Pharmaceutical Care Management Association

Pharmacy Benefit Management Savings In Medicare and the Commercial Marketplace & the Cost of Proposed PBM Legislation, 2008-2017

March 2007

PricewaterhouseCoopers

PRICEWATERHOUSECOOPERS

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I. Executive Summary

The Pharmaceutical Care Management Association (PCMA) retained PricewaterhouseCoopers (PwC) to estimate the value of pharmacy benefit management as well as the potential impact of enactment of proposed legislation that would restrict pharmacy benefit management (PBM) activities for consumers, private employers, health plans, unions, and state and federal governments.

Estimated PBM Savings:

- PricewaterhouseCoopers estimates that, on average, pharmacy benefit management reduces prescription drug costs by 29 percent compared to retail purchases with no pharmacy benefit management support.
- In 2008, pharmacy benefit management activities will reduce national prescription drug benefit costs by $85 billion, including $43 billion in reduced costs for the Medicare Part D program and its beneficiaries.
- PwC estimates that total savings from pharmacy management --including savings related to both the Medicare and non-Medicare populations-- will amount to about $1.3 trillion over the 2008-2017 period.
- For the Medicare Part D program and its beneficiaries, pharmacy benefit management activities are projected to save $693 billion over the 2008-2017 period.

The practices of pharmacy benefit managers are the subject of numerous legislative proposals under consideration in the various state legislatures. Many of these legislative proposals would restrict PBM operations and have the potential to reduce the savings from pharmacy benefit management. PwC estimated the national impact of two legislative proposals that are representative of the bills under consideration in various states: (1) require PBMs to disclose their contract terms; (2) require PBMs to bear fiduciary responsibility, and (3) require PBMs to bear fiduciary responsibility that included disclosure.

Estimated Cost of Proposed Restrictions on PBM Operations:

- PwC estimates that requiring PBMs to publicly disclose their contract terms would increase drug costs by 4.1 percent, or about $127 billion dollars over 2008-2017 for both the Medicare and non-Medicare populations.
- For the Medicare population alone, requiring PBMs to publicly disclose their contract terms would increase drug costs to beneficiaries and the government by $67 billion over 2008-2017.

- Requiring PBMs to bear fiduciary responsibility would increase drug spending costs by an estimated 3.0 percent, or about $92 billion over 2008-2017 for both the Medicare and non-Medicare populations.
- PwC estimates that imposing a fiduciary responsibility that included disclosure would increase drug costs by 7.1 percent or about $219 billion over 2008-2017 for both the Medicare and non-Medicare populations.

Higher prices would tend to reduce the number of companies that offer health insurance to their employees and the number of individuals that buy insurance, thus increasing the number of uninsured. PwC estimates that the enactment of both proposals would increase the number of uninsured by about 383,000 individuals in 2008.[1]

Table 1. National Impact of Legislative Proposals on PBM-Managed Drug Costs and Number of Uninsured

Legislative Proposal	Change in Managed Drug Spending (2008-2017)		Change in Uninsured Population, in thousands 2008
	Billions of Dollars	Percent Change	
Require PBM Disclosure	$127	4.1%	222
Non-Medicare	$60	4.1%	--
Medicare	$67	4.1%	--
Require Fiduciary Responsibility	$92	3.0%	160
Non-Medicare	$43	3.0%	--
Medicare	$49	3.0%	--
Require Fiduciary Responsibility with Disclosure	$219	7.1%	383
Non-Medicare	$103	7.1%	--
Medicare	$116	7.1%	--

Source: PricewaterhouseCoopers calculations.

II. Background

Beginning in the mid-1980s, spending on prescription drugs began increasing faster than spending on healthcare overall. Even though prescription drug therapy may have substituted in some cases for other, more expensive medical treatments, the sheer increase in this cost category prompted employers and health plans to seek solutions on how to better manage their drug benefits. Employee benefit managers, who are responsible for ensuring that their members or employees have access to affordable healthcare coverage, began to shift administration of their pharmaceutical benefits to companies that had the expertise to handle this complex area.

