Drug Transparency Report 2025

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Introduction

The Nevada Drug Transparency Report 2025 presents a comprehensive analysis of pharmaceutical pricing trends, practices, and patterns across the state's healthcare system. Mandated by Nevada Revised Statutes (NRS) 439B.650, this report compiles and analyzes data from calendar year 2024 to provide stakeholders with critical insights into the pharmaceutical supply chain.

History of the Nevada Drug Transparency Program

Initiated during the 2017 legislative session, this program began with a focus on diabetic medications but has since expanded. Currently, it evaluates essential diabetic medications that have seen significant price increases, as well as any prescription medication costing over $40 for a course of therapy that has also experienced a significant price increase based on the Wholesale Acquisition Cost (WAC). The Nevada Drug Transparency 2025 Drug Lists are available on the State of Nevada Drug Transparency Program website.

What is a Drug Transparency Program?

The intent of the State of Nevada Drug Transparency Program is to gather data from various entities that impact drug prices across the supply chain. The program then analyzes the data and the required reporting that each entity must submit. The intent is for this information to be helpful to both lawmakers making decisions about potential legislation, and consumers making decisions about acquiring their own medications at affordable prices.

More and more states have implemented drug transparency programs. They vary considerably in scope, the triggers for reporting requirements and what data is required. A state-by-state breakdown of those details is available through the National Academy for State Health Policy (NASHP) here: https://www.nashp.org/prescription-drug-pricing-transparency-law-comparison-chart/

According to NASHP, these programs shed light on drug pricing by requiring manufacturers and other supply chain entities to provide information on drug pricing. These programs establish accountability around manufacturers' price increases or high launch prices.

Over time many manufacturers have hired third parties to manage their reporting responsibility. This does not change their obligations in any way and has improved the timeliness of their reporting.

Obligations

The Department of Health and Human Services (DHHS) is mandated to compile lists of essential diabetic drugs (EDDs), those subject to price increases meeting specific criteria, and any other medications that meet similar criteria. These lists must be published by February 1 each year. Manufacturers are required to report data on production costs, profits, financial aid, and pricing

for medications included in these lists. PBMs must report rebates negotiated with manufacturers for drugs on both the Essential Diabetic Drug List and the Over $40 Drug List. Additionally, wholesalers must provide information on WACs and rebates. This WAC price was based on information provided on the last day of the reporting period, December 31, 2024.

Nevada's Drug Lists

Nevada's DHHS produces three key drug lists:

- List #1: This list is no longer provided
- List #2: Essential Diabetes Drug List (including National Drug Codes)
- List #3: Essential Diabetes Drug List with Significant Price Increase
- List #4: Over $40 Drug List with Significant Price Increase

Reporting Requirements

Various stakeholders must submit reports to DHHS:

- Manufacturers: Must report for drugs on the Essential Diabetic Drug List, including production costs, profits, and financial aid (NRS 439B.635). For drugs with significant price increases, justification is required (NRS 439B.640).
- Pharmacy Benefit Managers (PBMs): Must report on rebates for drugs on both the Diabetic Essential Drug List and the Over $40 Drug List (NRS 439B.645).
- Wholesalers: Must provide information on Wholesale Acquisition Cost (WAC), volume shipped to Nevada, and rebate details for drugs on Lists 3 Essential Diabetes Drug List (with Significant Price Increase and Over $40 Drug List (with Significant Price Increase).
- Pharmaceutical Sales Representatives: Must register with DHHS and annually report on drug samples and compensation provided to healthcare providers (NRS 439B.660).

DHHS Responsibilities

- Maintain a registry of pharmaceutical sales representatives (NRS 439B.660)
- Compile an annual report on compensation and samples provided to health professionals (NRS 439B.660)
- Analyze submitted information, prepare and present an annual report by June 1 (NRS 439B.650), including:
    - Price analysis of drugs on the current lists
    - Reasons for price increases
    - Potential opportunities to lower drug costs while maintaining access

Compliance Status

As of this writing, three manufacturers, three PBMs and one wholesaler are non-compliant and have been notified of potential penalties, pursuant to NRS 439B.695, if required reports are not submitted.

The Lists

DHHS created three lists of essential diabetes drugs and other prescription medications based on NRS 439B.630 requirements:

- List #1: No longer provided
- List #2: Essential Drugs: Comprehensive list of essential diabetes drugs, including 1019 National Drug Codes (NDCs) with various packaging formulations.
- List #3: Essential Drugs with Significant Increase: 123 NDCs of essential diabetes drugs that experienced significant price increases in 2023 and 2024, compared to the Consumer Price Index (CPI) Medical Care Component.
- List #4: Over $40 with Significant Increase: 239 NDCs of other prescription medications costing over $40 per course of therapy with significant WAC increases.

