

Drug Price
Transparency (DPT)
program

Annual Report 2023

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Executive summary

Key findings from carrier analysis

The average statewide premium for health insurance per person, *Table 1*, shows how premiums have increase each year the Drug Price Transparency (DPT) has data, rising from \$6,375.82 in 2017 to \$6,987.60 in 2020, a 9.6% increase.

Table 1: Average statewide annual premium per person

Year	Average annual premium per person	Percent increase from prior year
2017	\$6,375.82	NA
2018	\$6,752.85*	5.91%*
2019	\$6,889.11	3.27%
2020	\$6,987.60	3.29%

The proportion of the average statewide premium attributable to prescription drugs, shown in *Table 2*, rose from \$1,062.42 in 2017 to \$1,242.24 in 2020 (a 9.7% increase)*.

Table 2: Proportion of average statewide premium attributable to prescription drugs

Year	Average premium for prescription drugs	Percent increase from prior year
2017	\$1,062.42	NA
2018	\$1,110.90*	0.3%
2019	\$1,165.43*	6.6%
2020	\$1,242.24	2.8%

The proportion of the health care premium attributable to prescription drugs has increased from 2018 (16.45%) to 2020 (17.77%).

Much of the increase in prescription drug spending can be attributable to **specialty drugs**, which increased as a proportion of total drugs spend, rising from 43.32% in 2017 to 50.50% in 2020. Specialty drugs were also among the highest cost and highest rebated drugs for carriers, as show in *Table 3*.

Table 3: Prescription drug spending attributable to specialty drugs

Year	Specialty drug proportion
2017	43.32%
2018	46.25%
2019	50.24%
2020	50.50%

Key findings from PBM analysis

The total **wholesale acquisition cost (WAC)** of all paid drug claims has increased from \$940 million in 2018 to \$1.15 billion in 2020 (*Table 4*). It is unclear why the data shows an increase in paid drug claims. This significant difference could reflect different populations served by these pharmacy benefit managers (PBM) in Washington state. PBMs also contract with community pharmacies to be included in the pharmacy network that is offered to a health plan. These contracts have multiple levels of reimbursement in depending on which network the pharmacy has agreed to participate.

Table 4: Total WAC of all paid drug claims

Year	Total WAC of drug claims paid
2018	\$940 million
2019	\$1,70 billion
2020	\$1,15 billion

The top four PBMs in Washington state account for approximately 99% of the total dollar value of prescription drug claims, with the top two accounting for 68% of statewide dollars. PBMs continue to keep spread pricing, which is the difference between what the carrier pays the PBM and what the PBM pays the pharmacy for a drug claim. In 2020, 11 of the 16 PBMs reported retaining dollars due to spread pricing. The amount retained by these PBMs decreased from \$155 million in 2019 to \$36 million in 2020, a 65.4% decrease.

The amount Washingtonian members pay out-of-pocket for prescription drugs has increased each year, rising from \$37.1 million in 2018 to \$115.4 million in 2020.

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PBMs also make money by retaining some amount of rebate dollars for claims they process. In 2020, PBMs received \$774 million from manufacturers and retained \$227.5 million, with the difference passed on to carriers.

Pharmacies submitted 80,494* appeals between the two reporting years of 2018 and 2019. For the reporting year 2020 appeals decreased to 78,774, as shown in *Table 5*.

Table 5: Pharmacy appeals to PBMs on reimbursement of a drug’s cost

Year	Total appeals	Appeals approved	Appeals denied	Appeals overturned
2018	32,605	2,386	28,127	2,800
2019	47,889	4,386	42,243	1,260
2020	78,774	2,800	75,972	2

The denial rate for pharmacy appeals increased from 86.3% in 2018 to 96.4% in 2020, with the top 3 PBMs who received appeals from pharmacies denying 99.3%.

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Key findings from manufacturer analysis

In 2021, HCA received 269 notifications of New Drug Applications (NDA) and Biologics License Applications (BLA) submitted to the Food and Drug Administration (FDA) for review and approval to be marketed.

- Of these submissions, 90 drugs are expected to have a significant impact on prescription drug expenditure. *Table 6.*

In 2022, HCA received 97 notifications of NDAs and BLAs submitted to the FDA for review and approval to be marketed.

- Of these submissions, 34 drugs are expected to have significant impact on prescription drug expenditure.

Table 6: New Drug Applications and significant impact

Year	New drug applications	Significant impact
2021	269	90
2022	97	34

A total of 54 manufacturers introduced 70 **Covered Drugs** to the market with a WAC of \$10,000 or more for a course of treatment lasting less than one month or a 30-day supply. Thirty-six of those drugs were due to prices exceeding \$10,000 per month when introduced to market. Of the 70 covered drugs reported with a price increase:

- 31 covered drugs had a WAC increase of 20% within a 1-year period, and
- 2 covered drugs had a WAC increase of 50% within a 3-year period.

Conclusion

The data reported to HCA suggests that drug price increases lead to increases in health care premiums, but the exact relationship is unclear. Health care premiums are typically set using cost and utilizations data two years in the past (e.g., 2021 premiums are set in 2020 using 2019 data). The effect of drug price increases in this period may help illustrate how drug costs in 2018 affected premiums in 2020, but this would be an indirect comparison not knowing exactly how premiums were set by the carriers. Generally speaking, premium increases reported in this report may be the result of drug price increases, increases in utilization, and **new-to-market** drugs that occurred in two years prior to the years they were effective.

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Purpose

Washington State has an interest in the rising drug costs and consumers' ability to access prescription drugs. The State legislature created a Drug Price Transparency (DPT) program under [Chapter 43.71C RCW](#) and tasked the program with developing a better understanding of the drivers and impacts of drug costs. Health Care Authority (HCA) created this report in accordance with [RCW 43.71C.100](#) to analyze and report on the overall impact of drug costs, rebates, and other discounts on health care premiums. Data was submitted to HCA by health carriers, [pharmacy benefit managers \(PBM\)](#), [drug manufacturers](#), and [pharmacy services administrative organizations \(PSAO\)](#), collectively referred to as [Reporting Entities](#). This data is analyzed and presented in the Results section.

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Results

Data submission summaries

HCA received registrations from 24 carriers, 47 PBMs, 531 manufacturers, and three PSAOs as described in *Tables 7 and 8*. The carriers, PBMs, and PSAOs were required to submit their reportable information by the deadlines as communicated by HCA. Entities requesting an extension for technical assistance with submissions were granted on a case-by-case basis. Some entities that registered did not have data to report during this data period because they did not meet the requirements in [Chapter 43.71C RCW](#).

Table 7. Summary of registration and data reported to HCA from Carriers, PBMs, and PSAOs in 2020

Reporting entity type	Entities registered with DPT	Entities required to report this reporting period	Entities that submitted all required reports
Carriers	24	18	18
PBMs	47	16	16
PSAOs	3	0	N/A

Table 8. Summary of registration and data reported to HCA from Manufacturers in 2020

Reporting entity Type	Entities registered with DPT	Covered drug report	New drug application
Manufacturer	531	70	97

Drug manufacturers were required to report to HCA based on the timing of a qualifying drug price increase, a covered drug being introduced to market, or on the acceptance of an NDA or BLA to be reviewed by the FDA. In total, HCA received 70 reports on Covered Drugs from 54 and 97 reports on new drug applications from 60 registered drug manufacturers.