These companies have evolved and today are known as pharmacy benefit managers, or PBMs. Beginning around 1990, these PBMs provided real-time electronic claims adjudication. Many also provided and managed networks of pharmacies willing to accept negotiated discounts on drug prices and dispensing fees. PBMs' services have expanded to include clinical services, such as preventing dangerous drug interactions through drug utilization review. Mail-service pharmacy also has become a prominent part of PBMs' techniques for cost reduction. In addition, other organizations --such as health plans and employers-- have moved to adopt PBM-like techniques to control spending. For the purposes of this report, we include the impact of legislation on all organizations involved in managing pharmacy care through these techniques.

A. The Role of PBMs

PricewaterhouseCoopers estimates that 213 million people, or about 71 percent of the U.S. population, are in private plans with pharmacy benefit management. Beginning in 2006, most Medicare beneficiaries are enrolled in Part D prescription drug plans that generally are managed by PBMs.[2] Other government health programs do not usually use many of the key pharmacy benefit management services as described below. For that reason, this study omits public insurance programs other than Medicare Part D from all of the analyses reported below.[3]

Overall, we estimate that approximately 90 percent of the drug spending by the Medicare population will be in private plans managed by PBMs in 2008. For the non-Medicare population, approximately 76 percent of spending will be in private plans where the pharmacy benefit is managed. On average, approximately 82 percent of prescription drug spending will be done through privately-managed plans.

Competing PBMs contract with union-sponsored plans, small and large businesses, health plans, state and federal employee benefit plans, and state Medicaid plans. PBMs may be independent entities, subsidiaries of health plans, or operated by large retail chain drug stores.

PBMs provide purchasers a variety of tools and techniques that promote quality, improve outcomes, and help drive down the cost of prescription drugs. PBMs typically offer clients a set of core services designed to contain and improve the value of drug expenditures. PBMs also provide clients with clinically based services designed to improve the appropriateness, safety, and quality of pharmacy benefits. Taken together, these tools can help improve the cost-effectiveness of the drug benefit and include such activities as:

- Electronic claims processing;
- Formulary development and management;
- Networks of pharmacies;
- Generic substitution;
- Rebates and discounts;
- Therapeutic interchange;
- Mail-service pharmacy option;
- Drug utilization review (DUR);
- Disease management;
- Consumer information; and
- Consumer compliance programs.

PBMs use different approaches to optimize their ability to deliver on those practices. For example, one such approach is cost sharing with the patient. Cost sharing, in the form of copays or coinsurance, is used to encourage the use of certain "preferred" drugs. Organizations that contract with PBMs strive to establish cost-sharing structures that are "just right," accomplishing their specific cost, quality and efficiency goals regarding prescription drug benefits. Other approaches offered to health plan sponsors by PBMs help promote cost-effective drug therapies. For example, a report from the U.S. Department of Health and Human Services cited methods such as generic incentive programs, prior authorization and drug utilization review as moderating drug spending starting in the late 1990s.[4] In January 2006, CMS researchers released a study citing increased use of generic drugs and mail-service pharmacies as among several factors behind a slowing in the growth of prescription drug spending.[5] In 2005, growth in prescription drug spending fell to 5.8 percent, the lowest level

of growth since 1977 and less than one-third the level of growth in 1999, the highest growth on record.[6]

PBMs evaluate competing drugs in terms of cost and efficacy. The complexity of this role requires an intermediary that can focus on the thousands of drugs available. Spending on pharmaceuticals is determined by more than the price of individual drugs. The volume and selection of drugs also bear considerable weight in how much is spent on drugs. By coordinating drug benefits for plan sponsors, PBMs play an important role in affecting overall drug spending.

B. Purpose and Outline for This Report

While drug spending has been tempered in part by PBMs, health plans and employers continue to refine and seek innovation regarding how drug spending is managed to ensure appropriate use of the health benefit dollar.

