Prescription Drug Rebates in Colorado
2017-2019

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

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Key Findings
Colorado All Payer Claims Database, 2017-2019

- Across all payers, pharmacy spending without rebates grew 14%, but only grew 11% when factoring in drug rebates.
- Drug rebates as a percent of total pharmacy spending for all payers increased from 25% to 27%.
- For commercial payers, rebates as a percent of total spending increased from 21% to 24% for brand drugs, and increased from 10% to 13% for specialty drugs. In 2019, rebates represented 18% of total spending for brand and specialty drugs combined.
- Across all payers, in 2019, specialty drugs represent 39% of pharmacy spending, but only 1% of the total number of prescription drugs filled.

Prescription drugs represent the fastest rising health care expense in the United States according to research published by the Health Care Cost Institute, increasing by 26% from 2014-2018. Analysis of 2019 claims from the Colorado All Payer Claims Database (CO APCD)* shows over $4B — approximately 19% of total health care spending — was spent on prescription drugs. As costs for drugs critical to improving the health of Coloradans continue to rise, consumers, policy makers and others are actively seeking solutions to address prescription drug prices.

Efforts are underway to understand the impact of prescription drug rebates on the cost and utilization of prescription drugs. At a broad level, drug rebates are provided by manufacturers to health insurance payers and Pharmacy Benefit Managers (PBMs) in exchange for placing the drug on the payer's preferred drug list or formulary, which increases the drug's market share. Payers may share manufacturer drug rebates with their employer clients depending on the contract terms negotiated between the employer and their payer or PBM.

However, the exchange of drug rebate dollars is complex. Proponents of drug rebates say it is an effective way to lower drug costs, but opponents argue that rebates may incentivize the prioritization of more expensive drugs like specialty and brand name drugs. The true impact of drug rebates on pharmacy costs remains unknown. To combat the opaque rebate system, calls for increased transparency and further examination of the driving forces of prescription drug costs are expanding at a national and state level.

To better understand the role of rebates and their impact on prescription drug costs in Colorado, the Center for Improving Value in Health Care (CIVHC), administrator of the CO APCD, began collecting prescription drug rebate information from health insurance payers in the fall of 2018. This brief explores findings from rebate data submitted in the fall of 2020 and provides insights on drug rebates and their impact on prescription drug costs. These findings can help employers understand the impact of rebates and support their ability to negotiate higher levels of rebate sharing with payers and PBMs. The information can also be used to reduce total prescription drug spending and inform better long-term policies. It accompanies an interactive report, data file for download, and detailed methodology available at www.civhc.org.

**Pharmacy spending as a percent of all health care spending was calculated using 2019 claims submitted to the CO APCD, and only includes prescription drugs filled at a pharmacy. It does not include drugs administered by a provider in a hospital or outpatient setting and does not include premium payments made by employers or individuals.*

IMPORTANT DEFINITIONS

- **Prescription Drug Rebate** – Total rebates, compensation (*see below*), remuneration and any other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided fair market value bona fide service fees.
    - For the full definition of rebates and compensations, please see CIVHC's Data Submissions Guide
- **Pharmacy Benefit Manager (PBM)** – Intermediary between the health insurer and the pharmacy. They develop and maintain formularies for health insurers and negotiate rebates and discounts.
- **Formulary** – A list of prescription drugs that a health insurer will cover, typically developed by PBMs.
- **Brand Name Drug** – A drug sold by a drug company under a specific name or trademark that is protected by a patent.
- **Generic Drug** – A medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality, and performance characteristics.
- **Specialty Drug** – A subcategory of brand name drugs, specialty drugs usually treat complex and rare conditions and diseases and require special handling, storage, administration, and patient monitoring. Specialty drugs are most notably different than generic and non-specialty brand name drugs in that they are very expensive and often the only drug of their kind to treat certain conditions.

THE DRUG REBATE LANDSCAPE

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In the past decade, the continued rise of prescription drug costs and financial burden placed on patients triggered immense national concern. As policymakers have become increasingly eager to find a solution, drug rebates are one area of debate at both the state and federal level.

Praised by advocates as the best tool to provide leverage for payers pursuing lower drug prices and cited by critics as perversely incentivizing use of expensive brand and specialty drugs, the debate around rebates remains, and lawmakers in the national arena have proposed legislation which would effectively remove incentives for preferred formulary placement based on rebate amounts.