Carrier report

Trends in health insurance premiums

Health carriers are responsible for creating and providing health plans to cover medical costs, including hospitalizations, office visits, and prescription drugs. To cover the cost of these services, carriers set monthly premiums for enrollees to pay. Carriers must submit to DPT data regarding their health plan premiums, how much of their premiums are attributable to prescription drug spending, and other information necessary to understand how drug pricing impacts health care premiums.

From the data reported by the 18 carriers, HCA received information on health care premiums for approximately 2.04* million Washingtonians for 2018, and 2.09 million in 2020. This data can be found in *Table 9*.

78% of these Washingtonians (1.59 million) were enrolled in [Large Group](#) plans:

- 1.6* million (78%) in 2018
- 1.6* million (79%) in 2019
- 1.7 million (81%) in 2020

11% of these Washingtonians were enrolled in [Small Group](#) plans:

- 224,000* in 2018
- 207,000* in 2019
- 192,000 in 2020

11% of these Washingtonians were enrolled in [individual plans](#):

- 224,000* in 2018
- 227,000* in 2019
- 209,000 in 2020

Some Washingtonians may be enrolled in other health plans that are not required to report, including [Medicare](#), [Medicaid](#), [Employee Retirement Income Security Act \(ERISA\)](#) health plans offered by employers, other public or private

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health care, or are uninsured. Additionally, members enrolled in these health plans may not live in Washington, such as a child enrolled in their parents' health plan while attending an out-of-state college.

Table 9: Breakdown of Washingtonians per plan (millions)

Year	# of WA lives (millions)	Large groups	Small groups	Individual plan
2018	2.04*	78%	11%	11%
2019	2.07	79%*	10%*	11%*
2020	2.09	84%	9.2%	10%

The average statewide premiums for health insurance have increase each year the DPT has data. The average statewide premium was \$5,375.82 in 2017, but it has increased by \$611.78 to \$6,987.60 in 2020. However, the rate of change in annual premium has slowed since the initial increase reported in 2018 as shown in *Table 10* and *Table 11*.

Table 10: Average statewide annual premium per person

Year	Average annual premium per person	Percent increase from prior year
2017	\$6,375.82	NA
2018	\$6,752.85*	5.91%*
2019	\$6,889.11	3.27%
2020	\$6,987.60	3.29%

Table 11: Proportion of average statewide premium attributable to prescription drugs

Year	Average premium for prescription drugs	Percent increase from prior year
2017	\$1,062.42	NA
2018	\$1,110.90*	0.3%
2019	\$1,165.43*	6.6%
2020	\$1,242.24	2.8%

Annual premiums can change for many different reasons, including newly covered services or price increases for already covered services. The DPT requires carriers to report the change in premium attributable to prescription drug costs versus all other health care costs. Carriers reported changes in premiums as shown in *Table 12* and *Figure 1*. Most of the change from 2017 to 2018 was

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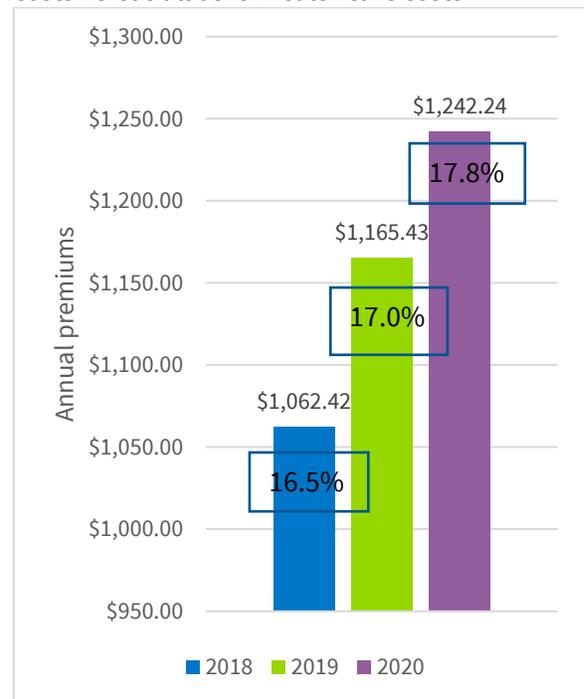
attributable to all care whereas the change from 2019 to 2020 was primarily due to prescription drugs. Consequently, the percentage of health insurance premiums attributable to prescription drugs rose. Health insurance premiums attributable to prescription drugs statewide increased 6.7% (\$77.55) in 2020 to the highest percentage since the DPT began receiving data.

This measure helps us understand how rising drug prices, increased utilization of drugs, and newly marketed drugs affects health insurance premiums.

Table 12: Annual premiums attributable to drug costs versus all other health care costs

Year	Premium change (all care)	Premium change (pharmacy)	Premium attributable to pharmacy
2018	6.0%*	4.6%*	16.5%*
2019	3.3%*	3.0%*	17.0%*
2020	3.3%	6.7%	17.8%

Figure 1: Annual premiums attributable to drug costs versus all other health care costs



Health carriers typically offer insurance within different lines of business depending on the business or individuals they are selling their health plans to. The different types of lines of business reflect different populations within Washington, so some people may feel the impacts of rising health care premiums differently.

Carriers reported changes in health insurance premiums for three different **lines of business**: Individuals, Small Groups, and Large Groups. The data reported over the last three reporting years shows the volatility in how health care premiums can change. Individual health plans offered in Washington state were more likely to experience volatile changes in health insurance premiums between years whereas health plans offered as Small Groups or Large Groups were more insulated from drastic changes in health insurance premiums between years.

Furthermore, it appears as though health plans with higher percentages of costs attributable to drugs were more likely to see drastic changes between years. The reasons why these health plans were affected greater than the others may be because they are more prone to increased spend due to rising drug costs or are limited in strategies in managing appropriate utilization of prescription drugs by enrollees.

Trends in health insurance premiums by drug type

Carriers reported the dollar value of health insurance premium attributable to three different categories of prescription drugs: brand-name drugs (brand), **generic drugs (generic)**, or specialty drugs (specialty). These values are displayed in *Table 13*.

Table 13: Overall health insurance premiums attributable to brand drugs

Year	Premium brand	Premium generic	Premium specialty
2017	\$358.27*	\$243.91*	\$460.24*
2018	\$365.00*	\$232.09*	\$513.87*
2019	\$357.14*	\$222.91*	\$585.56*
2020	\$374.01*	\$238.58	\$627.45

Table 14 shows the proportion of health insurance premiums attributable to these three categories of drugs. Despite brand and specialty drugs increasing in total dollar value, the rise in specialty drug spending accounts for a decrease in the proportion of brand drugs in the premium.

Table 14: Percentage of change in annual premium attributable to prescription drug spend

Year	Premium brand	Premium generic	Premium specialty
2017	33.7%*	22.9%	43.3%*
2018	32.9%*	21.0%*	46.2%*
2019	31.0%	19.1%	50.2%*
2020	30.0%	19.2%	50.5%

Of note, these values do not total 100% because non-drug related costs (e.g., diabetic supplies and other non-drug supplies) are not included in this drug mix.