Price increase criteria for Essential Drugs with Significant Increase:

- Exceeding 2.84% in one year (2024)
- Exceeding 6.61% in two years (2023-2024)

The CPI Medical Care Component, published by the U.S. Department of Labor, measures inflation in medical care goods and services, including professional services, hospital services, health insurance, medicinal drugs, and medical equipment.

The CPI measures the average percentage change over time in the prices paid by consumers for medical care goods and services.

For CPI medical care, the index is divided into two main components: medical care services and medical care commodities.

- Medical care services
    - Professional Services: Such as doctor visits, consultations, and other health care provider fees
    - Hospital and related services: Including inpatient and outpatient care
    - Health insurance: Premiums paid by consumers
- Medical care commodities
    - Medicinal drugs
    - Medical equipment and supplies

Positive values represent an inflation in the average costs for medical care goods and services.

To identify the drugs that meet List #3 criteria, diabetic drug price increases are compared to these values.

The price increase must exceed the previous year's CPI Medical Component or be double the previous two years. For this report, those numbers were 2.84% for one year (2024) and 6.61% for two years (2023 to 2024).

The weight of each CPI medical care index is determined by consumer out-of-pocket spending. The price change reflected by the indexes considers the total reimbursement to medical providers, including payments made on behalf of consumers.
The final list, "List #4", included 239 NDCs. It is a presentation of all other outpatient prescription medication that met the following criteria:

- The medication cost over $40 per course of therapy (or 30-day supply); and
- Has been subject to a 10% or greater WAC increase in the previous one year (2024); or
- Has been subject to a 20% or greater WAC increase in the previous two years (2023-2024).

Analysis

Nevada Medicaid claims data was analyzed to identify trends in prescription drug spending. The Nevada Medicaid Managed Care Organization and Fee-for-Service claims data was obtained from the DHHS Office of Analytics. This dataset included the total Medicaid expenditures per NDC. For a claim to qualify under a certain calendar year, the prescription must have been filled during that calendar year.

Since the program's inception, total prescription drug spending has increased significantly. The average cost per claim has also risen sharply, outpacing the Medical Consumer Price Index (CPI).

Table 1: Medications Billed to Medicaid

Year	Total Spend	Total Number of Medicaid Claims	Average Cost per Claim	Increase in Claim Cost Since Last Year	Medical CPI Increase
2017	$428,783,630	5,034,528	$85.17		
2018	$738,580,755	8,321,139	$88.76	4.22%	2.07%
2019	$680,200,258	7,309,635	$93.06	4.84%	4.62%
2020	$792,020,553	7,766,456	$101.98	9.59%	1.84%
2021	$813,233,775	7,427,940	$109.48	7.35%	2.39%
2022	$967,447,792	8,016,611	$120.68	10.23%	4.00%
2023	$1,025,675,211	7,920,399	$129.50	7.31%	0.45%

2024	$899,166,988	7,355,866	$122.24	-5.61%	2.84%

Table 1 represents medications billed to Medicaid from 2017 to 2024.

Spending and Claims:

- Total Medicaid spending on medications has increased significantly, from $428,783,630 in 2017 to $899,166,988 in 2024.
- This represents a 109.7% increase in total spend over seven years and a 43.5% increase in cost of an individual claim.
- The number of Medicaid claims fluctuated, peaking at 8,321,139 in 2018 and settling at 7,355,866 in 2024.
- The cost per claim in 2024 represented a 5.61% decrease from the prior year.

Comparison to Medical CPI:

- The increase in claim cost consistently outpaced the Medical CPI increase, except for 2024:
  - 2024: Claim cost decreased by 5.61% vs. Medical CPI increase of 2.84%
  - 2023: Claim cost increased by 7.31% vs. Medical CPI increase of 0.45%
  - 2022: Claim cost increased by 10.23% vs. Medical CPI increase of 4.00%
- This trend suggests that medication costs are rising faster than overall medical inflation.

Summary of Table 1 Findings:

- The data indicates a significant upward trend in Medicaid medication costs, both in total spending and on a per-claim basis. The outpacing of Medical CPI suggests potential challenges for healthcare affordability.
- The decrease in average cost per claim in 2024 is partially attributed to the introduction of more biosimilars into the market, particularly in the group of drugs called monoclonal antibodies.

Table 2: Top Three Medications Billed to Medicaid by Spend

Year	Drug*	Spend	Indication
2023	Biktarvy	$44,452,810	HIV Infection
2023	Humira	$41,085,244	Inflammatory diseases
2023	Kovaltry	$26,684,729	Hemophilia
2024	Biktarvy	$44,920,841	HIV Infection
2024	Ozempic	$34,557,741	Diabetes
2024	Kovaltry	$30,076,239	Hemophilia

*All strengths and NDCs are included for the drug listed.

