PRICEWATERHOUSECOOPERS

Estimated Impact of Disclosure Provisions of New York Assembly Bill 158 / Senate Bill 58

Prepared for

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Health Policy Economics

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Executive Summary

Pharmacy benefit managers, or PBMs, play an important role in helping private and public health plans administer their prescription drug benefits. PBMs work with health plans to negotiate lower prices from drug manufacturers and pharmacies and encourage cost effective drug utilization by plan enrollees. Plans typically can choose from a core set of services as well as other clinically based, optional services to improve the appropriateness, safety, and quality of pharmacy benefits. Some of the practices used by PBMs have become the subject of legislative proposals.

Legislation has been introduced in the State Assembly and Senate of New York (AB 158 and SB 58) that would limit the ability of PBMs to manage drug benefits for health plans. The Pharmaceutical Care Management Association engaged PricewaterhouseCoopers to estimate the impact of certain provisions of the legislation that would require PBMs to disclose proprietary contract terms and pricing data.

These provisions would result in increased prescription drug costs for enrollees in private plans. We have estimated the costs assuming that all private plans covering New York residents would be covered by the provisions, excluding Medicare Part D plans. Table E-1 presents our estimates.

Table E-1. Impact of Disclosure Provisions of AB 158 / SB 58 on New York State Drug Spending
(Millions of dollars)

	2010	2011	2012	2013	2014	2010-14	2010-19
Impact of Provisions on Total Prescription Drug Spending	$563	$605	$652	$707	$769	$3,297	$8,346
ERISA Plans	259	278	300	325	354	1,516	3,839
Commercial Plans	304	327	352	382	415	1,780	4,507

Note: Estimates assume that the provisions would apply to PBMs contracting with plans subject to both ERISA regulations and state law.
Source: PricewaterhouseCoopers calculations.

Overall, the disclosure provisions would increase spending in privately managed plans in New York State by $8.3 billion over the 2010 to 2019 period. We have assumed the provisions would not apply to Medicare Part D plans but would apply to all other health plans in the state, including those subject to regulation under the federal Employee Retirement Income Security Act (ERISA). Spending in ERISA plans would increase by $3.8 billion and in other commercial plans by $4.5 billion over the 2010 to 2019 period.

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Pharmacy benefit managers, or PBMs, play an important role in helping private and public health plans administer their prescription drug benefits. PBMs work with health plans to negotiate lower prices from drug manufacturers and pharmacies and encourage cost effective drug utilization by plan enrollees. Plans typically can choose from a core set of services as well as other clinically based, optional services to improve the appropriateness, safety, and quality of pharmacy benefits. Some of the practices used by PBMs have become the subject of legislative proposals.

Legislation has been introduced in the State Assembly and Senate of New York (AB 158 and SB 58) that would limit the ability of PBMs to manage drug benefits for health plans. As a result, the legislation would increase costs to individuals and families enrolled in health plans using PBMs. The Pharmaceutical Care Management Association engaged PricewaterhouseCoopers to estimate the impact of certain provisions of the legislation that would require PBMs to disclose proprietary contract terms and pricing data.

These provisions would result in increased prescription drug costs for enrollees in private plans. We have estimated these costs assuming that all private plans covering New York residents would be covered by the provisions, excluding Medicare Part D plans. Below we describe our baseline prescription drug spending, the disclosure provisions, and the basis for our estimates.

Baseline Drug Spending in New York

To establish our baseline, we project prescription drug spending by New York residents by insurance status through 2019. The baseline assumes that current law remains in effect over the entire period.

Insurance coverage for New York residents is based on characteristics from the Current Population Survey. Our projections are consistent with the National Health Expenditure actual data and projections as well as the data on the Medicare population, both from the Centers for Medicare and Medicaid Services (CMS). We assume that New York drug spending follows national patterns in terms of utilization of generic drugs and reliance on mail-service pharmacies.

The Medicare population is split into those covered by private plans, which would be subject to the legislation, and Part D plans, which we assume would not be affected by the legislation. Over the projection period, we assume a slight increase in the population covered by Part D plans as the population ages and some current Medicare beneficiaries shift from retiree plans to Part D plans.

We have also separately estimated spending in private plans subject to federal Employee Retirement Income Security Act of 1974 (ERISA) regulations. The ERISA regulations preempt state laws that attempt to regulate many private employer health plans. It is unclear if this preemption would apply to the legislation. If the disclosure provisions of AB 158 / SB 58 were found to affect the coverage decisions of employers, they would not apply to ERISA plans. We have estimated the share of privately-managed drug spending in plans subject to ERISA preemption based on national figures for self-insured plans, adjusted for the characteristics of the New York health insurance market. We estimate that ERISA plans are responsible for approximately 46 percent of private drug spending by the non-Medicare population.

Baseline PBM Savings

In our prior research, we have derived average discounts achieved by PBMs for private plans.[1] We have estimated these discounts based on the different cash flows under prescription drug insurance plans and each of the different activities undertaken by PBMs. The overall discount is based on independent research, conversation with PBM officials, and government estimates.