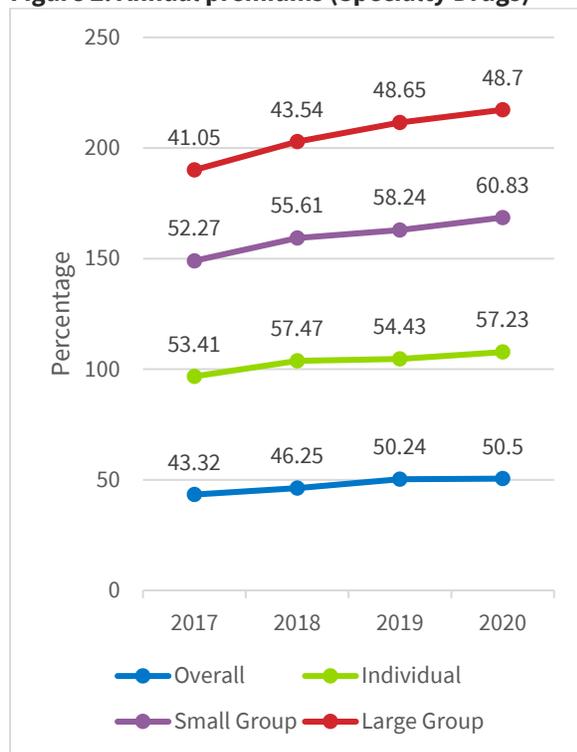
The range of percent of health insurance premium attributable to drug costs varied by type of plan between 2018 and 2020. For example, plans with smaller populations had more volatility in drug utilization and costs.

Between 2019 and 2020, individual health plans saw a decrease in percent of the premium attributable to generic drugs. We suspect this was due to the increase in the amount of premiums being attributed to brand and specialty drugs.

Specialty drugs plans saw increases in all prescription drug spending categories from 2017 to 2020, the rate at which they increased was variable, as shown in *Figure 2*.

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Figure 2: Annual premiums (Specialty Drugs)



Large Group health plans saw an increase in proportion attributable to specialty drugs between 2018 and 2020, rising from 41.05%* of prescription drug spending to 48.70%.

Small Group health plans have the highest proportion attributable to specialty drugs between 2017 and 2020, rising from 52.27%* of prescription drug spending to 60.83% 2020.

Trends in top 25 drugs by cost, utilization, rebates, and price

Next, we analyzed the carriers' reported lists of drugs as ranked by cost, utilization, [rebate](#) dollars received, and by increase in WAC, a standard of drug pricing set by manufacturers. We categorized these drugs by the conditions they treat to provide a general picture of how these types of drugs appeared in these rankings. Drugs used to treat various conditions appeared throughout these carrier reports, helping demonstrate what disease states may be attributable to higher drug

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expenditure, and therefore, higher health insurance premiums.

Summary:

- Drugs used for the treatment of diabetes appear in both the high utilization and high-cost categories.
- Drugs used for the treatment of diabetes are also reported for being among the highest amounts of rebates retained.
- Drugs used for the treatment of blood pressure and depression show high utilization and high price increases.

- Top 5 drug classes by utilization

Our analysis of the information reported by the carriers reflects the top 25 drugs most commonly treat:

- Thyroid conditions
- Cholesterol
- High blood pressure
- Diabetes
- Depression

- Top 5 drug classes by costs

Our analysis of the information reported by the carriers reflects the top 25 drugs most commonly treat:

- Arthritis
- Cancers
- HIV
- Diabetes
- Dermatology

- Top 5 drug classes by rebates retained

Our analysis of the information reported by the carriers reflects the top 25 drugs most commonly treat:

- Arthritis
- Diabetes
- ADHD
- Asthma and chronic obstructive pulmonary disease (COPD)
- Thyroid conditions

- Top 5 drug classes by price increase
Our analysis of the information reported by the carriers reflects the top 25 drugs most commonly treat:
 - High blood pressure
 - Diabetic supplies
 - Sleep disorders
 - Depression
 - Gastrointestinal disorders

Among the top 25 drugs, specialty drugs (as reported by the carriers in their specialty drug lists) were represented as some of the highest cost and highest rebate retained, while very few specialty drugs were submitted with a high utilization ranking. Single-source [non-specialty drug](#) types were represented as some of the highest cost and highest rebate retained rankings. Multi-source generics were predominately represented in the top utilization rankings.

In summary, HCA observed a statewide increase in health care premiums attributable to prescription drug spending, rising from \$1,062.42 in 2017 to \$1,1242.24 in 2020. Much of the increase in prescription drug spending can be attributable to specialty drugs, which increased in spend from \$460.24 in 2017 to \$627.45 in 2020.

The proportion of the health care premium attributable to pharmacy remained relatively steady rising from 16.5% in 2018 to 17.8% in 2020. These figures suggest that prescription drugs are contributing to rising health insurance premiums. The next section attempts to better understand some of the reasons why prescription drug spending has increased.

Pharmacy benefit managers report

Pharmacy benefit managers (PBM) are typically subcontractors of health carriers, responsible for managing almost all aspects of the prescription drug benefit for health plans. Some of their tasks include:

- Developing and maintaining drug formularies or [preferred drug lists \(PDL\)](#)
- Contracting with pharmacies to set reimbursement rates for drugs
- Creating pharmacy policies and handling prior authorization reviews for drugs with utilization management
- Handling customer service calls from patients and prescribers
- Negotiating rebates or discounts with manufacturers

Formularies or PDLs are one of the most important strategies for managing prescription drug benefits. PBMs manage access and cost-sharing to prescription drugs covered under health plans by placing drugs into tiers on the formulary or PDL. These tools are methods of structuring cost-shares and utilization management to optimize costs and utilization of drugs. Drugs that are proven to be safe, effective, and cost-effective for the general population are often placed on the lowest tier of a formulary, thus incentivizing their use, whereas drugs that are less cost-effective or have questionable safety or efficacy will be placed on higher tiers or have prior authorization to justify their medical necessity for the patient.

Given their central role in managing virtually all aspects of prescription drug benefits, PBMs have important data to help improve drug price transparency and the relationship of how drug costs impact health insurance premiums.

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Trends in pharmacy benefit management

PBMs reported data to HCA pursuant to [RCW 43.71C.030](#) through [RCW 43.71C.040](#). These required data elements were divided into a formulary management report, a PBM ownership report, and a pharmacy [appeals](#) report.

HCA received data from PBMs regarding how money was collected, distributed, and retained between different businesses within the health care industry, including with carriers, manufacturers, pharmacies, and patients. This data helps us understand how PBMs serve health plans and generate revenue as well as their role in explaining the relationship between drug costs and health insurance premiums.

The results of the PBM analyses were aggregated consistent with [RCW 43.71C.100\(2\)](#), and the results displayed in this section represent different groupings of at least two PBMs together, including the top two PBMs in each analysis. This means that each analysis does not necessarily reflect the same two PBMs throughout the report.

