated for generic retail and non-affiliated mail order claims only. This was estimated by calculating the difference between allowed cost from incurred claims in Connecticut (from APCD) and an estimated acquisition cost (lower of NADAC, PAC, or total allowed). An estimated Pharmacy Gross Margin (see the "Methodology and Data Sources" section above for details) was then subtracted. The remaining amount was estimated as PBM Spread. (Table 4)

[4] Affiliate Pharmacy Revenue was calculated for claims (both brand and generic) incurred at mail order and specialty pharmacies incurred at affiliated with the Big 3 PBMs only. This was estimated by calculating the difference between allowed cost from incurred claims in Connecticut (from APCD) and an estimated acquisition cost (see the "Methodology and Data Sources" section above for details). The remaining amount was estimated as Affiliate Pharmacy Revenue. (Table 5)

[5] Other PBM revenue includes administrative fees, reporting fees, clinical fees, copay maximizer fees, distributor revenue, and any other sources not captured in other revenue sources. This was calculated as the difference between total gross profit (6) and calculated revenue sources (rebate retention (1), GPO fees (2), spread (3), and affiliate revenue (4)).

[6, 7, 8, 9] Total gross and net profit margins were estimated by calculating the gross and net profit margin from each respective PBMs earnings reports for 2023 (which were not specific to Connecticut). The percent of gross and net profit as calculated from the earnings reports was applied to total allowed amounts specific to each PBMs volume in Connecticut to estimate the gross profit and net profit in Connecticut. For the small volume of Connecticut claims that was not affiliated with a PBM that we calculated earnings on, an average gross and net profit margin was applied from the calculated PBMs. A higher weighting of this total (60/40) was applied to the commercial line of business versus the Medicare line of business based on additional revenue streams available in commercial.

[241] https://www.gao.gov/assets/gao-19-498.pdf

[242] Trend in Profitability and Compensation of PBMs and PBM Contracting Entities. Available for download here: https://mailchi.mp/nephronresearch.com/pbmcompensation

Caveats and Limitations – Supplement

This report was commissioned by the State of Connecticut Office of Health Strategy (OHS). Milliman does not intend this information to benefit any third party, even if we permit the distribution of our work to such third party. This information is intended to assist OHS with estimating and understanding PBM Rebates, Spread, and Profits in Connecticut for calendar year 2023. The results presented herein are estimates based on partial experience data in Connecticut provided by the State and other data sources that may not be specific to Connecticut. Differences between our estimates and actual amounts depend on the extent to which unknown experience conformed to the assumptions made for this analysis. It is certain that actual experience did not conform exactly to the assumptions used in this analysis. Actual amounts will differ from estimated amounts to the extent that actual experience deviates from unknown experience.

In preparing this information, we relied on the following:

1. Connecticut All-Payer Claims Database (APCD)
2. CMS's Virtual Research Data Center (VRDC)
3. Managed Markets Insight & Technology's (MMIT) Payer Landscape Files
4. Connecticut Insurance Department (CID) Pharmacy Benefit Manager Rebate Report
5. Preliminary Information for the 2025 Connecticut's Cost Growth Benchmark Target Reporting
6. Medi-Span's Master Drug Database (MDDB)
7. Milliman analysis of SSR Health data
8. Glass Box Analytics' Predictive Acquisition Cost (PAC)
9. Center for Medicare & Medicaid Services (CMS') National Average Drug Acquisition Cost (NADAC)
10. Publicly available information cited in the report.

To the extent that any of the data or information publicly sourced is inaccurate or incorrect, the results could be materially affected.

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