December 15, 2022

Mr. Eric Linzer
President & CEO
New York Health Plan Association

Mr. Anthony Fiori
Coalition of New York State Public Health Plans
Senior Managing Director
Manatt, Phelps & Phillips, LLP

Re: Estimated New York Medicaid Pharmacy Carve-out Financial Impact

Dear Eric and Anthony:

Wakely Consulting Group (Wakely) was retained by the New York Health Plan Association (NYHPA) and the Coalition of New York State Public Health Plans (Coalition) to develop an independent estimate of the financial impact associated with carving out the pharmacy benefit from Medicaid managed care and administering it through the state's fee-for-service (FFS) program. The New York Medicaid program is administered by the New York State Department of Health (DOH). DOH contracted with Deloitte to develop the Medicaid Managed Care (MMC) and Health and Recovery Plan (HARP) capitation rates.

This letter documents the results and methodology used by Wakely to estimate the financial implications of the Medicaid pharmacy benefit carve-out. Wakely does not intend to create a reliance to third parties. When distributed, this document should be provided in its entirety. We relied on Medicaid State Drug Utilization Data (SDUD),[1] MMC and HARP information sharing reports, DOH's pharmacy carve-out administrative cost and 340B savings estimates, and on various other publicly available sources to perform this analysis.

EXECUTIVE SUMMARY

Effective April 1, 2023, the Medicaid pharmacy benefit is scheduled to be carved out for MMC, HARP, and HIV-SNP managed care populations and will be administered through New York's Medicaid FFS program.[2] This transition has many financial implications, including the change to FFS pharmacy fee schedule reimbursement levels, anticipated drug mix shift from moving to the

[1] https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html

[2] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_transition/docs/2022-08-16_carve_out_ffs.pdf

state's preferred drug list (PDL),[3] higher rebate and 340B savings, pharmacy administrative cost transfer, and capitation revenue-related impacts.

Wakely repriced New York's calendar year (CY) 2021 Medicaid SDUD managed care experience to estimate the impact of reimbursing claims at the Medicaid FFS fee schedule. We further modeled the expected drug mix shift by comparing utilization patterns by therapeutic class against four states that have an extended history operating under a Medicaid pharmacy carve-out model: Missouri, Tennessee, West Virginia, and Wisconsin.[4] Associated differences in national and supplemental rebates, 340B-related savings, administrative costs, and premium taxes were also evaluated to estimate relative costs between the managed care and carve-out pharmacy models. Table 1 summarizes the results of this analysis.

Table 1: Estimated Annual NY Medicaid Pharmacy Carve-out Cost/(Savings) Impact ($M)

Category	Total State and Federal Shares	State Share Only[5]
FFS Repricing Ingredient Costs	($188.3)	($94.1)
FFS Repricing Dispensing Fees	$647.2	$323.6
FFS Repricing Total Impact*	**$458.9**	**$229.5**
FFS Drug Mix Impact*	$802.9	$401.4
Medicaid Drug Rebate Program Rebates*	($563.9)	($281.9)
Supplemental Rebates*	($65.6)	($32.8)
340B Savings	($166.0)	($83.0)
340B Reinvestment Funds	$102.0	$51.0
Administrative Costs	($98.1)	($49.1)
MCO Premium Tax Revenue	$0.0	$35.6
MCO Underwriting Gain	($71.3)	($35.6)
Total Impact	**$398.9**	**$235.1**

**Excludes impact to 340B experience*

Table 1 shows that transitioning the managed Medicaid pharmacy benefit to FFS is estimated to increase annual New York State-specific expenditures by about $235M. The primary drivers of the higher state expenditures include increased net drug costs due to higher dispensing fees

[3] Note that "PDL" and "formulary" are used interchangeably throughout this report.

[4] As of July 2019, these were the four states that primarily administered their Medicaid pharmacy benefit using a carve-out model (https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/)

[5] Estimated State impacts do not consider the temporary 6.2% Federal Medical Assistance Multiplier (FMAP) increase under the Families First Coronavirus Response Act. They are developed using a 50.0% FMAP, since CHIP and ACA Expansion are separate programs from the MMC, HARP, and HIV-SNP populations considered in this analysis.

under Medicaid fee-for-service contracts, higher expected brand dispensing rates, and loss of state premium tax revenue due to reduced capitation rates. These increases are partially offset by increased Federal and supplemental rebates and assumed 340B and administrative savings.