This report provides an objective analysis of the savings achieved by PBMs and organizations that provide PBM functions. These savings could be at risk, depending on the outcome of various legislative proposals. Knowing the savings achieved through various pharmacy benefit methods, policymakers can make better decisions about the outcomes of such legislative proposals.

Some of these legislative proposals would interfere with the ability of PBMs to effectively manage drug benefits. To the degree benefit costs increase as a result, the legislation could affect an employer's decision to offer health insurance. As health insurance premiums have increased in recent years for a variety of reasons, more employers are opting not to offer insurance, or to raise the employees' contribution to health insurance premiums. Both cases contribute to rising levels of uninsured.

The following section of the report will provide estimates of the savings currently provided through pharmacy benefit management activities like those carried out by PBMs. Next, we will present our estimates of three illustrative legislative proposals to limit pharmacy benefit management.

III. Savings from Pharmacy Benefit Management

PBMs, as discussed in the previous section, reduce the cost of prescription drugs through a variety of techniques including formularies, disease management, retail pharmacy networks, manufacturer rebates, and management of prescription drug utilization. This section presents PricewaterhouseCoopers' estimates of the magnitude of these savings relative to spending on prescription drugs and in terms of total dollar savings to U.S. consumers and third-party payers.

A. Estimated Percent Savings from Pharmacy Benefit Management

The total savings from pharmacy benefit management varies across health plans and depends on the level of PBM services elected by clients. Some clients contract with PBMs only for administrative services, such as claims and benefit administration. Others adopt a whole range of PBM services, such as formulary, clinical control, and disease management. The level of PBM services utilized depends on the client, which may be an employer, health plan, union, or state or federal government.[7]

Health plans that agree to the narrowest retail networks, tighter formularies, and most aggressive management techniques are able to reduce prescription drug costs by 40 percent or more. Alternatively, plans that have broad networks, completely open formularies, and little management intervention probably save only 15 percent or less compared to retail purchases with no management (see Table 2 below).[8]

Table 2. Savings Generated by PBMs
(Relative to Unmanaged Sales at Average Retail Prices)

	Level of Management		
	Low	**Average**	**High**
Total Reduction in Costs	**15%**	**29%**	**40%**

Source: PricewaterhouseCoopers.

Overall, we estimate that pharmacy management results in savings of 29 percent of retail prices.

PBMs rely upon a variety of tools and techniques to help lower the cost of prescription drugs for consumers and health care purchasers:

- **Network discounts and dispensing fees.** Network discounts are negotiated by PBMs and are taken at the time the prescription drug is dispensed. Pharmacies may be willing to give discounts in exchange for the increased business that PBMs can bring. Offsetting the network discount, PBMs pay retail pharmacies a dispensing fee as part of their retail pharmacy network contracts. The dispensing fees for prescriptions dispensed through mail-service pharmacies are often much lower. Costs are lower in highly managed drug benefit plans, in which clients may choose options such as mandatory mail-service pharmacy for maintenance drugs related to managing chronic conditions. In part because mail-service pharmacies are automated, the cost of dispensing prescriptions is much lower.

- **Formularies.** Among the most important tools developed by PBMs to manage prescription drug benefits are formularies. A formulary is a list of prescription drugs approved for reimbursement by the plan sponsor contracting with a PBM. In developing a formulary, the primary considerations are safety, efficacy and clinical appropriateness.

  PBMs use panels of experts, called Pharmacy and Therapeutics (P&T) committees, to make formulary recommendations to the plan sponsor. P&T Committees are comprised of physicians, pharmacists, and others with other appropriate clinical expertise. Often, health professionals with special expertise are consulted when considering medications within particular therapeutic classes. Development and maintenance of formularies is an ongoing activity, as they must be continually updated to keep pace with new therapies, recent evidence from clinical research, changes in medical practice, and FDA guidance.