Trends in total WAC paid to pharmacies and reimbursement discount

Of the data reported to HCA, the approximate dollar value of drug claims processed by PBMs, defined as the total WAC of all paid drug claims in a year, was:

- \$940* million dollars in 2018
- \$1.70* billion in 2019 (difference of 81%*)
- \$1.15 billion in 2020 (difference of -31.8%)

The change in \$217 million between 2018 and 2020 is likely due to the changes to the number of covered lives served by PBMs in Washington State, though the population sizes of these PBMs were not reported in this data.

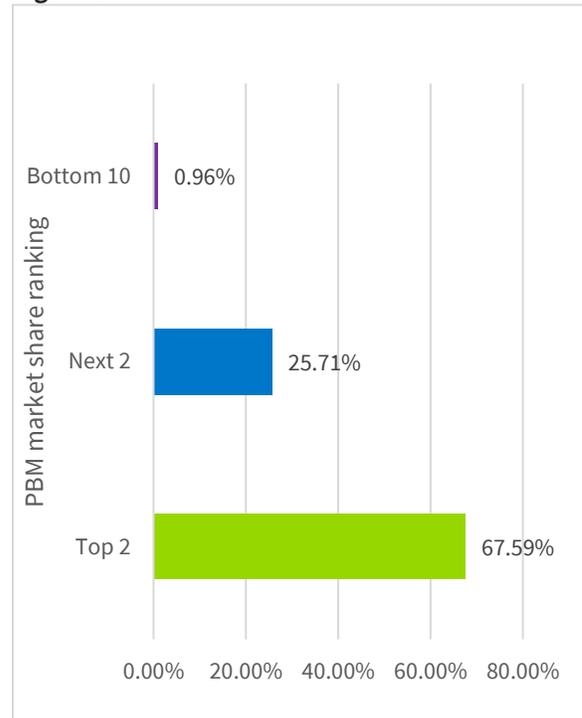
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The 2020 data reported to HCA shows:

- The top two PBMs in terms of dollar value accounted for 68%
- Next two PBMs account for 26%
- The bottom 10 PBMs account for 1% of the PBM market

This market dominance of these top four PBMs can be seen in *Figure 3*.

Figure 3: PBM in terms of dollar value



The amount of money PBMs pay pharmacies is typically a percentage of a pricing benchmark that is negotiated between the pharmacy or a PSAO. The WAC is a price set by manufacturers, meaning we can relate it to pricing data reported by manufacturers, but it is not the primary method for how PBMs reimburse pharmacies.

PBMs contract with community pharmacies to be included in the pharmacy network that is offered to a health plan. These contracts have multiple levels of reimbursement in depending on which network the pharmacy has agreed to participate.

The pharmacy reimbursement percentage varies between PBMs, pharmacies, drugs, *and* prescriptions. In aggregate of all data submitted by PBMs for 2018-2020, pharmacies received the following percentages of the cost of WAC:

- 65.5%* in 2018 and 2019
- 88% in 2020

Total pharmacies received when total WAC paid by PBMs was:

- Pharmacies paid \$940 million in drug costs in 2018 and were reimbursed \$712* million (76%) by PBMs.
- Pharmacies paid \$1.70 billion in drug costs in 2019 and were reimbursed \$1.02 billion (60%) by PBMs.
- Pharmacies paid \$1.15 billion in drug costs in 2020 and were reimbursed \$1.02 billion (88%) by PBMs.

These costs by pharmacies for drugs are reported by PBMs and may not accurately reflect actual paid amounts. Since DPT does not receive data from pharmacies, we can only estimate based on the data submitted by PBMs. Part of the reason that pharmacies are not reimbursed the full amount for the cost of the drug may be due to the discounted prices they are able to purchase from their *wholesaler* and due to direct and indirect fees assessed by PBMs on pharmacies.

Trends in gross and net paid to pharmacies and direct and indirect fees

DPT collected two measures of how PBMs reimburse pharmacies for dispensing prescription drugs to patients:

- The gross amount paid by PBMs to pharmacies is the amount of all reimbursements paid by the PBM to the pharmacy for each drug dispensed.
- The net amount paid by the PBMs is the amount of all reimbursements paid to pharmacies minus all direct and indirect fees.

Direct fees may be assessed by the PBM to the pharmacy for each claim, such as a cost to submit a claim to a PBM for them to process. Indirect fees may be assessed by the PBM to the pharmacy that are not attributable to any specific claim, such as a fee to be in the PBM’s preferred pharmacy network. To account for this indirect relationship, the PBMs were instructed to report the total indirect fees to a pharmacy or pharmacy chain by the total number of claims dispensed by that pharmacy or pharmacy chain. The trend from 2018 to 2020 can be seen in *Table 15*.

Table 15: Overall health insurance premiums attributable to brand drugs

Year	Gross amount PBM to pharmacies	Difference between gross to net amount	Percent difference
2018	\$712 m	\$39 m	4.1%
2019	\$1,018 b	\$61 m	7.3%
2020	\$1,015 b	\$118 m	11.6%

The gross amount paid by PBMs to pharmacies increased by 43.3% from 2018 to 2020 whereas the difference between gross-to-net, or an estimate of the direct and indirect fees assessed by PBMs to pharmacies, increased by 210.5%.

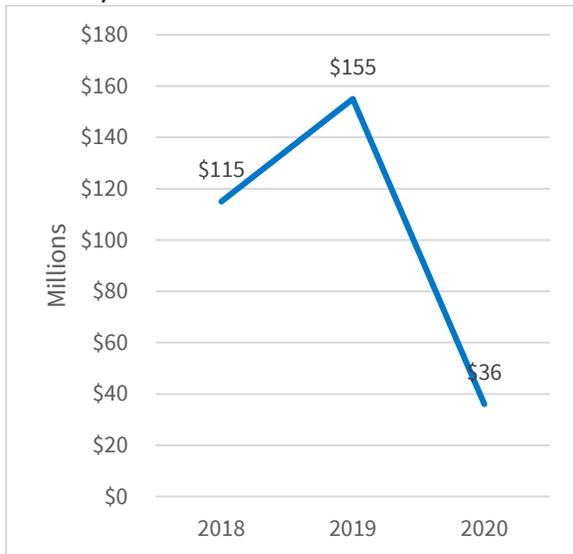
Trends in spread pricing between carriers and pharmacies

The spread amount, or the difference between what the carrier pays the PBM for a claim and the amount reimbursed to a pharmacy for that same claim, was also reported. The amount that the PBM pays to the pharmacy may not be the same amount charged to the plan. The difference is the “spread”, which the PBM retains as revenue. For example, the PBM pays a pharmacy \$10 for a prescription but charges the plan \$30 and the PBM keeps the \$20 difference. Typically, these contract arrangements are put in place to “subsidize” the administrative costs of managing the pharmacy benefit.

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- Ten of 13 PBMs reported retaining a spread amount in 2018.
 - The total spread amount retained by the ten PBMs was \$115 million.
- Twelve of 16 PBMs reported retaining a spread amount in 2019.
 - The total amount retained by the 12 PBMs was \$155 million.
- Eleven of 16 PBMs reported retaining a spread amount in 2020.
 - The total amount retained by the 11 PBMs was \$36 million, as shown in *Figure 4*.

Figure 4: Total amount retained by PBMs (in millions)



This data seems to demonstrate that only a couple of PBMs dominate the state in retaining dollars through spread pricing, though this is similar to the pattern to the market size of the PBMs in Washington as determined by the dollar value of claims processed.