METHODOLOGY

Carving the Medicaid pharmacy benefit out of managed care will significantly impact both drug reimbursement levels and utilization patterns. To estimate this impact, Wakely relied on CY 2021 Medicaid SDUD experience which is published by CMS as part of the Medicaid Drug Rebate Program (MDRP). This data contains National Drug Code (NDC)-level utilization and paid amounts for managed care organization (MCO) and Medicaid FFS delivery methods, excluding 340B drugs.[6] Our financial analysis compared New York's MCO costs against estimated costs under a carve-out model by evaluating the following seven pharmacy benefit cost components:

1. Ingredient Costs and Dispensing Fees
2. Drug Utilization Differences Under a Carve-out PDL
3. National Rebates
4. Supplemental Rebates
5. 340B Savings
6. Administrative Costs
7. Impact on Taxes and Underwriting Gain on MCO Capitation Rate Changes

The methodology used to estimate the financial impact for each of these components is described in the following sections.

1. Ingredient Costs and Dispensing Fees

MCOs generally use pharmacy benefit managers (PBMs) to provide pharmacy services to their members. Dispensing fees are typically much lower than FFS under this arrangement, with an assumed $0.50 per script included in our modeling based on recent PBM contracting levels.[7] This compares to a $10.18 dispensing fee under New York's current FFS fee schedule.[8] Conversely, ingredient costs paid under the managed pharmacy benefit are often higher than those under a FFS fee schedule.[9]

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[6] https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/state-drug-utilization-data-faq/index.html

[7] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2020-03-05_waiver_ext_app.pdf

[8] https://www.health.ny.gov/health_care/medicaid/program/docs/pharmacy_reimbursement.pdf

[9] PBM spread pricing has historically been a significant contributor to higher ingredient costs. However, effective October 2019, spread pricing was prohibited in PBM contracts and therefore is not considered in our analysis (Source: MMC and HARP information sharing reports)

Wakely segmented CY 2021 SDUD MCO costs into ingredient costs and dispensing fees by assigning dispensing fees of $0.50 per prescription and allocating the remaining drug payments to ingredient costs. MCO drug experience was then repriced to New York's Medicaid FFS fee schedule to estimate unit cost differences relative to the managed care payment levels reflected in the SDUD data. We applied the following criteria to reflect the New York FFS schedule:

- We applied National Average Drug Acquisition Cost (NADAC) per unit pricing when an NDC mapped to an associated NADAC price[10]
- When NADAC was unavailable for a given NDC, we applied Wholesale Acquisition Cost (WAC) discounted at 3.3% for brand and WAC discounted at 17.5% for generic drugs.

Note that the New York FFS fee schedule will also consider the State Maximum Allowed Cost (SMAC) or Usual and Customary (U&C) amounts, which are unavailable to Wakely. As a result, our repriced amounts may be overstated to the extent that greater discounts are achievable through these sources. Table 2 provides a summary of our repricing results.

Table 2: Estimated New York FFS Fee Schedule Repricing Cost/(Savings) Impact ($M)

Metric	Drug Cost Component	Brand	Generic	Total
MCO Costs	Ingredient Costs	$5,219.1	$876.3	$6,095.4
	Dispensing Fees	$3.9	$29.6	$33.4
	Total Costs	**$5,223.0**	**$905.9**	**$6,128.8**
MCO Costs Repriced to NY's FFS Fee Schedule	Ingredient Costs	$5,141.1	$766.0	$5,907.1
	Dispensing Fees	$78.5	$602.1	$680.7
	Total Costs	**$5,219.6**	**$1,368.1**	**$6,587.8**
Difference	Ingredient Costs	($78.0)	($110.3)	($188.3)
	Dispensing Fees	$74.7	$572.5	$647.2
	Total Costs	**($3.3)**	**$462.2**	**$458.9**

Tables 1 and 2 show that ingredient costs are reduced under the FFS fee schedule (-$188.3M), but this is outweighed by the significant increase in dispensing fees (+647.2M). The resulting financial impact is estimated to be +$458.9M, which represents a 7.5% increase to total pharmacy expenditures. This cost increase arises entirely from generic drugs, as changes in ingredient costs and dispensing fees for brand drugs largely offset.