For commercial plans, we estimate that the average PBM discount, relative to a cash-paying customer in a retail setting, is 32 percent. We use this figure to assess the impact of the legislative proposals on private spending.

Disclosure Provisions of AB 158 / SB 58

PBMs reduce pharmaceutical costs through negotiation with large retail drug stores for discounted reimbursement rates and with pharmaceutical manufacturers for rebates and other retrospective utilization discounts. These negotiations and resulting pricing structures are currently private information and are not publicly available. The parties do not disclose the details of contract negotiations because such information could affect their competitive position in future negotiations.

There are a number of provisions in the New York legislation that would mandate that a PBM disclose proprietary contract information. In particular, the legislation would require that a PBM:

- Disclose to prospective health plan clients the contents of all contracts and other agreements it directly or indirectly has with drug manufacturers, labelers, or other third parties. This disclosure would cover all payments the PBM receives in connection with any service provided to the health plan.
- Report to health plan clients all contracts and other agreements entered into during the quarter that pertain to the drug benefit. Any agreements between the PBM and any manufacturer, labeler, repackager, distributor, network pharmacy, or any other third party would be included.
- Provide the health plan with access to all financial, utilization, pricing and claims information and documents attributable to the PBM services for the client.
- Provide the New York State Department of Health with access to records, books, and other documents of the PBM and its affiliates which pertain to the PBM's compliance with the law.
- Allow the client to conduct, on its own or with an auditor of the client's choice, annual audits of the PBM's business that is fairly attributable to the client.

These broad disclosure mandates would restrict the ability of PBMs and pharmaceutical companies to have private contractual relationships relating to pricing and incentives. Requiring the disclosure of such information would alter the nature and/or structure of those agreements. If these private concessions were made public, pharmacy networks and drug manufacturers may be less willing to offer terms as generous as they currently do because their incentive to bid aggressively would be diluted. Several federal agencies have found that requiring disclosure could lead to tacit collusion between manufacturers and increase drug prices.[2]

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[1] See PricewaterhouseCoopers, *Pharmacy Benefit Management Savings in Medicare and the Commercial Marketplace & the Cost of Proposed PBM Legislation, 2008-2017*, March 2007, prepared for PCMA.

[2] In comments on several state legislative proposals requiring disclosure, the Federal Trade Commission has found that tacit collusion could raise costs to consumers and decrease insurance coverage. For example, see Letter from Office of Policy Planning to Assemblywoman Nellie Pou, New Jersey General Assembly, April 17, 2007. The Congressional Budget Office estimated that requiring disclosure as a part of Medicare Part D would increase the costs of the program over the ten-year period, 2008 to 2017, by less than $10 billion, but potentially by significantly less. See CBO, Letter to Honorable Joe Barton and Honorable Jim McCrery, Potential Effects of Disclosing Price Rebates on the Medicare Drug Benefit, March 12, 2007. The CBO estimates only reflect the

Impact on Spending

Based on the analysis above, we estimate that the disclosure provisions of New York AB 158 / SB 58 would increase prescription drug costs in the state by $8.3 billion over the 2010 to 2019 period (see Table 1).

Table 1. Impact of Disclosure Provisions of AB 158 / SB 58 on New York Drug Spending
(Millions of Dollars)

	2010	2011	2012	2013	2014	2010-14	2010-19
Baseline Rx Drug Spending	$25,793	$27,735	$29,989	$32,575	$35,473	$151,566	$385,941
Privately Managed Spending [a]	14,960	16,055	17,324	18,781	20,410	87,530	221,540
ERISA Plans	6,882	7,385	7,969	8,639	9,389	40,264	101,908
Commercial Plans	8,079	8,669	9,355	10,142	11,021	47,266	119,632
Impact of Disclosure Provisions of AB 158 / SB 58 on Total Rx Drug Spending	$563	$605	$652	$707	$769	$3,297	$8,346
ERISA Plans	259	278	300	325	354	1,516	3,839
Commercial Plans	304	327	352	382	415	1,780	4,507
Percent Change in Overall Rx Drug Spending	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%
Percent Change in Privately Managed Spending [a]	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%

[a] Excludes spending under Part D plans.
Source: PricewaterhouseCoopers calculations.

The provisions would increase prescription drug spending in plans covered by ERISA by $3.8 billion and in other commercial plans by $4.5 billion over the 2010 to 2019 period.

Key Assumptions

Several assumptions underlie the estimates presented above:

1. Medicare Part D plans are assumed to be exempt from the legislation. These plans are governed by federal laws and are not subject to state law.
2. Plans covered by ERISA are assumed to be covered by the legislation.
3. New York residents are assumed to be covered by the legislation, no matter where their health insurance carrier is located or where the drugs are purchased.

To the extent the legislation is assumed to have broader or narrower application, the estimates presented in this report would need to be revised accordingly.

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change in cost to the Federal government associated with rebates paid under PDPs. Our estimates reflect the impact on spending by all parties (plan costs, government costs, and out-of-pocket costs) and discounts in all forms (rebates and network discounts). Adjusting for these differences, our estimates are within the range suggested by CBO.