Unfortunately, the way the data is reported to HCA does not allow HCA to analyze the impact of spread pricing on health insurance premiums.

Trends in member cost share

Although PBMs may not determine the cost-share for prescription drugs when health carriers create a health plan, they do influence how much patients

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pay for drugs based on how they manage the plan and what tier a drug is on the formulary or PDL. The amount Washington members pay for prescription drugs at pharmacies or member cost share was analyzed. The trends are reported below.

- \$37.1* million in 2018
- \$58* million in 2019
- \$115.4 million in 2020

Trends in rebates received and retained by PBMs

Some manufacturers will offer rebates to PBMs depending on how a drug is covered by a health plan. These rebates are paid by the manufacturer to the PBM, but it is not always clear how these rebates are shared with health carriers or what impact they may have in reducing health insurance premiums. PBMs are required to report information about how many rebate dollars they receive from manufacturers as well as how many dollars they retain and do not pass on to their health plans.

Of the rebate data reported to HCA, PBMs received:

- \$48.6* million in 2018
- \$194.3* million in 2019
- \$227.5 million in 2020

The increase in rebate dollars received by the PBMs is largely attributable to the increase in claims processed.

Of the rebate data received by PBMs (approximately):

- \$371* million (0.7%) in 2018
- \$448* million (0.2%) in 2019
- \$774 million (0.3%) in 2020

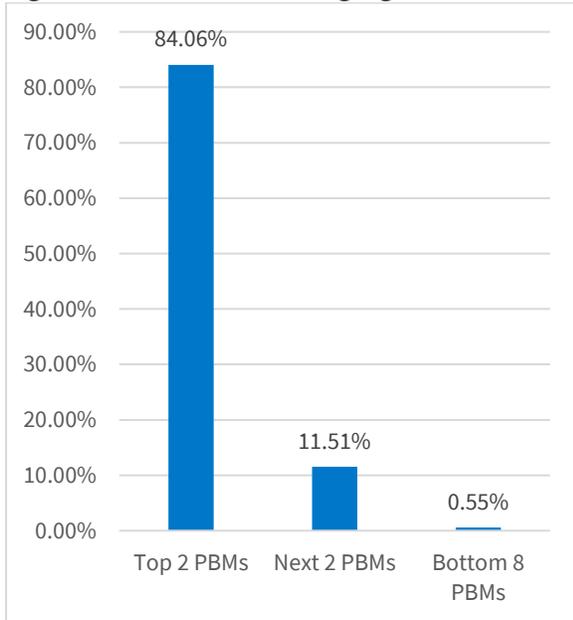
Of all the rebate dollars retained by PBMs, the top 2 PBMs that retained the most dollars each year accounted for:

- 94.9% in 2018,
- 71.9% in 2019
- 83.1% in 2020

In 2020, the top two PBMs that received the highest rebates as shown in *Figure 5*.

- Top two PBMs received 84.06%
- Next two PBMs received 11.51%
- Bottom eight PBMs received 0.55%

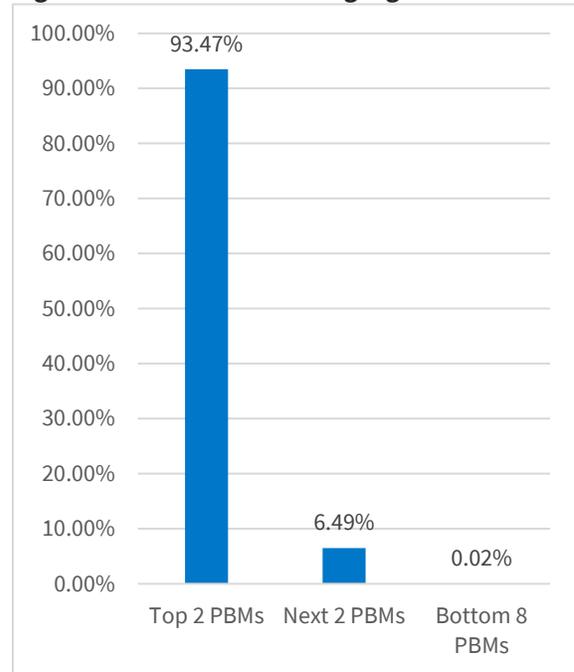
Figure 5: 2020 PBMs receiving highest rebates



In 2020 the top two PBMs retained the highest rebates as shown in *Figure 6*.

- Top two PBMs retained 93.47%
- Next two PBMs retained 6.49%
- Bottom eight PBMs retained 0.02%

Figure 6: 2020 PBMs retaining highest rebates



This data shows that PBMs collect a significant amount of money from manufacturers in the form of rebates. Additionally, different PBMs have different practices around how they retain or share rebates.

Trends in administrative fees paid by carriers

PBMs may offer carriers different options for paying for their services; charging administrative fees is a common method as reported by PBMs. These fees can be collected or assessed in several different ways, but the most common method in Washington is by drug claim. This means that a PBM charges a carrier for every claim processed, and the amount of revenue is generated depending on how many prescriptions the members of the health plan use. Another type of administrative fees are annual fees, which are set prior to a plan year. Only one PBM manages their contract with a carrier using a ‘per-member-per-month’ fee, which is similar to a health plan premium as it charges a set amount depending on the number of members enrolled in the plan for that month.

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Summary of trends in how PBMs manage prescription drug benefits

In summary, four PBMs dominate prescription drug benefits in Washington State, as demonstrated by the volume of claims processed by dollar amount, by fees assessed to pharmacies, by spread pricing between carriers and pharmacies, by member cost share, and by rebate dollars received and retained. Several other PBMs serve smaller populations and may not use all the methods measured, which explains why the size of the bottom grouping of PBMs is different between measures.

Since the PBM data and carrier data are not linked at a health plan level, which is where annual premiums, covered services, and benefit designs are determined, it is challenging to draw conclusions between the data reported in the carrier section and the data reported in the PBM section.

Trends in PBM ownership

HCA received data from PBMs regarding their ownership interests in carriers and pharmacies and any ownership interest in them from carriers or pharmacies. Of the 18 PBMs that reported, 9 reported different ownership entities than the PBM as defined by different Employer Identification Numbers (EIN). The different EIN does not necessarily represent whether a carrier or pharmacy has ownership in the PBM or whether the PBM has ownership in a carrier or pharmacies. Of the 10 that reported different ownership EIN, only half had some type of ownership interest in a carrier or pharmacy or a carrier or pharmacy had ownership in the PBM.

Trends in pharmacy appeals to PBM

In 2014, Washington State created a law, now codified as [RCW 48.200.280\(3\)](#), by which PBMs must have a process for pharmacies to appeal predetermined reimbursement costs for multisource generic drugs. Pharmacies may need

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to appeal to a PBM to be reimbursed the actual acquisition costs of a drug when a PBM sets the reimbursement rate below what a pharmacy may be able to pay when acquiring a generic drug. For example, if a PBM sets the reimbursement for Drug A at \$0.10 per unit and the pharmacy can only acquire the drug at \$0.12 per unit, the pharmacy would lose money dispensing the drug on every prescription because they would be reimbursed \$0.02 less per unit dispensed. With this law in effect, the pharmacy could appeal to the PBM and request a reimbursement rate that is appropriate to reflect what the pharmacy may be able to purchase. This law was made as an attempt to help ensure pharmacies are reimbursed appropriately for their services, but no analysis on the effectiveness of this law has been published to date.