[10] NADAC schedules are updated weekly. Given that SDUD experience is available by quarter, we relied on the February 21, 2021 schedule for 1Q 2021; May 19, 2021 schedule for 2Q 2021; August 18, 2021 schedule for 3Q 2021, and November 17, 2021 schedule for 4Q 2021 (https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html). NADAC mapped to approximately 75% of total drug spend using this approach.

2. Drug Utilization Differences Under a Carve-out PDL

MCOs currently utilize their own formularies that vary from the PDL used in New York's FFS program. MCOs use formularies to negotiate greater discounts with pharmaceutical manufacturers for allowing their drugs to be included on the formulary. MCOs can also limit the number of drugs on their formulary and design it to emphasize the use of generic drugs. States operating carve-out models are unable to limit the brand drugs on their PDLs due to their participation in the Medicaid Drug Rebate Program. This program provides significant rebates, but it can limit the states' use of the most cost-effective drugs.

The 2021 SDUD experience underlying our analysis reflects drug utilization under the various MCO formularies in effect during 2021. Transitioning to a carve-out model requires the prescription drug benefit to use the NY FFS program's PDL, which would impact the drug mix being utilized. The impact of this utilization shift was modeled by adjusting the drug mix within each therapeutic class to the distribution observed in the four states that have historically operated under pharmacy carve-out models: Missouri, Tennessee, West Virginia, and Wisconsin. We specifically compared New York and each benchmark state's drug distributions within 770 therapeutic classes, which were primarily based on MediSpan's Generic Product Identifier sub-class (GPI-6).[11] Table 3 provides a summary of the drug mix impact and generic dispensing rate (GDR) for each of these carve-out benchmark states. Note that the drug mix impacts in this table reflect the FFS repriced drug experience from Step 1.

Table 3: Estimated Pharmacy Carve-out Drug Utilization Mix Impact

State Drug Mix	Total Cost ($M)	Drug Mix Impact ($M)	GDR
New York (current drug mix)	$6,587.8	n/a	88.5%
Missouri	$7,435.7	$847.9	86.1%
Tennessee	$7,230.6	$642.8	86.9%
West Virginia	$7,349.1	$761.3	86.0%
Wisconsin	$7,547.3	$959.6	86.9%
Avg. of 4 Benchmark States	**$7,390.7**	**$802.9**	**86.5%**

Table 3 indicates that the drug shift impact from transitioning to FFS is expected to be significant, with an average cost increase of $802.9M (or +12.2%) based on experience from the four benchmark states. This cost increase is mostly driven by the significantly lower generic usage within each carve-out scenario, as observed by each benchmark state exhibiting GDRs between 1.6% and 2.5% lower than the current New York GDR of 88.5%. Cost increases were also observed within several therapeutic classes due to a shift in certain brand drugs toward other,

[11] Several GPI-6 sub-classes, including "Simulants – Misc." and "Adhd / Anti-Narcolepsy Agents Amphetamines", were segmented by duration (short acting vs. long acting). "Human Insulin" and "Beta Adrenergics" sub-classes were further segmented by dosage form.

costlier brand alternatives. Table 4 provides a summary of the 10 therapeutic classes with the highest average drug shift impact across the four benchmark states. This table shows that 10 of the 770 therapeutic classes account for $583.5M (or 72.7%) of the estimated drug mix impact.

Table 4: Estimated Pharmacy Carve-Out Drug Utilization Mix Impact by Top-10 Therapeutic Classes

Therapeutic Class	Avg. Impact of 4 Benchmark States ($M)
Human Insulin - Rapid Acting (Pen)	**$85.4**
Adrenergic Combinations - Long Acting	**$83.9**
Stimulants - Misc. - Long Acting	**$77.0**
Human Insulin - Long Acting (Pen)	**$73.5**
Beta Adrenergics - Short Acting (Inhalers)	**$66.0**
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	**$55.2**
Opioid Partial Agonists - SUD Agent	**$39.3**
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	**$36.7**
Hepatitis C Agent – Combinations	**$33.7**
ADHD/Anti-Narcolepsy Agents:Amphetamines - Long Acting	**$32.9**
Total Impact (Top 10 Classes)	**$583.5**
Total Impact (All Classes)	**$802.9**
% of Impact from Top 10 Classes	**72.7%**

Note that these drug shift impacts represent a fully transitioned carve-out model, as the benchmarks states have operated a carve-out model since at least 2019. These results do not consider any phasing-in of the FFS formulary, such as through grandfathering provisions, which would lessen the impact directly following carve-out implementation.