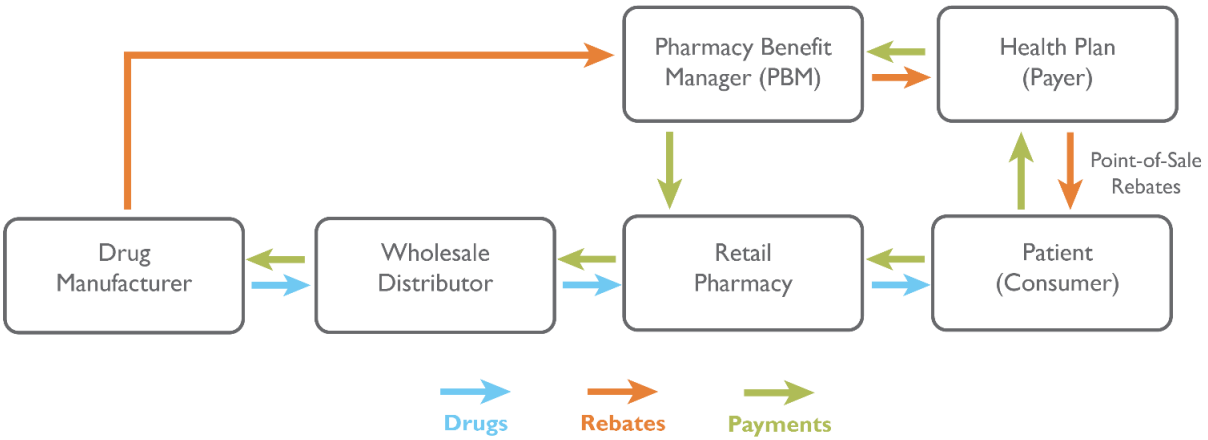
With action to alter the current rebate system growing both in the government and marketplace, demands for further transparency into the opaque process are multiplying. Players in health care policy are seeking to understand the true impact of rebates on drug prices, the nature of the driving forces behind drug costs, and who ultimately reaps the benefits of rebates.

WHAT IS A DRUG REBATE?

The system of drug rebates is complex and includes pharmaceutical manufacturers, health insurers, pharmacy benefit managers (PBMs), pharmacies, wholesalers, and patients. Drug manufacturers set prices and sell drugs to wholesalers which then sell them to retail outlets, like a local pharmacy. A rebate is a return of part of the purchase price by the buyer to the seller, typically negotiated between the seller and payer (insurer or PBM). Rebates are typically paid by a pharmaceutical manufacturer to a PBM, which then shares the majority with the health insurer.

The graphic below illustrates the flow of services and payments, including rebates:

PRESCRIPTION DRUG SUPPLY CHAIN AND FUND FLOW



Rebate payments vary depending on the negotiations between manufacturers and PBMs, but typically, they function as a lever of negotiation to earn favorable placement within a drug formulary. Although rebate levels are negotiated "up front," with the exception of point-of-sale rebates directly to patients, the rebates are not applied at the time of the transaction, but applied to PBMs and payers retroactively. In effect, rebates reduce the cost of drugs to the PBM or health plan. Manufacturers claim that higher listing prices can help them offer larger rebates. However, rebate contracts are considered trade secrets, making it difficult to track the payment and distribution chain. This leads to a number of questions on how the flow of savings in rebates is used and to whose benefit.

REBATES BY PUBLIC AND PRIVATE PAYER

National studies show the size of rebates and methods of reporting differ across payer types in crucial ways:

- Medicaid – Medicaid receives the largest rebate as a percentage of prescription drug spending, roughly 50%-52%. This is partly because of the federal Medicaid Drug Rebate Program, which requires manufacturers to provide rebates to offset Medicaid pharmacy costs. The rebates Medicaid receives are publicly reported and used to reduce government spending.
- Medicare Part D – Medicare Part D receives 18-22% of spending back in rebates. Federal restrictions prevent Medicare Part D from negotiating drug prices and all savings are publicly reported to reduce government spending and premiums.
- Commercial – Commercial payers receive lower rebates of prescription drug spending at 12% due to having more drugs covered and manufacturers being able to offer direct to consumer coupons to help increase drug use without use of rebates. It is not clear how commercial health insurance payers use rebates.