  Once a drug is evaluated and classified by the P&T committee, it can be further classified as preferred, non-preferred or generic. Such classification is known as tiering. Tiered formularies are developed based on the needs of the plan sponsor and what co-pay structure and cost sharing they wish to include in their prescription drug benefit. Often, generic drugs are assigned the lowest co-payment, followed by preferred, and finally non-preferred drugs.

- **Therapeutic interchange programs.** To better manage drug utilization, PBMs encourage physicians to prescribe drugs that are preferred on the plan's formulary. PBMs may contact the prescribing physician when a non-preferred formulary drug has been written and suggest that the physician authorize the interchange of the original drug to the preferred drug. Therapeutic interchange always requires the approval of the prescribing physician and a new prescription from the physician.

- **Utilization management.** PBMs also rely upon a variety of other tools to help lower the cost of prescription drugs, including generic substitution, prior authorization for classes of drugs that are often prescribed in a manner inconsistent with accepted best medical practice and other specific classes of drugs, drug utilization review, disease management, and patient education. Clients seeking greater savings will seek higher levels of intervention by their PBM. Savings in this area require more intervention by the PBM than either network discounts or rebates, both of which come from the client's willingness to put in place certain plan features in the initial plan design. Savings from higher and more intensive levels of management require continual input and monitoring by PBMs to assure appropriate utilization of cost-effective and clinically proven drugs.
- **Rebates.** Manufacturer rebates also lower the overall cost of prescription drugs. Pharmaceutical manufacturers typically provide rebates to encourage the inclusion of their drug on a formulary at a preferred level when other equivalent, competing drug products are available. The manufacturer of a preferred drug may also provide additional rebates if the market share of their product increases because of the PBM's efforts to encourage prescribers to adhere to the formulary.

The savings generated by these techniques are offset by the costs of administering drug benefits. Like other businesses, PBMs have other costs in sales and benefit administration and a required return. Some of the functions that PBMs must pay for include call centers, clinical staff, information technology, and robotics. In some cases these costs are reimbursed through a direct fee while in other instances PBMs subtract administrative costs from the rebates they receive from pharmaceutical companies before sharing them with clients.

B. Total Savings from Pharmacy Benefit Management Activities, 2008-2017

PricewaterhouseCoopers estimates that the total savings in drug costs from pharmacy benefit management are $85 billion in 2008 and $1.3 trillion over the 2008 to 2017 period. The details behind this estimate are presented in Table 3 below. (Total savings may not add up due to rounding.)

PricewaterhouseCoopers derived the total savings from PBMs based on the following factors:

- The official estimates of prescription drug spending 2008-2016 from the National Health Accounts as published by the Centers for Medicare and Medicaid Services (CMS). These estimates project that national spending on prescription drugs will grow from $248 billion in 2008 to an estimated $544 billion in 2017, for a total over the 10-year period of $3.8 trillion dollars.[9]

- PricewaterhouseCoopers estimates that prescription drug spending managed by private, third-party payers (that almost universally rely on PBM arrangements) will account for 82 percent of prescription drug spending in 2008, or about $204 billion.
- PricewaterhouseCoopers estimates that savings in the private plans, as discussed in detail above, are about 29 percent.
- When combined with our estimate of how many dollars are managed by PBMs, PricewaterhouseCoopers estimates that total savings will be $85 billion in 2008, increasing to $187 billion in 2017, for a total over the 10-year period of $1.3 trillion in savings.[10]

Table 3. Total Savings Generated by PBMs
(In billions of dollars)

	2008	2008-17
Total Drug Spending		
Total	$248	$3,759
Non-Medicare	$135	$1,943
Medicare	$113	$1,816
Managed Private Spending		
Total	$204	$3,085
Non-Medicare	$102	$1,449
Medicare	$102	$1,636
Managed Private Spending as a Share of Total		
Total	82%	82%
Non-Medicare	76%	75%
Medicare	90%	90%
PBM Discount on Managed Private Spending		
Total	$85	$1,291
Non-Medicare	$42	$598
Medicare	$43	$693

Source: PricewaterhouseCoopers calculations.

