

RCW 43.71C.020 Health carriers—Cost and utilization data reporting. Beginning October 1, 2019, and on a yearly basis thereafter, a health carrier must submit to the authority the following prescription drug cost and utilization data for the previous calendar year for each health plan it offers in the state:

- (1) The twenty-five prescription drugs most frequently prescribed by health care providers participating in the plan's network;
- (2) The twenty-five costliest prescription drugs expressed as a percentage of total plan prescription drug spending, and the plan's total spending for each of these prescription drugs;
- (3) The twenty-five drugs with the highest year-over-year increase in wholesale acquisition cost, excluding drugs made available for the first time that plan year, and the percentages of the increases for each of these prescription drugs;
- (4) The portion of the premium that is attributable to each of the following categories of covered prescription drugs, after accounting for all rebates and discounts:
 - (a) Brand name drugs;
 - (b) Generic drugs; and
 - (c) Specialty drugs;
- (5) The year-over-year increase, calculated on a per member, per month basis and expressed as a percentage, in the total annual cost of each category of covered drugs listed in subsection (4) of this section, after accounting for all rebates and discounts;
- (6) A comparison, calculated on a per member, per month basis, of the year-over-year increase in the cost of covered drugs to the year-over-year increase in the costs of other contributors to premiums, after accounting for all rebates and discounts;
- (7) The name of each covered specialty drug; and
- (8) The names of the twenty-five most frequently prescribed drugs for which the health plan received rebates from pharmaceutical manufacturers. [2019 c 334 § 3.]