Drug rebates: a complicated series of questions

Public payers like Medicare and Medicaid use drug rebates to reduce the cost of government health insurance coverage. However, how rebates are used by commercial payers and PBMs lacks transparency, leaving it unclear how rebates impact utilization of particular drugs and total pharmacy spending. The rebate savings could be used to provide an indirect benefit to consumers and employers through lowering premiums. However, if they are not being used to reduce premiums, consumers may see no benefit because they are not likely shared to reduce copays at the point of sale. If rebates are shared with consumers at the point of sale to offset their out of pocket costs, that policy could actually increase prescription drug spending by incentivizing increased utilization of higher cost drugs. It could also incentivize manufacturers to raise their brand name and specialty drugs prices to enable higher rebates – creating a concerning cycle of rising brand name drug prices.

The impact of rebates remains ambiguous at both a national and state level. A study by the PEW Charitable Trusts found that as pharmaceutical drug spending grew by 36% from 2012 – 2016, manufacturer rebates also grew significantly by 125% and did play a role in offsetting growth of list prices. Research done by the Schaeffer Center at USC showed a "near one-to-one relationship between rising rebates and rising list prices for branded prescription drugs," with every $1 correlating with a $1.17 increase in list price.

Although the debate over methods of reform — or elimination of — rebates is ongoing, there is a general agreement among stakeholders that more transparency is necessary to evaluate the true relationship between rebates and list prices and ultimate impacts on affordability for consumers.

> "Policy solutions that increase transparency throughout the distribution system would enable a better understanding of how rebates and drug prices are related, thereby ensuring that profits throughout the system are rewarding value-adding activities, rather than anti-competitive ones"
>
> "The Association Between Drug Rebates and List Prices" – USC Schaeffer

Drug rebates in Colorado

Information From Payers:

Payers submitted drug rebate files to CIVHC based on data from their PBM:

- Total Prescription drug spending
  (excluding rebates, in total and by type of drug – specialty, non-specialty, brand and generic)
- Prescription drug rebate amounts
  (in total and by type of drug)

Until recently, little was known about the amount of drug rebates being collected by commercial payers in Colorado. To address this issue, and as part of state efforts to constrain health care costs, CIVHC began collecting drug rebate information under a regulatory change to the Data Submission Guide enacted in October 2018, which required health insurance payers in Colorado to submit rebate and other compensation information on an annual basis.

In September of 2019, payers provided their first files which included drug rebate and total spending information for 2016, 2017, and 2018. This report is based off of data received in the second collection year (2020) and includes 2017, 2018 and 2019 information. Of commercial payers using a PBM, payers reported to CIVHC that 99% of total rebate dollars were passed from the PBM to the payer. CIVHC worked in close collaboration with payers along the way to evaluate each submission and establish clear requirements. More information can be found in the accompanying complete methodology.

CONSIDERATIONS

It is important to consider the context this brief provides regarding drug rebates. Because transparency is lacking around how drug rebates are being used by PBMs and health plans, as well as information about how they influence the use and prices of expensive drugs, no conclusions can be made about the full impact of rebates in Colorado. Further, it is important to consider that payers used their own definition of specialty, brand, and generic drugs to report rebates and spending. CIVHC worked to validate payer-submitted drug rebate files by comparing member, member month and total prescription drug spending with those derived from CO APCD prescription drug data submitted each month by payers.

Additionally, one large commercial payer was unable to report at the specific drug type level, and as a result has been removed from the results below. Therefore, "All Payer" data in this year's report will not exactly match all payer data from previous or future years.