3. National Rebates

Congress created the Medicaid Drug Rebate Program (MDRP) in 1990 prior to most states moving to managed Medicaid for medical and pharmacy services. The MDRP requires drug manufacturers to enter into a federal rebate agreement for their drugs to be covered under Medicaid. MDRP parameters require manufacturers to pay states statutory rebates based on the utilization of their drugs which are in turn shared with the federal government. The current rebate amounts are the lesser of (a) 23.1% of the drug's average manufacturer price (AMP) or (b) the

difference between AMP and the lowest price negotiated by private payers for brand name drugs and 13% of AMP for generic drugs.[12]

Our analysis assumes that New York currently achieves a national rebate of 51% of total drug costs based on federal fiscal year (FFY) 2019 rebate levels.[13] Under a carve out model, the State is expected to achieve higher national rebates due to drug mix changes anticipated under a FFS formulary (which typically target higher utilization of brand drugs). Since these rebates are primarily attributable to brand drugs, national rebate increases were estimated for the four carve-out benchmark scenarios by adjusting aggregate rebate amounts by the change in repriced brand drug costs developed in Steps 1 and 2 above. Table 5 provides a summary of the estimated increase in national rebates for each of the four carve-out benchmark states. This table shows that estimated national rebate retained through the MDRP are greater under a carve-out model, which is driven by higher brand drug utilization.

Table 5: Estimated Pharmacy Carve-out National Rebate Impact

State Drug Mix	Est. National Rebates ($M)	Est. Increase in National Rebates ($M)
New York (current drug mix)	$3,125.7	n/a
Missouri	$3,721.1	$595.4
Tennessee	$3,575.2	$449.5
West Virginia	$3,685.7	$560.0
Wisconsin	$3,776.5	$650.8
Avg. of 4 Benchmark States	**$3,689.6**	**$563.9**

4. Supplemental Rebates

In addition to the national rebates retained under the MDRP, MCOs and states negotiate supplemental rebates with drug manufacturers for preferential status on their PDLs. Transitioning the pharmacy benefit to New York's FFS program will result in MCO supplemental rebates being replaced by the supplemental rebates achieved by the state. Our modeling assumes MCO supplemental rebates represent 5.3% of total drug spend based on the April 2021 MMC and HARP information sharing reports.[14]

[12] While most brand drug rebates are based on 23.1% of AMP, certain pediatric and clotting brand drugs have a lower rebate of 17.1% of AMP. There is also an inflationary component included in the final rebate calculation to account for the rising cost of drugs. (https://www.kff.org/medicaid/issue-brief/understanding-the-medicaid-prescription-drug-rebate-program/)

[13] https://www.phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/Medicaid-2020/NY-One-Pager_20.pdf

[14] Sourced from Appendix D.2 of the MMC and HARP information sharing reports, which includes the adjustment to remove supplemental rebates from pharmacy base experience

New York's state-achieved supplemental rebates represented 3.7% of drug spend based on the FFY 2017 CMS-64 reports.[15] The supplemental rebates contained in CMS-64 reports for FFY 2018 and later did not appear to be reliable[16] and were not used in this analysis. As a result, our modeling assumes that current state-achieved supplemental rebates are 5.3%, consistent with levels collectively achieved by the MCOs. However, aggregate supplemental rebates are expected to increase due to the overall increase in drug spend expected under a FFS PDL. Table 6 provides a summary of the supplemental rebate change under each of the four carve-out benchmark states.

Table 6: Estimated Pharmacy Carve-out National Rebate Impact

State Drug Mix	Est. National Rebates ($M)	Est. Increase in National Rebates ($M)
New York (current drug mix)	$326.1	n/a
Missouri	$394.1	$68.0
Tennessee	$383.2	$57.1
West Virginia	$389.5	$63.4
Wisconsin	$400.0	$73.9
Avg. of 4 Benchmark States	**$391.7**	**$65.6**

Note that the DOH analysis factors in a reduction to current supplemental rebate levels under FFS relative to a managed care environment. It subsequently assumes a 1% increase to current FFS levels due to additional negotiating leverage with drug manufacturers under a FFS PDL.[17] Based on this, we believe our current estimate, which maintains the managed care supplemental rebate levels, provides a reasonable (and potentially conservative) estimate.