Summary of Table 2 Findings:

- The spending on Humira was in the top three in 2022 and 2023 but dropped out in 2024. This was approximately $49 million in 2022, $41 million in 2023, then$14 million in 2024. This drop is likely due to the introduction of biosimilars.
- Biktarvy remained in the top three with $40 million in 2022, $44 million in 2023, and $45 million in 2024.
- Factor drugs (used to treat hemophilia) have been in the top three all years, though the products have varied.
- Ozempic moved into the top three in 2024 at $35 million, up from $21 million the previous year.

Table 3: Top Three Medications Billed to Medicaid by Volume

Year	Drug*	# of Claims	Indication
2023	Atorvastatin	213,999	Hyperlipidemia
2023	Albuterol	207,834	Asthma, COPD
2023	Ibuprofen	196,963	Pain, Inflammation
2024	Albuterol	183,122	Asthma, COPD
2024	Ibuprofen	182,512	Pain, Inflammation
2024	Atorvastatin	178,715	Hyperlipidemia

*All strengths and NDCs are included for the drug listed.

This year, the List #2 included 1,019 diabetic drugs. Of those, 123 had a price increase that met the criteria for List #3. This is less than in previous years, as depicted in Table 4 below.

Table 4: Percent of Essential Diabetic Drugs (EDDs) with a Price Increase by Year

Year	Percent of EDDs with Price Increase	Percent of EDDs with Price Increase (new methodology)
2018	22.4 %	
2019	18.5 %	
2020	18.6 %	14.6 %
2021	23.0 %	14.7 %
2022		13.4 %
2023		17.7 %

2024		12.1 %

Note: The methodology for calculating those with a price increase pursuant to NRS 439B.630(1)(b), depicted in Table 4, changed in 2020. Previously, this list was limited to medications billed to Medicaid only. Starting in 2020, any medication determined to be essential to treat diabetes was included in List #2, without determining if they appeared in Medicaid billing. This was because Medicaid does not represent all the Nevada population. At this point, the Transparency Program does not have access to all payer data and a product not appearing in Medicaid billing does not mean it was not utilized in Nevada.

Table 5: Claims and Cost per List by Year

Year	List #2		List #3		List #4	
	Number of claims	Cost	Number of claims	Cost	Number of claims	Cost
2021	343,422	$90,537,141	71,714	$47,931,753	4,544	$4,308,591
2022	362,839	$107,132,015	87,741	$64,121,929	23,270	$5,840,407
2023	355,451	$123,128,634	108,173	$89,286,666	11,240	$7,801,817
2024	329,687	$106,212,817	99,415	$85,058,899	20,776	$4,336,965

In the table above, the percentage spent exceeds the percentage of claims. This indicates that the cost of the medications on that list exceeds the cost of the medication in an average claim.