HCA received data from PBMs regarding the number of appeals and their outcomes under this law. Of the data HCA received there were:

- 32,605 appeals in 2018
- 47,889 appeals in 2019
- 78,774 appeals in 2020

Of the 159,268 total appeals made during this three-year reporting period:

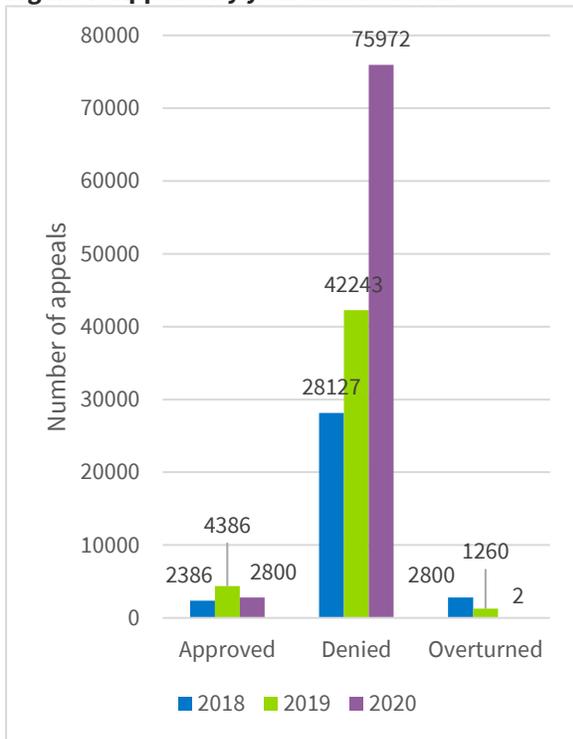
- 38% were made to only two PBMs
- 36% were made to the next five PBMs
- Among the other PBMs, eight reported the remaining 0.12% of appeals
- 12 PBMs reported no appeals

In 2020, of the 78,774 appeals made, only 2,800 (4%) were approved, 75,972 (96.4%) were denied, and 2 (.002%) were originally denied before being overturned by the Office of the Insurance Commissioner (OIC) as shown in *Table 16 and Figure 7*.

Table 16: 2020 PBMs receiving highest rebates

Decision	2020	Percentage
Approved	2,800	4%
Denied	75,972	96.4%
Overturned	2	0.002%
Totals	78,774	100%

Figure 7: Appeals by year and decision



are not adequately reimbursed for the prescriptions they dispense.

In 2020, a total of 166 pharmacies or pharmacy chains submitted at least one appeal to any PBM during this period. Of the 78,774 appeals submitted, 66 pharmacies or pharmacy chains submitted at least 100-999 appeals, and 12 submitted at least 1,000 appeals.

The top three pharmacy chains with the most appeals submitted had 45,413 in this reporting period:

- 321 (0.7%) were approved
- 45,092 (99.3%) were denied
- Zero appeals were overturned

The data suggests that many pharmacies are using the appeal process, with approximately 145 appeals being made every day over the last three-year (2018-2020) reporting period. Despite this process, many of these claims are denied with few being overturned by OIC, meaning that pharmacies may not be adequately reimbursed by PBMs for the claims they dispense. Given the high rate of denials and subsequent appeals to OIC, pharmacies may be discouraged from submitting appeals and that these numbers may actually be suppressed compared to the frequency at which pharmacies

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Drug manufacturers report Trends in manufacturer drug pricing

2022 (September 1, 2021, through
August 31, 2022)

Manufacturers are required to report to DPT when drugs become covered drugs, either from having a qualifying price increase or when they enter the market with a price of over \$10,000. These notices of covered drugs help DPT monitor and report on trends in how manufacturers set the prices of drugs.

Drug manufacturer data

54 drug manufacturers submitted data for 359 drugs.

- One manufacturer had 10 or more covered drugs reported (covered drugs with a WAC of \$10,000 or more for a course of treatment lasting less than one month or a 30-day supply).
- Four manufacturers reported drug price increases for drugs with only a one-year change of 20% or greater.
- One manufacturer reported drug price increases for drugs with only a three-year change of 50% or greater.
- Five total manufacturers reported drug price increases for drugs that met both the one-year and three-year change criteria.
- 16 total manufacturers reported introduced drugs to market.
- Four covered drugs per reports were submitted.

70 covered drugs due to prices of \$10,000 or more for a course of treatment lasting less than one month or a 30-day supply, whichever period is longer. Of these 70 Covered Drugs, the price of these introduced to market drugs ranged from just over \$10,000 to over \$3,930,000, with an average price of \$214,915 and a median of \$21,597 as shown in *Table 17*.

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Table 17: Drug manufacturers data

Year	Number of drug manufacturers	10 or more covered drugs	1-year price change of 20% or greater	3-year price change of 50% or greater	Met both 1- and 3-year requirements	Number of drugs that met the introduced to market criteria	Number of covered drugs per report
2021	89	6	11	14	19	33	5
2022	54	1	4	1	5	16	4

Covered drugs

Of the 70 drugs that met the definition of covered drug through WAC increase shown in *Table 18*:

- 31 drugs met the definition of covered drug by having a 20% WAC increase within a 1-year period.
 - Average price increase of these drugs was 23%.
- Two drugs met the definition of covered drug by having a 50% WAC increase within a 3-year period.
 - Average price increase of these drugs was 50%.
- 13 drugs met both criteria for 20% increase in a 1-year period and a 50% increase in a 3-year period.
 - Average price increase of these drugs in one-year was 36.34%.

It is important to note that drugs that did not meet the definition of a covered drug in [Chapter 43.71C RCW](#) were not required to be reported by manufacturers.

Table 18: Covered drugs

Year	Covered drugs	Number of drugs with a 20% WAC Increase within a 1-year period	Number of drugs with a 50% WAC Increase within a 3-year period	Number of drugs with a both 20% and 50% increases
2021	217	86	34	97
2022	70	31	2	13

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Qualifying price increase

- 44 covered drugs with qualifying price increases over a one-year period as shown in *Table 19*
 - Average price after increase was \$401
- 15 covered drugs with a qualifying price increase over a three-year period
 - Average price after increase was \$999
- Of these covered drugs, the drugs increased on average by \$1,533.

It is important to note that drugs that did not meet the definition of covered drug in [Chapter 43.71C RCW](#) were not required to be reported by manufacturers.

Table 19: Qualifying price increase

Year	Covered drugs with a qualifying price increase over 1-year period	Average price after price increase	Covered drugs with a qualifying price increase over 3-year period	Average price after price increase	Average covered drug price increase
2021	183	\$1,285	131	\$1,634	\$806
2022	44	\$401	15	\$999	\$1,533

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Trends in manufacturer submitting NDAs and BLAs

Drug manufacturers reported submitting New Drug Applications (NDA) and Biologics License Applications (BLA) to the FDA to review for approval to be marketed in the United States, pursuant to [RCW 43.71C.060](#). The data was analyzed and reported below to describe potentially impactful drugs to Washington State expenditures.