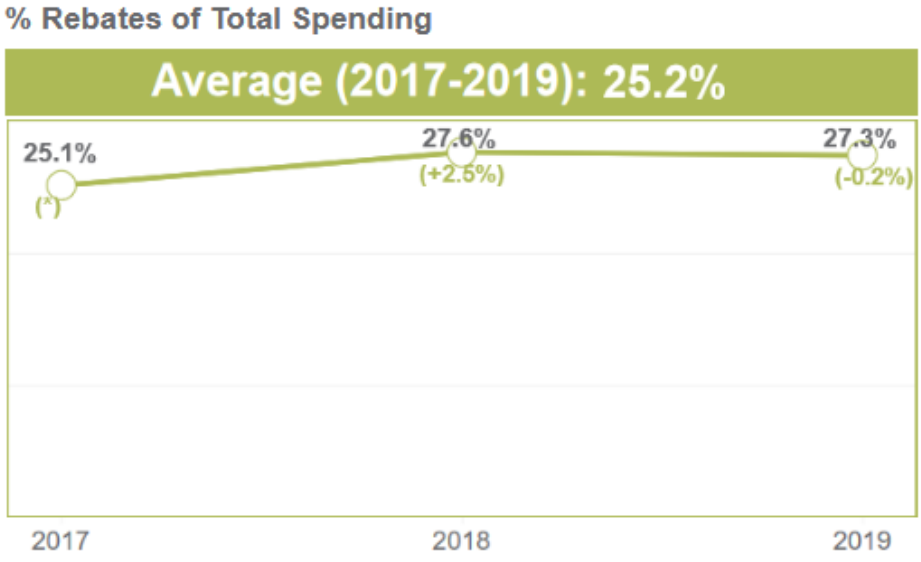
These findings do, however, establish a lens to identify trends in overall pharmacy spending and rebates collected, and highlights certain areas that may drive future health policy discussion.

COLORADO RESULTS

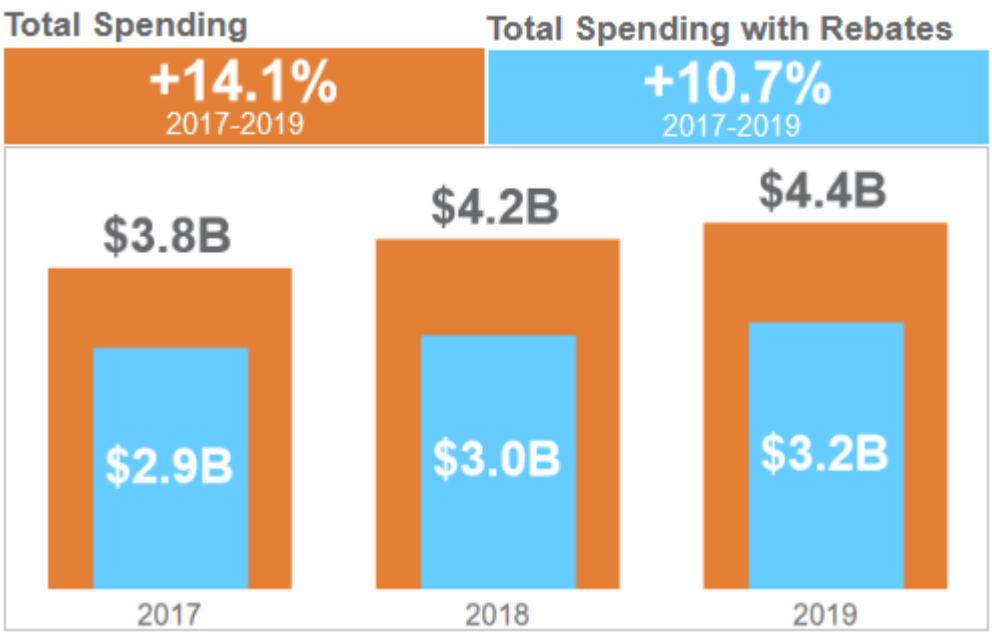
The following results reflect 2017-2019 prescription drug rebate information submitted by health insurance payers to the CO APCD. All spending represents pharmacy spending, and only includes prescription drugs filled at a pharmacy. It does not include drugs administered by a provider in a hospital or outpatient setting and does not include premium payments made by employers or individuals.

→ Across all payers, rebates represent 27% of total pharmacy spending, and increased from 25% to 27% from 2017 to 2019.

Total Pharmacy Spending, Total Spending Net Rebates, and % Rebates
CO APCD, All Payers (2019)