The savings generated by PBMs are not only large relative to prescription drug spending, they are also an important element of managing private insurance costs overall. According to CMS

forecasts, total personal health care spending by private insurance companies will total $15 trillion over the 2008 to 2017 period. Without the savings from PBMs, those total overall health care costs, of which prescription drug spending is just one component, would rise by about 9 percent and premiums would have to rise correspondingly to cover that increase.

The importance of PBM savings is also illustrated by calculating the per capita savings-roughly, $397 for each person enrolled in private health plans in 2008. Because Medicare beneficiaries use more prescription drugs, the savings are about $1,090 per Medicare beneficiary in private plans in 2008.[11]

IV. Impact of Legislation That Would Restrict Pharmacy Benefit Management Activities

While the tools and techniques PBMs rely upon have been embraced by a broad spectrum of private and public purchasers - most recently through the Medicare Modernization Act - some groups have been critical of PBMs. A number of states are considering legislation that would further regulate, restrict, or eliminate PBM operations. Because PBMs administer nearly all private drug plans and, increasingly, a larger share of public programs' drug plans, restrictions on their operations would have broad impacts. Not only PBMs, but also consumers, physicians, pharmacists, health plans, small and large employers, labor unions, drug distributors, and drug manufacturers have a financial interest in how resources are allocated.

As PBMs have emerged in the marketplace, critics of certain PBM practices have lobbied in the legislative arena for restrictions on certain practices of the PBM industry. As a result, some states are considering legislation to place limits on the activities of PBMs. In 2006, 22 states --Alabama, Colorado, Connecticut, Delaware, Hawaii, Iowa, Maryland, Minnesota, Mississippi, Missouri, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington State, and West Virginia-- considered proposals calling for additional PBM regulation, specifically proposals imposing fiduciary and/or "disclosure" requirements on PBMs.[12] None passed.

Table 4 summarizes PricewaterhouseCoopers' findings presented in this section with respect to the impact of three illustrative legislative proposals similar to those introduced by various states in 2006 that would:

1. Require PBMs to Disclose Contract Terms
2. Require PBMs to Bear Fiduciary Responsibility
3. Require PBMs to Bear Fiduciary Responsibility that Requires Disclosure of Contract Terms

We describe each of the options and the basis for our estimates below. Note that in each case, these estimates are consistent with our estimates of the overall savings generated by PBMs, and our estimates assume the legislation will be enacted on a national scale.[13]

Table 4. Impact of Legislative Proposals on PBM-Managed Drug Costs and Number of Uninsured

Legislative Proposal	Change in Managed Drug Spending (in billions of dollars)			Change in Uninsured Population, in thousands 2008
	2008	2008-17	Percent Change	
Option 1: Require PBM Disclosure	$8	$127	4.1%	222
Non-Medicare	$4	$60	4.1%	--
Medicare	$4	$67	4.1%	--
Option 2: Require Fiduciary Responsibility	$6	$92	3.0%	160
Non-Medicare	$3	$43	3.0%	--
Medicare	$3	$49	3.0%	--
Option 3: Fiduciary Responsibility with Disclosure	$14	$219	7.1%	383
Non-Medicare	$7	$103	7.1%	--
Medicare	$7	$116	7.1%	--

Source: PricewaterhouseCoopers calculations.

Option 1: Require Disclosure of Contract Terms & Pricing Data

Background

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.

Proponents of the legislation believe that increasing the transparency of PBM and manufacturer interactions will provide plans and patients with more information that they can use to assess the actual discounts they receive on drugs. Some consumer advocates and third-party payers believe that they have not been paid all the discounts that PBMs have negotiated on their behalf, and they believe that this legislation would give them the necessary information to ensure that they receive all the discounts to which they are contractually entitled.

The type of disclosure mandated in legislation generally is not required of other healthcare organizations. In an environment where a limited number of drug manufacturers are competing against each other for position on a formulary, the ability to negotiate in confidentiality is paramount. Without such confidentiality, the competitive pressures on manufacturers and the resulting benefits are eroded. Those benefits include lower drug costs.