Table 6: Average Cost per Claim over Time by List

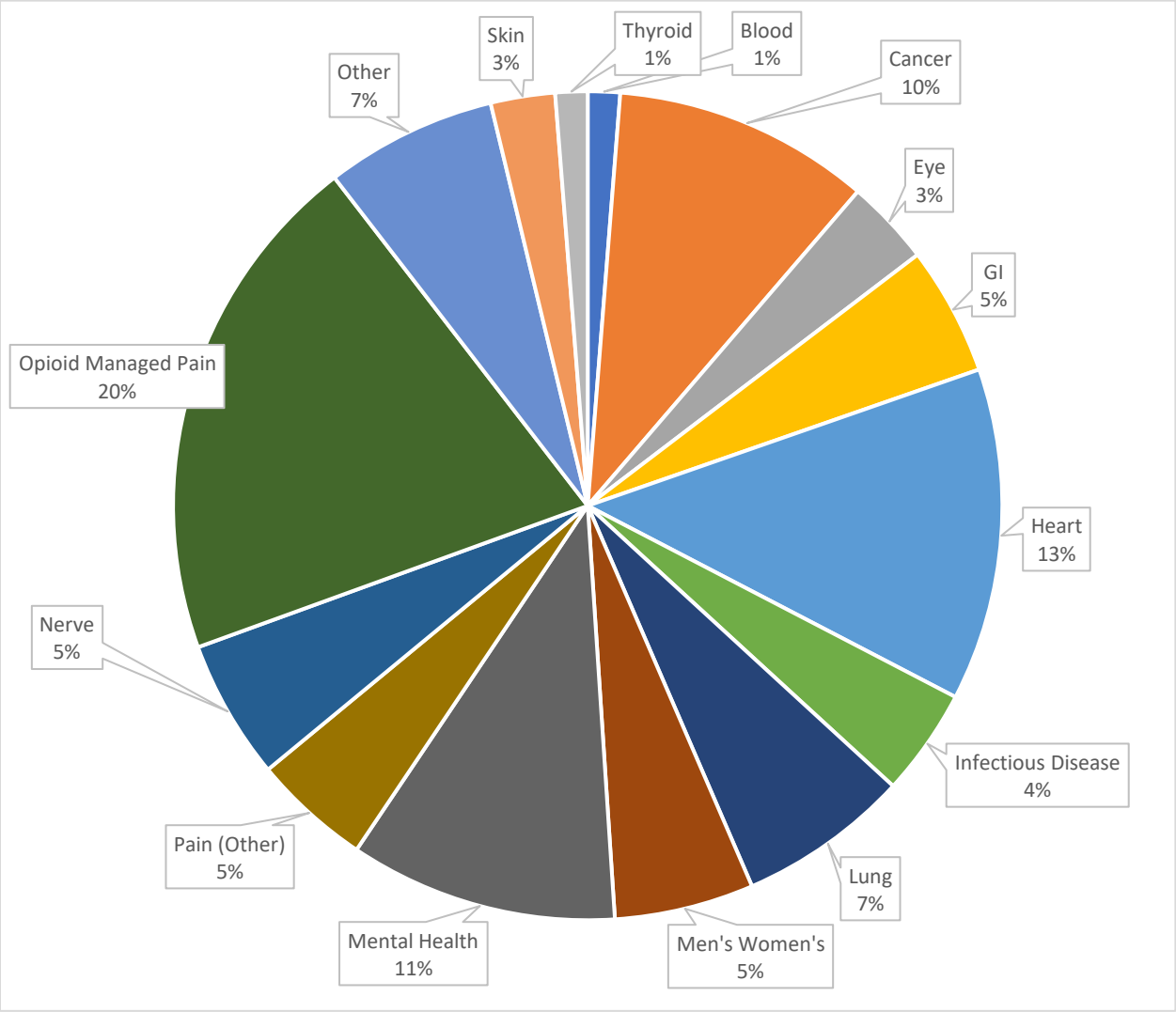
	2021	2022	2023	2024
List #2	$264.44	$295.26	$346.40	$322.16
List #3	$668.37	$716.13	$825.41	$855.59
List #4	$948.19	$250.98	$694.11	$208.75

Table 6 above illustrates the average cost of claims since the inception of List #4. The values for List #2 and #3 have increased each year. The medications on List #4 have not been consistent.

Medications that cost over $40 for a course of therapy and had a price increase that met criteria were also evaluated. This represents List #4 and includes 239 NDCs.

Figure 1 evaluates drugs that are over $40 by the type of condition or system the drug treats. This is broken down by the number of drugs on the list (not number of claims).

Figure 1. Compare Over $40 Drugs by Drug Type



(Values of <1% were included in "other" in the figure above.)

The most prevalent group seen in Figure 1 was opioid managed pain. That means that opioids used to manage pain make up most of the drugs that appear on the "over 40 list" at 20%. Notably, when analyzing the number of Medicaid claims submitted for each of these drugs, opiates continue to be the most heavily represented, at 90%.

The following includes health conditions grouped into each major category utilized in Figure 1:

- Blood Disorder: Anemia, Venous Thromboembolism, Kidney Conditions, Blood Clots

- Cancer: Cancer, Chemotherapy, Carcinoid Syndrome Diarrhea, Cancer-Related Nausea and Vomiting
- Digestive Health/GI: Acid Reflux, Bowel Prep Kit, Crohn's Disease, Ulcerative Colitis, Exocrine Pancreatic Insufficiency, Heartburn, Hemorrhoids, Irritable Bowel Syndrome, Overactive Bladder, Pancreatic Enzymes, Ulcer
- Eye: Conjunctivitis, Dry Eye, Eye Drops, Eye Pain and Swelling, Glaucoma, Macular Degeneration
- Heart Conditions: Angina, Atrial Fibrillation, Cardiovascular Disease, Heart Attack, Stroke, Heart Disease, Heart Failure, High Cholesterol, Hypertension
- Infectious Disease: Anti-fungal, Anti-parasite, Antibiotic, Cold Sores, Tonsillitis, Toxoplasmosis, Antibacterial, Shingles, HIV, Fungus, Ear Infection, Rotavirus, Hepatitis C Virus, Urinary Tract Infection, Herpes
- Lung: Asthma, Chronic Obstructive Pulmonary Disease
- Men's & Women's Health: Birth Control, Endometriosis, Erectile Dysfunction, Fertility - Women's Health, Menopause, Morning Sickness, Prostate, Testosterone, Vaginal Dryness, Osteoporosis
- Mental Health: Attention Deficit Hyperactivity Disorder, Binge Eating Disorder, Parkinson's Disease, Alzheimer's Disease, Antidepressant, Bipolar Disorder, Depression, Schizophrenia
- Nerve: Multiple Sclerosis, Epilepsy, Parkinson's Disease, Neuropathy, Restless Leg Syndrome
- Other: Items in small amounts too small to be included in chart
- Pain (other): Migraine, Muscle Relaxer
- Pain Treated by Opiates: Opiate Medications
- Skin: Acne, Actinic Keratosis, Angioedema, Anti-Inflammatory Steroid, Antipruritic, Athlete's Foot, Botox, Dermatitis, Eczema, Psoriasis, Rosacea, Severe Acne, Seborrheic Dermatitis
- Thyroid: Thyroid Disorders