5. 340B Savings

Drug manufacturers must participate in the federal 340B program as a condition of the MDRP. The 340B program offers significant drug discounts to certain safety net providers covering underserved populations, including Federally Qualified Health Clinics, tribal/urban Indian health centers, Ryan White HIV/AIDS Program grantees, and children's hospitals. 340B ceiling prices

[15] https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html

[16] The CMS-64 report field capturing supplemental rebates (Drug Rebate Offset - State Sidebar Agreement) increased from $32M in FFY 2017 to $85M in FFY 2018 and then was greater than $200M in FFY 2019 and later. This suggests the report may be capturing additional state savings unrelated to the supplemental rebates intended for this analysis.

[17] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2020-03-05_waiver_ext_app.pdf

are set to Medicaid prices net of rebates, but manufacturers can provide additional discounts to 340B providers if they chose.[18]

States are prohibited from accessing national or supplemental rebates for 340B claims to avoid duplicative discounts. Specifically, 340B claims should be excluded from MCO and state FFS drug invoices submitted to manufacturers for MDRP national rebates and are therefore excluded from the SDUD experience used in the prior cost components of this analysis. MCOs are understood to reimburse 340B eligible claims using their usual retail pharmacy reimbursement, so the state's ability to retain these rebates is effectively lost under a carved-in model.[19]

Wakely did not have access to 340B experience for this analysis. As a result, we relied on DOH's estimated savings opportunity of $166M,[20] which is understood to represent the net impact of repricing 340B claims to FFS reimbursement levels and additional 340B-related rebates. Our analysis also includes the impact of the $102M reinvestment fund described in DOH's fiscal analysis. The reinvestment fund is intended to partially offset expected revenue reductions experienced by 340B covered entities under a pharmacy carve-out model.[21] This reinvestment could be significantly higher than the $102M commitment which was intended for State Fiscal Year 2021-22, and would offset much of the 340B-related savings.

6. Administrative Costs

Carving out the managed Medicaid pharmacy benefit results in certain MCO administrative costs being transferred to the state. MCO-specific administrative cost reductions will result largely due to the transition of pharmacy claims processing costs. However, a significant portion of MCO pharmacy-related administrative functions is expected to remain despite the carve-out. For example, the MCOs will need to retain pharmacy staff to support and manage remaining functions such as benefit requests, case management, member and provider complaints, and care coordination. They will also undertake additional efforts with the state to reconcile the necessary data required to coordinate member medical and pharmacy benefits.

MCO pharmacy administrative cost reductions will be effectuated through removing administrative costs attributable to the pharmacy component within the MMC, HARP, and HIV-SNP capitation rates. MCO pharmacy-related administrative functions that remain following the carve-out should still be considered in rate development. Wakely estimated this rating administrative cost reduction as 2.0% of the pharmacy component based on the adjustment

[18] (https://www.kff.org/medicaid/issue-brief/understanding-the-medicaid-prescription-drug-rebate-program/view/footnotes/#footnote-438418-26)

[19] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/meetings/docs/2020-08-05_340b_advisory_mtg1.pdf

[20] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/meetings/docs/2020-08-26_340b_advisory_mtg2.pdf

[21] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2020-03-05_waiver_ext_app.pdf

applied for California's Medicaid programs, which similarly underwent a pharmacy carve-out effective January 2022.[22] This assumption compares to the 3.07% pharmacy administrative costs included in CY 2019 capitation rates, which DOH references in their pharmacy carveout fiscal impact analysis. It is unclear whether this higher figure would remove funding for pharmacy-related administrative functions that need to be maintained in a carve-out scenario. Also, this figure appears to capture additional expenses from PBM spread pricing which was prohibited effective October 2019. As a result, we believe our assumed 2.0% admin cost reduction is appropriate.[23]

The aggregate reduction was calculated by applying the assumed 2.0% administrative cost reduction to total projected pharmacy administrative costs underlying the April 2021 capitation rates.[24] The resulting annual pharmacy administrative cost reduction is $141.1M. This reduction is offset by administrative cost increases in the NY FFS Medicaid program as it scales up its operations to handle the additional load of covering significantly more members. Wakely relied on DOH's estimate of $43M for these cost increases, which yields a net savings of $98.1M for the pharmacy administrative cost transfer.