Under this legislation, PBMs would be required to provide to covered entities all financial and utilization information relating to the provision of benefits and services. Specifically, the legislation would require PBMs to disclose publicly the following agreements:

- An agreement with a manufacturer to provide rebates, discounts, incentives, retrospective utilization discounts, or other economic incentives.
- An agreement with a manufacturer that favors one manufacturer's product over another's product.
- An agreement to place a product on a formulary or preferred drug list.
- An agreement to encourage the prescribing of a preferred drug over another within a given therapeutic class.
- An agreement to bill a client at amounts higher or lower than the amount a PBM reimburses a pharmacy.
- Any other revenue sharing agreements.

Estimated Impact

This legislation would restrict the ability of PBMs and pharmaceutical companies to have a private contractual relationship relating to pricing and incentives. This information would alter the nature and/or structure of those agreements. If required to make their private concessions public, pharmacy networks and drug manufacturers may be less willing to offer terms as generous as they currently do. The public disclosure of the terms offered by pharmacies and manufacturers would dilute incentives to bid aggressively. Several federal agencies have found that requiring disclosure could increase drug prices.[14] As a result, we estimate that the network discounts and manufacturer rebates would decline significantly.

- Drug costs for individuals in PBM-managed plans would rise by $8 billion in 2008.
- Over the 2008 to 2017 period, this increase would translate into additional costs of $127 billion, a 4.1 percent increase. Of that, $67 billion in costs would be borne by the Medicare Part D program and its beneficiaries.
- PwC estimates that the 4.1 percent increase in prescription drug costs would lead to about 222,000 individuals losing health insurance in 2008. [15]

Option 2: Require PBMs to Have a Fiduciary Duty

Background

Currently, PBMs contract with health plans and large employers to manage the prescription drug portion of health benefits offered. Decisions relating to the scope of those pharmaceutical benefits (or indeed, whether to offer them at all) are made by a plan sponsor, normally the employer or union. PBMs serve in an administrative and advisory role for their clients, performing claims processing and other administrative tasks. PBMs are private entities with duties to their shareholders and contractual business relationships with their clients – the covered entities.

This legislation changes those contractual relationships and transforms each PBM into a "fiduciary" of its clients. This state-imposed creation of a "fiduciary duty" is applicable to the entirety of the relationship between the PBM and its clients. In addition, creating fiduciary responsibilities for PBMs will require them to change the way they contract with manufacturers for rebates and other fees. Further, like Option 1, a fiduciary duty may require PBMs to publicly disclose their contract terms. Our analysis in this section focuses on a fiduciary duty that does not include public disclosure of contract terms.

Imposing such fiduciary duties on PBMs could subject them to broader legal liabilities than under current law because it transforms an arm's length contractual relationship into one where one party is responsible for assets that belong to another, such as a trustee relationship.

In addition, the laws imposing such fiduciary duties also require the PBM to discharge its duties with respect to the covered entity for the "primary purpose of providing benefits to covered individuals." That provision can create inconsistencies between its obligation to its client (the covered entity) to assure that a formulary and choice of drugs is cost-effective versus its obligation to the ultimate beneficiary, where cost-effectiveness is not normally an issue. Further, legislative creation of a fiduciary duty imposes obligations on PBMs to (1) disclose all financial terms and arrangements with manufacturers, pharmacies, and others; and to (2) pass through any payments or benefits to the covered entity, regardless of the terms of the contracts.

Under proposed legislation, specifically, a PBM would have to fulfill the following obligations:

- Act in good faith and in the best interest of a covered entity.
- Show duties of loyalty, care, and reporting to a covered entity.

- Notify in writing to a covered entity any activity, policy, or practice that directly or indirectly presents any conflict of interest with a covered entity.
- Provide to a covered entity financial and utilization information requested by the covered entity relating to the provision of benefits to covered individuals through that covered entity and financial and utilization information relating to services to that covered entity.