Another way to look at changes in prescription prices is depicted in the figures below. Figures 2 and 3 look at all medication price changes, independent of drug lists, that have been billed to Medicaid over the years this program has been in place. For each year, the number evaluated is based on NDCs billed to Medicaid in that year. The price change is measured from December 31 of the previous year through December 31 of the year indicated.

Figure 2 depicts the number of NDCs billed to Medicaid that had significant price increases each year.

Figure 2. Number of Drugs with WAC Increases by Year

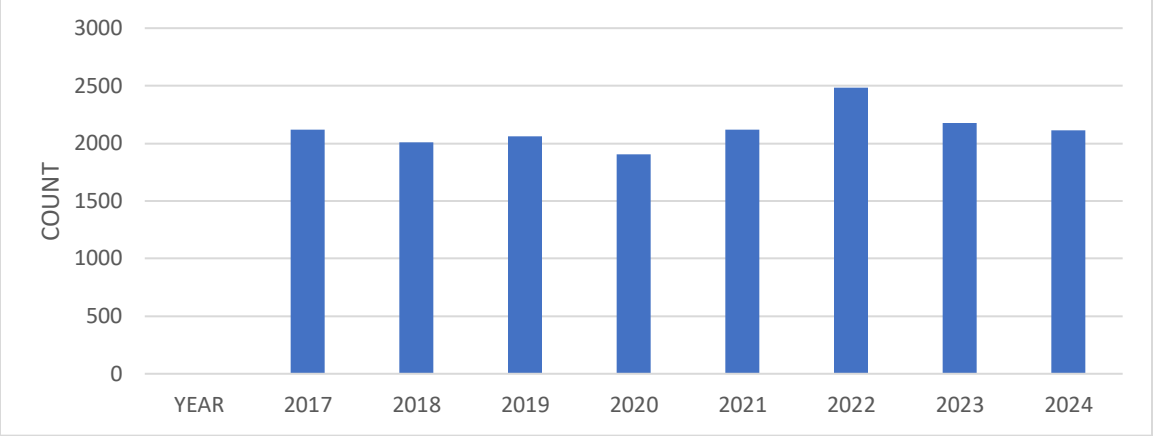
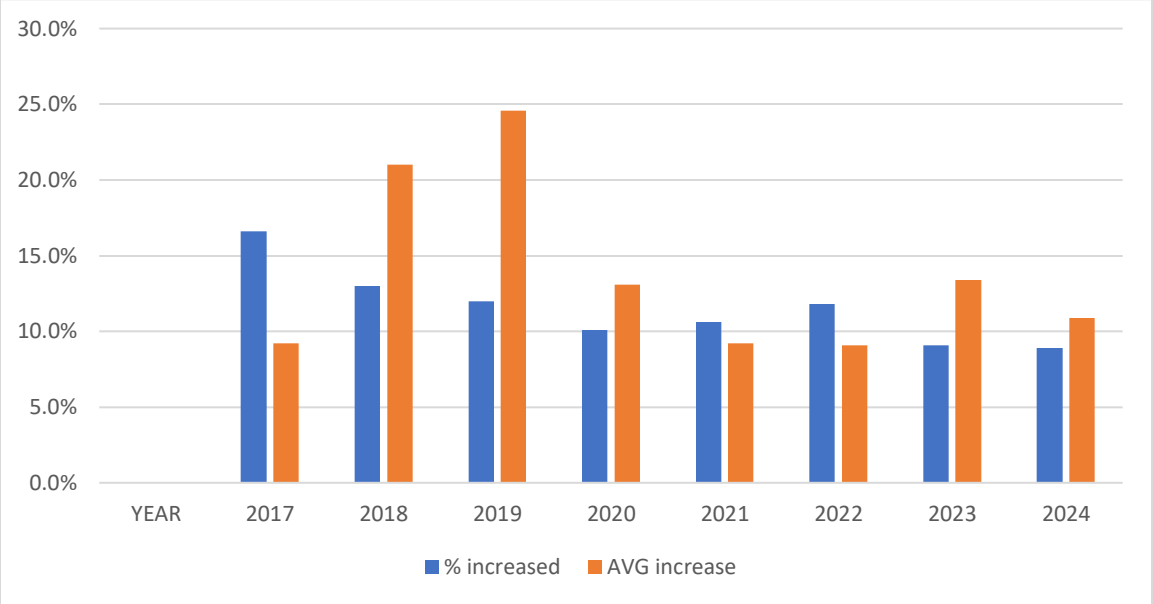


Figure 3 depicts the number of NDCs represented in Figure 2 as a percentage of all NDCs billed to Medicaid that year, alongside the average percent increase in WAC. This is displayed year over year.