HCA received new NDAs or BLAs

86 new drug reports, of these submissions:

- 57 were submitted as NDAs
- 29 were submitted as BLAs
- 11 were submitted as abbreviated new drug applications (ANDAs)
- 34 (35.05%) drugs that had the potential of significant expenditure.
 - 15 were submitted as BLAs
 - 20 were submitted as NDAs
- 52 (53.6%) of the new drug reports received by HCA may not have been for new chemical entities as other versions of these chemical entities were already marketed in the US, either by the current manufacturer or by another company.
- 97 new drugs reported by 64 different manufacturers. Of those 97 new drugs reported 39 listed new chemicals. *Table 20*.

Table 20: New drug applications received

Year	Number of applications received	NDAs	BLAs	Significant expenditure	New chemical entities
2021	269	60	30	90	54
2022	97	57	29	34	45

These submissions may be related to new dosage forms of existing chemical entities or requests for the FDA to review new indications for use.

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Pharmacy services administrative organizations (PSAO)report

HCA did not receive any data from PSAOs during this reporting period. HCA assumes PSAOs did not report because they are exempt from reporting under [RCW 43.71C.080\(2\)](#) due to their payment structure with pharmacies. The statute does not require that PSAOs who identify as exempt from attesting or proving their exemption status, nor does it allow for HCA to require the PSAOs attest or prove their exemption status.

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Conclusions

Overall impact of drug costs on health care premiums

In this report, HCA analyzed data received from the reporting entities serving Washingtonians for the purpose of describing how drug pricing impacts health care premiums. HCA also presented the data from prior data submissions and data analyses to create a longitudinal picture of how prescription drug benefits changed from 2017 to 2020. As mentioned in the report, health carriers use prescription drug data from the prior year to set premiums for the subsequent year (e.g., in 2019, a carrier may use data from 2018 to set a premium for a health plan in 2020). This means we're beginning to understand how drugs with a price increase in 2017 may have led to increased expenditures in 2018. These impacts may be reflected in the premiums set. For example, a drug price may experience an increase in one year and a PBM or carrier may respond by not covering the drug and requiring patients to switch to a lower-cost and equally effective alternative. This type of information is not reportable under the current requirements of [Chapter 43.71C RCW](#), yet it would help explain how carriers and PBMs are responding to drug prices and drug cost increases. To properly identify the exact relationship and nature of how drug prices impact health care premiums and other aspects of health care costs and access a more robust data set of health claims data and all drug price increases would be required.

The DPT program now has four years (2017-2020) of data to compare and pass along to the legislature.

HCA acknowledges that drug price increases may have an impact on health care premiums, but the exact relationship and the nature of this impact is indeterminate from the data that HCA can receive under the Drug Price Transparency program. HCA is limited in its ability to properly analyze all components of change in health care premiums without a complete and comprehensive set of claims data for all health plans in the state, where these changes in drug costs and drug utilization are

identifiable. Therefore, although the trends in the data received from these entities indicate there is a relationship between increasing drug pricing, increasing drug expenditure, and increasing health care premiums, the exact relationship and magnitude of these factors cannot be determined.

New ServiceNow project

Entities can now log in to a portal and update or make edits to their own accounts. This process used to be time consuming for both the entity and HCA. It involved the entity emailing the DPT program manager who would then send a ticket to have several other HCA staff change and update lists. Entities can request an extension through this same process.

We have improved the submission process with this project. In the past, an entity would submit their required report and at 6 p.m., DPT would kick off the validation process. The entity would get an email notifying them if the report passed or failed technical validation. If the report failed, they would fix their errors and try again the next night.

Now, an entity submits a required report and receives immediate feedback if their report passed or failed. If the report fails, they receive the errors that must be corrected. The entity can now fix any errors and resubmit within minutes. If the report passes, they receive a message that the upload was successful.

Updated Data Submission Guides

Yearly updates to the data submission guides (DSG) are completed to reflect the needs of HCA and to clarify to the entities what the DPT program is asking for with every single field. If we find that reports must be sent back or are rejected because they are submitting the wrong information or giving the information to us incorrectly, then we know we need to explain it better in the DSG.

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These DSGs go through our internal DPT review and are sent to the entities for their review for 30 days. DPT takes their comments into consideration when making language determination. Finally, DPT publishes and updates the templates the entities will use for the next reporting cycle.

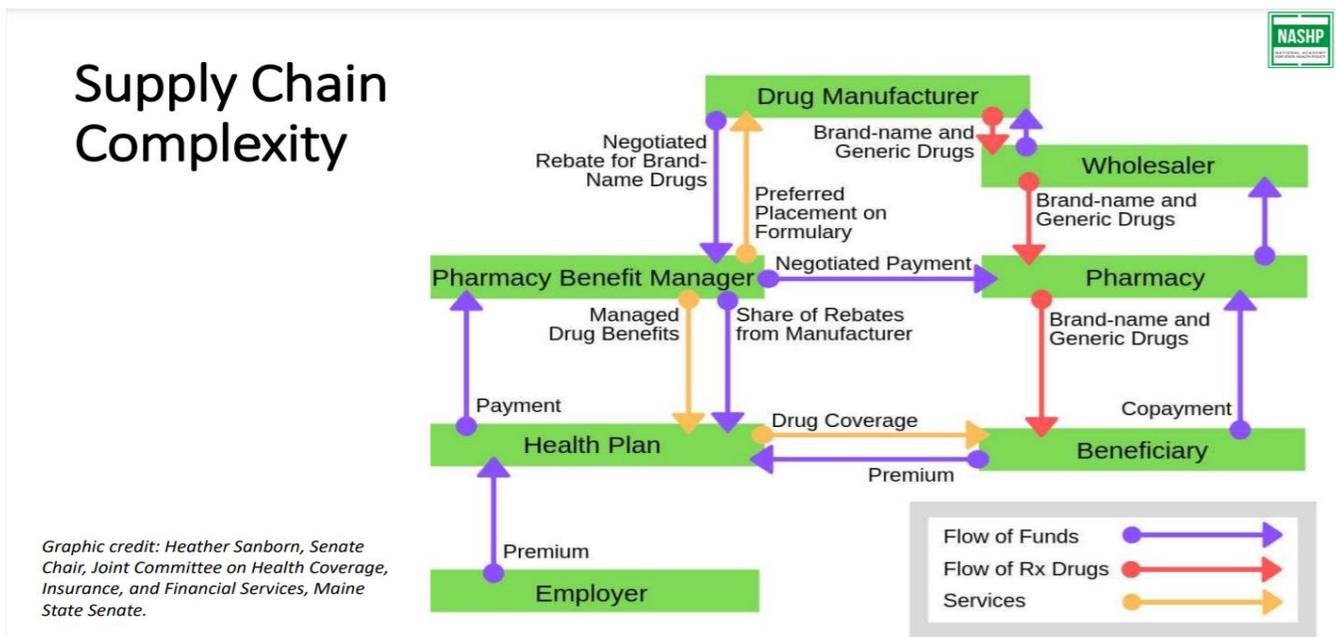
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Appendix

Prescription drug supply chain

The prescription drug supply chain ensures that safe and effective drugs are made available to patients. However, many different and parallel steps occur that result in the drug being sold by a manufacturer to being administered by a patient or provider. In *Diagram 1*, a simplified model shows the complexity of the prescription drug distribution system.