7. Impact of Taxes and Underwriting Gain on MCO Capitation Rate Changes

MCO capitation rates are based on projected claim and administrative costs plus a provision for underwriting gain and MCO premium taxes. Therefore, the state will lose part of the MCO premium tax revenue if the pharmacy benefit is no longer covered under managed Medicaid. Capitation rate payments will decrease under a carved-out model due to the lack of prescription drug costs and because the administrative costs, premium taxes, and underwriting gain attributable to the drug portion of total benefit costs will no longer apply. The removal of the underwriting gain portion attributable to pharmacy costs results in a cost savings, other things equal. By comparison, the elimination of premium taxes associated with the pharmacy benefit will result in a revenue reduction to the state, since it represents a portion of capitation rate payments that are federally funded, whereas all premium tax receipts are retained by the state.

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[22] Sourced from the CY 2022 Medi-Cal Managed Care Rate Certification (https://hmais.healthmanagement.com/california/ca-medi-cal-managed-care-rate-certification-2022/)

[23] From DOH's fiscal impact analysis, "*administrative costs are a critical component to financial plan budget savings. Administrative costs that are included within the current managed care capitation rates along with the level of spread pricing included within the managed care reimbursement allows for MCOs and PBMs to realize a profit when administering the pharmacy benefit. Administrative costs paid to managed care plans to administer the Medicaid pharmacy benefit were $285 million in 2019*"

(https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2020-03-05_waiver_ext_app.pdf)

[24] Total projected pharmacy costs in the April 2021 MMC and HARP information sharing reports were $6.9B. These costs are significantly larger than Table 2 MCO pharmacy costs reported in SDUD ($6.1B) primarily due to the inclusion of 340B claims. Note that HIV-SNP rating documents were unavailable to Wakely for this analysis. This is not assumed to materially impact the results of our analysis given the program's relatively small size (less than 16,000 members as of October 2022). https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm)

The MMC and HARP capitation rates include a Franchise Tax of 1.75% plus a separate 0.30% Metropolitan Transportation Authority (MTA) surcharge in applicable regions[25] to all for-profit MCOs. Meanwhile, no premium taxes are applied for not-for-profit MCOs. We estimate a premium tax revenue of approximately 1.0% of premium in our modeling. This blended figures is based on the observed MMC and HARP enrollment distribution by MCO and region.[26]

The capitation rates also include a 1.0% provision for risk margin. These percentage loads were applied to total projected costs including the 2.0% administrative cost load from Step 6 to estimate premium tax revenue lost and underwriting gain savings under the pharmacy carve-out model.

CONCLUSION

This analysis was developed on behalf of the NYHPA and Coalition-member health plans to present an independent financial cost estimate for the NY Medicaid pharmacy carve-out effective April 2023. Other uses may be inappropriate. We relied on Medicaid State Drug Utilization Data, MMC and HARP information sharing reports, DOH's pharmacy administrative costs and 340B savings estimates, and on various other publicly available sources documented in this letter to perform this analysis.

Sam Rickert and Taylor Pruisner are responsible for this communication. We are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this letter. We completed this analysis using sound actuarial practice. To the best of our knowledge, the letter is in compliance with the appropriate Actuarial Standards of Practice with no known deviations.

Outside parties receiving this work should retain their own experts and form their own opinions. Wakely does not intend to create a reliance to these outside parties and these materials may not be released to third parties without Wakely's prior written consent, and when consent is granted, the materials should be provided in their entirety.

Users of this memorandum should be qualified to use it and understand the results and the inherent uncertainty. There are no known relevant events subsequent to the date of the information received that would impact the results of this analysis. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate the conflict of interest risk in serving our various clients. Except as noted here, Wakely and the undersigned actuaries are financially independent and free from conflict concerning all matters related to

[25] The MTA surcharge applies to the Long Island, Mid-Hudson, Northern Metro, and NYC Metro regions

[26] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from NYHPA, Coalition, and their member health plans.

Please do not hesitate to call if you have any questions or if we may be of additional assistance.

Sincerely,

Sam Rickert, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting
(470) 777-3535

Taylor Pruisner, FSA, MAAA
Director & Senior Consulting Actuary
Wakely Consulting
(720) 226-9808