Figure 3. Percent Increase and Average WAC Increase



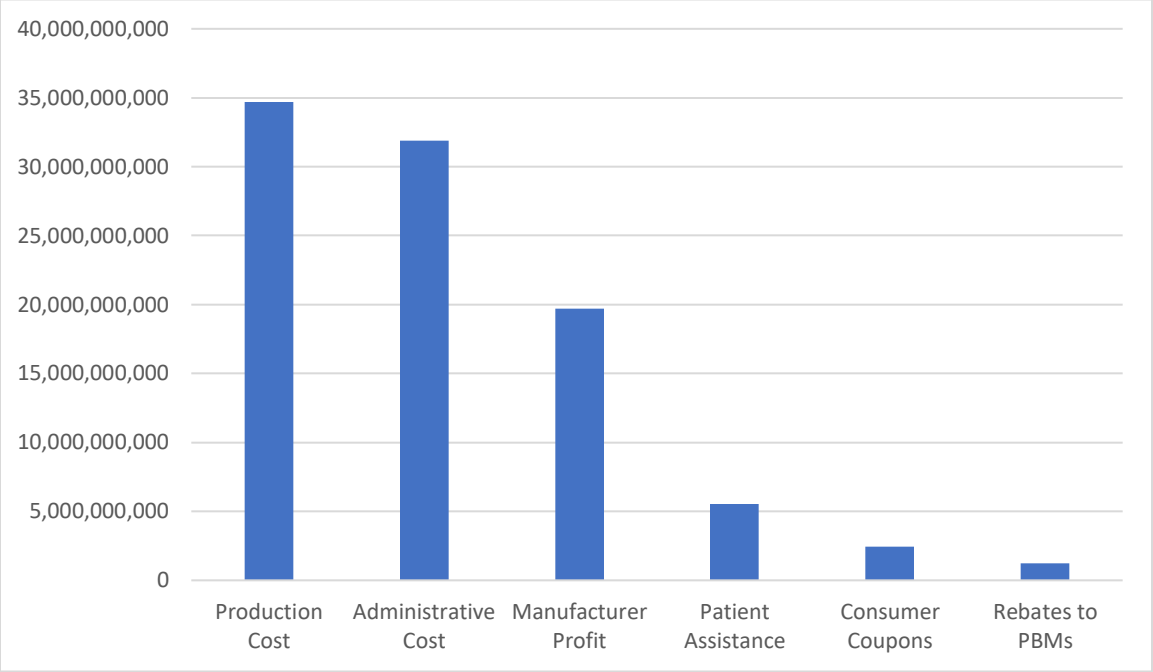
Drug Manufacturer Financial Assistance and PBM Rebates

Manufacturers reported the financial assistance provided to consumers and rebates that were provided to PBMs (Figure 5).

Many of the Essential Diabetic Drugs are generic and typically do not provide aid in the form of rebates, patient assistance, or coupons. The total amount of financial assistance provided through patient prescription assistance programs was $5,543,095,234.

The value of the aggregate rebates that manufacturers provided to PBMs that were reported to this program for Nevada drug sales was $1,215,562,800. Some responders reported they are unable to separate out data specific to Nevada and instead reported their data for the entire U.S.

Figure 4. Manufacturer Profit Compared to Other Expenses



Manufacturer Price Increase Justifications

Price increases were reported in two places. Manufacturers of medications on List #2 and #4 had to explain any increases in the last five years. This included even minimal increases that did not meet criteria (defined in NRS 439B.630). This information is depicted in Figure 6.

Increases that met the criteria described in NRS 439B.640 were reported separately via the "increase" report. Those increases are depicted in Figure 7.

Justifications for price increases were standardized into ten major categories. These responses were then quantified and compared for their relative prevalence. In some cases, a single drug had more than one price increase justification.