Diagram 1. Model of prescription drug distribution system



In *Diagram 1*, three of the four reporting entities for the DPT program are represented. In this model PSOs, who may or may not be part of a wholesaler, help contract between pharmacies and PBMs.

Tracking the flow of a prescription drug (red arrows), the journey begins with the manufacturer who sells their products to wholesalers.

Wholesalers purchase from many different manufacturers and sell their products to pharmacies who often order daily from wholesalers. Wholesalers then distribute the selected drugs to pharmacies who keep the drugs in storage until a prescription for a patient arrives. When the prescription is processed, the pharmacy dispenses the drug to the patient.

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Following the flow of funds (purple arrows), employers and patients pay a monthly premium to the carrier for the health plan. Carriers, who subcontract services to a PBM, provide the PBM with the funds to reimburse pharmacies for a paid claim on a covered drug. The pharmacies use these funds to replenish their stock of prescription drugs by purchasing from wholesalers, who purchase directly from manufacturers. PBMs make their revenue through:

1. The administrative fees charged to the carrier
2. PBMs collecting a spread between the carrier and the pharmacy on claims processed
3. Rebates from manufacturers retained by the PBM
4. A combination of the above three methods

The four reporting entity types identified in [Chapter 43.71C RCW](#) may have information pertaining to how drug prices affect health care costs. Drug manufacturers, the entities responsible for developing, producing, and selling drugs set the price of drugs sold in the United States. Carriers are businesses that offer health insurance and manage health plans, where they set a monthly premium for enrollment based on the services provided and the employer or member cost. PBMs are businesses that manage the prescription drug benefit for carriers. They help negotiate the reimbursement of drugs with pharmacies, contract for rebates with drug manufacturers, and provide clinical and operational services to carriers. Pharmacy services administrative organizations (PSAO) negotiate with PBMs on behalf of a pharmacy or group of pharmacies for drug reimbursement rates, network participation, and other fees.

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Glossary of terms

Appeals – Washington State created a law, now codified as RCW 48.200.280(3), by which PBMs must have a process for pharmacies to appeal predetermined reimbursement costs for multisource generic drugs.

Carriers – A disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

Covered Drugs – Any prescription drug that:

- (a) A covered manufacturer intends to introduce to the market in Washington state at a wholesale acquisition cost of ten thousand dollars or more for a course of treatment lasting less than one month or a thirty-day supply, whichever period is longer; or
- (b) Meets all of the following:
 - (i) Is currently on the market in Washington state;
 - (ii) Is manufactured by a covered manufacturer; and
 - (iii) Has a wholesale acquisition cost of more than one hundred dollars for a course of treatment lasting less than one month or a thirty-day supply, and, taking into account only price increases that take effect on or after October 1, 2019, the manufacturer increases the wholesale acquisition cost such that:
 - (A) The new wholesale acquisition cost is twenty percent higher than the wholesale acquisition cost on the same day of the month, twelve months before the date of the proposed increase; or
 - (B) The new wholesale acquisition cost is fifty percent higher than the wholesale acquisition cost on the same day of the month, thirty-six months before the date of the proposed increase.

Employee Retirement Income Security Act (ERISA) – Establishes minimum standards for pension plans in private industry.

Generic Drugs – Are a copy of a brand name drug.

Individual Group – A health plan offered to a single subscriber that does not belong to any group or collective risk pool.

Large Group – In general, a group health plan that covers employees of an employer that has 51 or more employees. In some states large groups are defined as 101 or more.

Lines of Business – The Line of Business you are reporting on. Possible values are: Large Group, Small Group, Individual, ERISA, Medicaid, Medicare, or Other.

Manufacturers – A person, corporation, or other entity engaged in the manufacture of prescription drugs sold in or into Washington state. "Covered manufacturer" does not include a private label distributor or retail pharmacy that sells a drug under the retail pharmacy's store, or a prescription drug repackager.

Medicare Part D – Voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans.

Medicaid – Health coverage for low-income adults, children, pregnant women, elderly adults, and people with disabilities. In Washington state, Medicaid is referred to as Apple Health.

National Drug Code (NDC) – 3-segment numeric identifier assigned to each medication listed under Section 510 of the U.S. Federal Food, Drug and Cosmetic Act.

New-to-Market Drugs (New Covered Drug) – Means any prescription drug that:

- (a) A covered manufacturer intends to introduce to the market at a wholesale acquisition cost of ten thousand dollars or more for a course of treatment lasting less than one month or a thirty-day supply, whichever period is longer; or
- (b) Is currently on the market, is manufactured by a covered manufacturer, and has a wholesale acquisition cost of more than one hundred dollars for a course of treatment lasting less than one month or a thirty-day supply, and, taking into account only price increases that take

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effect after July 28, 2019, the manufacturer increases the wholesale acquisition cost at least:

- (i) Twenty percent, including the proposed increase and the cumulative increase over one calendar year prior to the date of the proposed increase; or
- (ii) Fifty percent, including the proposed increase and the cumulative increase over three calendar years prior to the date of the proposed increase.

Non-Specialty Drugs – Drugs that treat both chronic and acute diseases that affect larger populations in the U.S. In contrast to specialty medications, non-specialty drugs are typically small-molecule medications, meaning they are chemically synthesized.

Office of Insurance Commissioner (OIC) – Regulates the insurance industry.

Preferred Drug List (PDL) – List of medications that Medicaid will cover the cost for without the need to request a prior authorization.

Pharmacy Benefit Managers (PBM) – A person that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060.

Pharmacy Service Administrative Organizations – An entity that contracts with a pharmacy to act as the pharmacy's agent with respect to matters involving a pharmacy benefit manager, third-party payor, or other entities, including negotiating, executing, or administering contracts with the pharmacy benefit manager, third-party payor, or other entities and provides administrative services to pharmacies.

Per-Member-Per-Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan.

Rebate – Means negotiated price concessions or, discounts, however characterized, that accrue directly or indirectly to a reporting entity in connection with utilization of prescription drugs by reporting entity members. These include but are not limited to, rebates, administrative fees,

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market share rebates, price protection rebates, performance-based price concessions, volume-related rebates, other credits, and any other negotiated price concessions or discounts that are reasonably anticipated to be passed through to a reporting entity during a coverage year, as well as any other form of price concession prearranged with a covered manufacturer, dispensing pharmacy, PBM, rebate aggregator, group purchasing organization, or other party which are paid to a reporting entity and are directly attributable to the utilization of certain drugs by reporting entity members.

Reporting entity – Carriers, covered manufacturers, carriers, health plans, PBMs, and pharmacy services administrative organizations, which are required to or voluntarily submit data according to Chapter 43.71C.

Small Group – Most states define small group as 1-50 employees.

Specialty Drugs – High-cost prescription medications used to treat complex, chronic conditions.

Wholesale Acquisition Cost (WAC) – With respect to a prescription drug, the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, excluding any discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale acquisition cost guides or other publications of prescription drug pricing.

Wholesaler – A person or company that sells goods in large quantities at low prices, typically to retailers.