

Assessing the Budgetary Implications of Increasing Transparency of Prices in the Pharmaceutical Sector

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Since the debate surrounding the enactment of the Medicare Modernization Act in 2003 (MMA), policymakers have considered proposals to increase the transparency of pricing information generated, in transactions along the pharmaceutical industry supply chain, under public program auspices. Advocates of these changes point out the advantages of greater transparency for consumers, who bear an increasingly large share of drug costs out of pocket. Opponents of these changes warn of adverse changes in pharmaceutical industry pricing if transaction prices are disclosed.

The latest entrant into this debate is proposed legislation from Senator Ron Wyden, the Ranking Minority member of the Senate Finance Committee. Senator Wyden's legislation contains three relevant policies, which would apply to both the Part D program, and to drug benefit plans offered through the Exchanges under the Affordable Care Act (ACA).

First, confidentiality restrictions imposed on information on prescription drug pricing that drug plan sponsors presently submit would be loosened so that only plan specific information on specific products would be protected.

Second, the legislation would direct the Secretary to impose a minimum percentage threshold for the amounts that Pharmacy Benefits Managers (PBMs) must pass through to plan sponsors.

Third, the bill would require all pricing adjustments PBMs obtain on behalf of plan sponsors to be applied to the negotiated prices plans are obligated to pay at the point of sale.

The Moran Company was engaged by the Pharmaceutical Care Management Association (PCMA), the trade association of PBM companies, to evaluate the budgetary implications of enacting these policies. Specifically, we were asked to project how the Congressional Budget Office (CBO) might "score" this legislation were it to be actively considered in the legislative process. Our findings are as follows:

- We assume that, in evaluating this legislation, CBO would focus on the effect of these policies in increasing the access of market participants to information about their competitors' pricing behavior.
- Based on its stated precedents, we assume that CBO would find such disclosure to be cost-increasing, because such disclosures would have a dampening effect on the magnitude of rebates available to large plan sponsors such as Medicare Part D.
- We developed a model to estimate the degree of "compression" CBO might estimate if market actors are given greater access to the pricing information of their competitors.
- Our work with that model suggests CBO could reasonably conclude that the effect on branded drug pricing could be greater than 2% over time.

- Based on these assumptions, we project an increase in Federal direct spending of more than \$20 billion over the ten-year budget horizon (2018-2027).
- The magnitude of this estimate is primarily due to the size of current law Federal subsidies for branded drug benefits under Part D and the ACA, which we estimate to total \$1.115 trillion over the period.
- Against this background, even very small percentage changes in branded drug pricing produce very large budgetary impacts.

In the balance of this report, we describe the data we employed, and the methodology we used, to reach these conclusions.

Prior Precedents from CBO

From the beginning of this debate, CBO has consistently represented that it expects increasing transparency to lead to higher costs, although CBO's estimates of the magnitude of those costs has varied over time.

In scoring the so-called "Cantwell Amendment" to the MMA in 2003, CBO estimated that requiring manufacturer price transparency would raise Part D program costs by \$40 billion over the ten-year scoring horizon.¹

CBO's contemporaneous logic, which it has not since publicly recanted, was that pricing transparency would cause manufacturers to "compress" the range of rebates and other discounts offered, most adversely affecting large program sponsors, such as the Medicare Part D program, who would otherwise be able to extract the largest discounts. CBO also expressed concerns about increasing "tacit collusion" that could arise if market participants could obtain increasing knowledge of their competitors' pricing practices.

In subsequent communications with the Congress in 2007, CBO scaled back the magnitude of its prior estimates, indicating that evidence of robust competition among plan sponsors, combined with unexpectedly large growth in generic market share, materially diminished concerns about decreased rebates for branded drugs facing competition in a therapeutic class—the expected focus of manufacturer rebate activity.²

¹ Congressional Budget Office Cost Estimate. "H.R. 1 Medicare Prescription Drug and Modernization Act of 2003 As passed by the House of Representatives on June 27, 2003 and S. 1 Prescription Drug and Medicare Improvement Act of 2003 As passed by the Senate on June 27, 2003, with a modification requested by Senate conferees" (July 22, 2003). <https://www.cbo.gov/sites/default/files/108th-congress-2003-2004/costestimate/hr1s100.pdf>

² CBO March 2007 Letter to Representatives Barton and McCrery (March 12, 2007). <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/03-12-drug%20rebates.pdf>

Our Current Estimate

At PCMA's request, we have evaluated data that shed light on the market dynamics driving rebates, and created a spreadsheet-based model to evaluate what conclusions CBO might reach were they to take a fresh look at the rebate implications of transparency.

Over the last decade, pharmaceutical industry pricing dynamics have changed from the conditions prevailing when CBO last publicly opined on the budgetary implications of transparency legislation. First, the magnitude of manufacturer rebates has increased significantly, from approximately 9% of WAC in 2007 to approximately 25% in 2015. Second, most market observers believe that, within the next few years, generic market share will plateau in the range of 92-93% of prescriptions, comprising slightly more than 30% of prescription sales dollars. The combined effect of these two trends is likely to increase markedly CBO's baseline projection of branded drug rebate volume affected by transparency policies.

To approximate this baseline trend, we started with CBO's January 2017 Baseline projections for net Federal subsidies under both Part D and the ACA. The ACA subsidy baseline was deflated, using information from the National Health Expenditures projections, for prescription drug spending as a percentage of private health insurance spending. Both subsidy estimates were further deflated to exclude the estimated share of spending on generics, which CBO has typically indicated are not comparably affected by price transparency concerns.

To evaluate the implications of the policy, we constructed a naïve model of the distribution of achieved rebate percentages around a national mean of 25% of Wholesale Acquisition Cost. (WAC) We based this assumption, and other rebate-related parameters, on information which we found in proprietary market research reports. Based on that information, we distributed rebates across an array of 50 assumed PBMs, based on the assumption that the top 3 PBMs comprised 70% of the market, while the top 7 comprised 90%.

Across this array, we capped the imputed rebate percentages at the square root of the ratio of the largest rebate percentage to the mean—our assumed proxy for the “compression” effect CBO has cited as the primary consequence of price transparency. We assumed that rebate percentages below that trim point would be unaffected by this policy

We then assumed a four-year phase-in to the compression factor we derived from the model, which was more than 2%.

The data and methodology described generated a ten-year estimate of \$20 billion in budget costs (2018-2027).

In evaluating the magnitude of this estimate, it is important for policymakers to understand that the major determinant of this estimate is the magnitude of the 10-year baseline for Medicare subsidies for branded drug purchases under Part D and the ACA. Our estimate, generated in the manner described above, projects a ten-year base of drug subsidies of \$1.115 trillion. Against that baseline, even relatively small percentage changes in assumed pricing will show large budgetary effects.