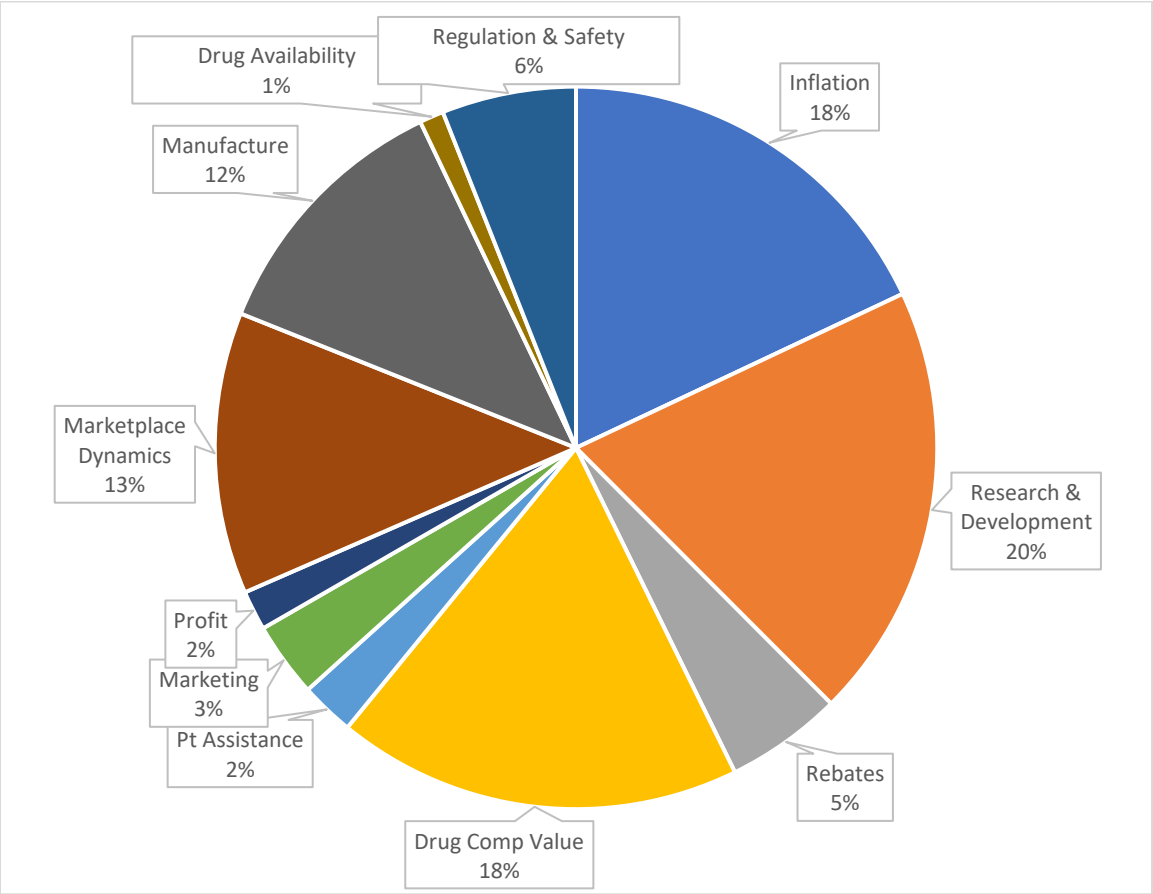
Below is a summary of each price increase justification category. This summary applies to both Figure 5 and Figure 6.

- Advertising and Marketing: Responses indicated a need to promote awareness of drugs through advertisements and further workforce training relating to sales.

- Drug Has More Competitive Value: Responses outlined that the drugs had more value to patients and the market. Drugs were also defined as innovative and effective and thus having more economic value to patients compared to other drugs on the market.
- Inflation: Responses referenced general inflation that occurs in the medical market.
- Manufacturing Cost: This category related specifically to investments in manufacturing or improving or constructing new drug manufacturing facilities. This includes responses that outlined higher drug production costs and higher costs relating to commercial transportation.
- Marketplace Dynamics: Responses indicated that market or commercial conditions induced in part the need for a price increase.
- Patient Assistance and Educational Programs: Responses specified that additional funds were needed to cover the costs of administering patient assistance and educational programs.
- Profit: Responses referenced that manufacturer had a responsibility to improve or maximize value for investors or shareholders. It was also indicated that manufacturers needed to increase prices to avoid not generating a profit at all.
- Rebates: Drug manufacturers enter contractual agreements to pay intermediaries like PBMs, insurers, labelers or distributors, group purchasing organizations, and other entities. Multiple responses indicated that PBMs and other entities are requiring larger discounts and rebates.
- Regulatory and Safety Commitments: Responses in this category related to drug manufacturers' responsibility to fulfill governmental safety, licensing, and reporting responsibilities, including new or additional regulatory requirements.
- Research and Development: This category includes responses indicating that additional funds would support research and development of existing Essential Drugs and future medicines. It was indicated by manufacturers that drug research continues even after the FDA approves their drugs to verify safety and improve product formulations.

Figure 5: Justifications for Any Price Increases for EDDs and Over $40 Drugs

For Figure 5 the most reported answer was research and development at 20%.