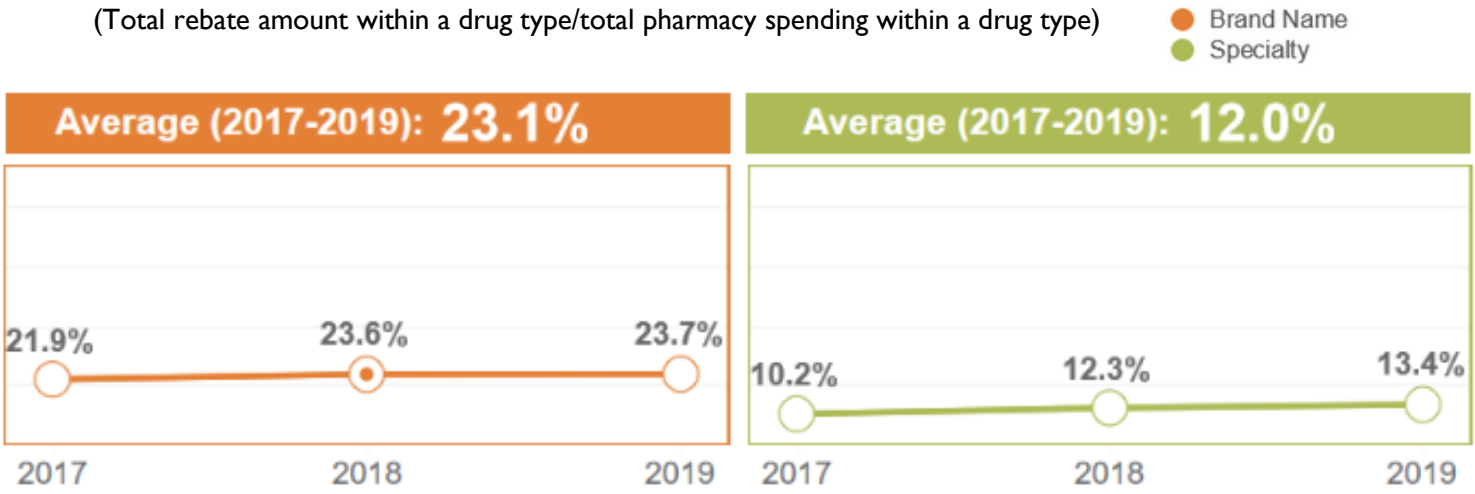
→ Across all payers, total pharmacy spending without rebates grew 13%, but only grew 11% when factoring in drug rebates.



→ For commercial payers, rebates as a percent of total spending increased from 22% to 23% for brand drugs, and increased from 10% to 13% for specialty drugs. In 2019, rebates represented 18% of total spending for brand and specialty drugs combined.

Commercial % Rebates of Total Spending for Brand and Specialty Drugs

(Total rebate amount within a drug type/total pharmacy spending within a drug type)



→ Across all payers, specialty drugs represent 39% of pharmacy spending, but only 1% of the total number of prescription drugs filled.

Volume v Spending by Drug Type, 2019						
All Payers (Commercial, Medicare FFS and Advantage, Medicaid)	Generic % Claims	Generic % Spending	Brand % Claims	Brand % Spending	Specialty % Claims	Specialty % Spending
	84.7%	19.7%	14.1%	41.5%	1.2%	38.7%

Next Steps

As Colorado policymakers continue to consider how to address the price of prescription drugs, the data provided from the CO APCD provides valuable insights to evaluate price and rebate trends and progress towards curbing the rising costs of prescription drugs. As a step towards achieving cost savings, the Department of Health Care Policy and Financing (HCPF) established prescription drug price transparency and creation of a Prescription Drug Affordability Board (PDAB) as two prioritized solutions in addressing prescription drug costs in Colorado.

In June 2021, the creation of the PDAB was approved through passage of SB21-175, which establishes a board to review affordability and creates upper payment limits for certain drugs, sets drug payment limits for manufacturers, and requires submission of more detailed prescription drug rebate information to the CO APCD. Access to drug utilization and spending data in the CO APCD provided by CIVHC will be critical to supporting the analysis of this board as it works to identify what is driving increased drug costs across Colorado.

Information in this report can also be used by a variety of other stakeholders, including consumers, providers, and employers, who all have a part to play in stemming the soaring prescription drug costs in our state.

POTENTIAL OF THE DATA

- → **Employers:** Discuss rebate shared savings with payers and PBMs, and design benefit plans to limit use of specialty and brand name drugs when alternatives exist.
- → **Policy Makers:** Seek greater transparency on how manufacturers set prices and how rebates and other compensations are being used.
- → **Researchers:** Study the pros and cons of drug rebates and their impact on utilization and prices of specialty and brand name drugs, and how this affects spending and clinical outcomes.
- → **Consumers:** Ask health providers about alternative drug options, including generics, that may provide the same results at a lower cost.

View the full interactive Drug Rebates report, download the data, and access the detailed methodology.