Estimated Impact

Requiring PBMs to owe a fiduciary duty to covered entities would expose PBMs to increased legal risk that may result in the need to adopt defensive business and operating strategies to avoid the threat of litigation. The added cost of increased insurance exposure could drive pharmaceutical costs higher for patients.

Additionally, mandating fiduciary status for PBMs would require that plan design decisions and authority that currently resides with the health plan be extended to PBMs. The difficulty with these proposals is that they presume PBMs are managing the assets of the payer, rather than two entities operating at arm's length.

Operationally, we believe that an important impact of the legislation is to expose PBMs to legal liability for the drug benefits that they manage. PBMs would have to boost their liability insurance and might limit the use of utilization techniques to avoid potential lawsuits.

In 2001, total insurance premiums for liability insurance represented about 1.5 percent of total health spending.[16] We estimate that PBMs would be forced to purchase broader liability insurance and that would lower the average discount by 0.5 percent of spending. Further, we expect that PBMs would be less likely to exercise management techniques, cutting the discount by another 1.5 percentage points.[17]

- Overall, we estimate that these effects would combine to increase drug costs for individuals in PBM-managed plans by 3.0 percent or about $6 billion in 2008.
- Over the 2008 to 2017 period, this increase would translate into additional drug costs of $92 billion. Of that, $49 billion in costs would be borne by the Medicare Part D program and its beneficiaries.
- PwC estimates that the 3.0 percent increase in prescription drug costs would lead to about 160,000 individuals losing employer-sponsored health insurance in 2008.

Option 3: Fiduciary Responsibility Requiring Disclosure

Mandating fiduciary status could lead to the required disclosure of proprietary business information and trade secrets. As described under the first option, such disclosure would dramatically undercut the negotiating advantage of PBMs with drug companies and retail pharmacies, thereby increasing drug costs for health plans and their enrollees.

If legislation were enacted that required PBMs to disclose publicly the results of negotiations with pharmacy networks and required drug manufacturers as a part of a fiduciary responsibility, the overall impact of the combination would be an increase in costs of 7.1 percent, or about $14 billion in 2008.

- Over the 2008 to 2017 period, this increase would translate into additional drug costs of $219 billion.
- PwC estimates that the 7.1 percent increase in prescription drug costs would lead to nearly 383,000 individuals losing health insurance in 2008.

[1] Our estimates are based on the assumption that a one percent increase in health insurance premiums causes a 0.3 percent reduction in health insurance coverage. This reduction applies only to employer-sponsored benefits. No increase in uninsured individuals under Medicare is projected.

[2] According to CMS, 22.5 million Medicare beneficiaries were enrolled in Medicare Prescription Drug Plans (PDPs) and another 16.1 million were enrolled in "creditable" plans such as those provided by employers and government programs.

[3] Excluding public programs from the analysis reduces the overall savings attributed to PBMs. It also reduces the lost savings estimates in Section IV but only to the extent that legislation also includes public programs, which in some cases it may not.

[4] See Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin "Trends in US Healthcare Spending, 2001," *Health Affairs*, January/February 2003, and Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens, "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, March/April 2006.

[5] See Smith, Cowan, Heffler, et al, Centers for Medicare & Medicaid Services (CMS), "National Health Accounts in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, 25, no. 1, (2006: 186-196). Available at www.healthaffairs.org.

[6] PricewaterhouseCoopers calculations and John A. Poisal, et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs*, Web Exclusive (21 February 2007: w242-w253). Available at www.healthaffairs.org.

[7] As noted previously, this report does not include state or federal government use of pharmacy benefit management in its analysis or estimates.

[8] These figures are based on reports and testimony from the General Accounting Office, Congressional Research Service reports, financial reports from PBMs, discussion with industry consultants, conversations with PBMs, and other private research.

[9] CMS estimates for prescription drug spending by source of payment, 2004-2016 can be found on their website at: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf. The National Health Accounts do not include projections for 2017. The 2017 value was projected assuming the 2016 growth rate held for the following years.

[10] The total dollar savings in 2008 is calculated by multiplying the average saving percentage, 29 percent, and total undiscounted spending subject to pharmacy management, or $204 billion / (1 - 29 percent).

[11] As a percent of retail spending without management, the savings from private prescription drug management in 2008 is approximately the same in both the Medicare and nonMedicare populations. The dollar savings is much higher for Medicare beneficiaries because spending per capita is higher for Medicare beneficiaries who are either elderly or have disabilities.

[12] Information provided by PCMA.

[13] State regulations generally only apply to plans and entities not covered under Federal ERISA rules. For the purposes of this study, we have assumed that the legislative proposals will be implemented at the national level and therefore apply to all plans managed by PBMs. Once we have calculated the national estimate, we allocate the impacts to the state level. If an individual state were to implement the proposal, the impact on that particular state could differ from our estimates because only those plans under state regulation would be affected.

[14] 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 FTC staff to Rep. Patrick T. McHenry on North Carolina House Bill 1374 (July 15, 2005). The FTC findings cite empirical research from other industrial sectors in which government-required disclosure increased prices. See Svend Albaek, et al., "Government Assisted Oligopoly Coordination? A Concrete Case," *Journal of Industrial Economics*, v. 45 No. 429, 1997.

During the period that led up to passage of the Medicare Modernization Act of 2003, the Congressional Budget Office estimated that the cost of disclosure on federal spending alone would be $40 billion over the eight-year period, 2006-2013. More recently, however, CBO 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 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.

[15] Our estimates are based on the assumption that a one percent increase in health insurance premiums causes a 0.3 percent reduction in health insurance coverage. We view this as a conservative estimate. In past estimates the Congressional Budget Office has assumed an elasticity of 0.6 for premium increases not accompanied by increases in benefits. In other words, a 1 percent increase in health insurance premiums leads to a 0.6 percent reduction in the purchase of health insurance. The PwC estimate includes an adjustment for those who drop their primary insurance but still maintain coverage through another family member's employer-sponsored plan, other private insurance, or public insurance programs.

In an estimate by CBO of a premium increase accompanied by an increase in benefits (in this case, an increase in coverage due to a mental health parity mandate), a one percent premium increase was estimated to increase the number of uninsured by about 200,000 (an elasticity of about 0.14 percent). The smaller elasticity in this case is because people are less likely to drop insurance coverage if the increase in cost is accompanied by an increase in benefits as opposed to solely an increase in costs.

See *Behavioral Assumptions for Estimating the Effects of Health Care Proposals* (CBO, November 1993) and *CBO's Estimates of the Impact of the Mental Health Parity Amendment in H.R. 3103* (CBO, May 13, 1996).

[16] A study from the Joint Economic Committee of the U.S. Congress estimated that the direct costs of premiums for medical liability insurance were $21 billion in 2001 (See Joint Economic Committee, "Liability for Medical Malpractice: Issues and Evidence," May 2003). These premiums represent almost 1.5 percent of total health spending in the National Health Accounts. The ratio must be adjusted to estimate the liability insurance premiums that PBMs would have to pay under the proposal. The ratio sums premiums across all providers, and some providers (such as physicians) face more risk than others, resulting in higher

liability premiums. Also, some of the risks PBMs will face under a fiduciary duty will be new risk, but some will be risk that other providers already face (and insure against). We feel that PBM premiums of 0.5 percent of drug spending represent a conservative estimate.

[17] Researchers have found that defensive medicine raises health costs by 5 to 9 percent (see Kessler, D. & McClellan, M, "Do Doctors Practice Defensive Medicine," *Quarterly Journal of Economics*, 111(2): 353-390, 1996). Assuming a similar relationship between the low end of the range and average liability premiums, we estimate that PBMs would adjust their drug management techniques to lower discounts by 1.5 percentage points (5 percent (lower bound of defensive medicine costs) / 1.5 percent (overall liability premium) * 0.5 percent (assumed PBM premium) is approximately equal to 1.5 percent).

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