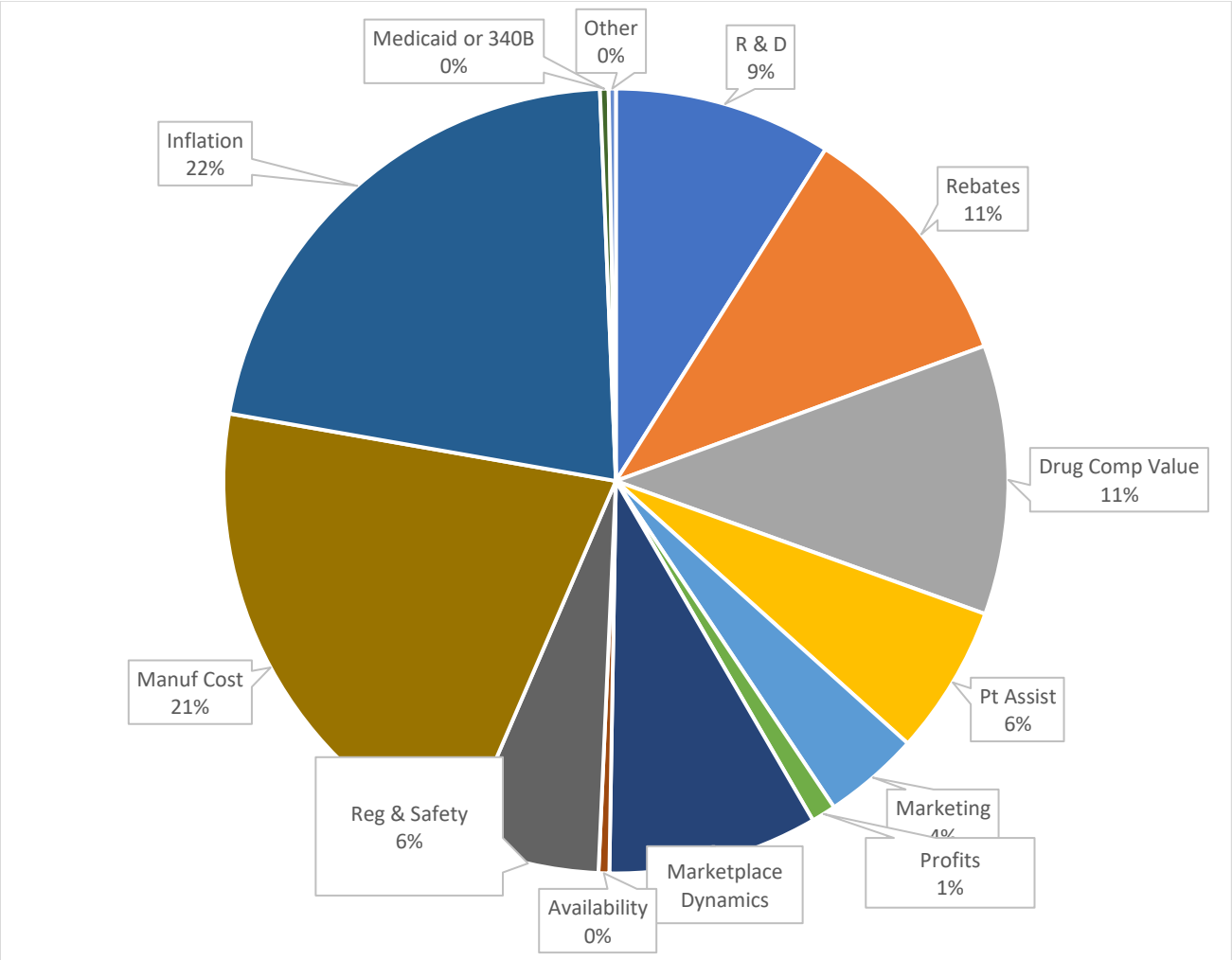


Manufacturer Price Increase Justifications per NRS 439B.640

Drugs on list #3 or #4 that experienced an increase that met criteria also require reporting on the justification for the price increase from the prior reporting year. This differs from what is reported in Figure 6 due to the time periods that are to be addressed (five years for Figure 6 and two years for Figure 7). However, the responses were similar.

Notably, some respondents reported a philosophy regarding how drugs should be priced, rather than drug specific information.

Figure 6: Justifications for Price Increases per NRS439B.640



For Figure 6, the most reported justification was inflation at 22%, which is the same as last year.

Pharmacy Benefit Manager Reporting

PBMs reported the rebates negotiated with drug manufacturers and pharmacies during the immediately preceding calendar year for prescription drugs included on Nevada Drug Lists. PBMs reported the rebates they retained, as well as the rebates that were negotiated for purchases of such drugs for use by:

- recipients of Medicaid,
- recipients of Medicare,
- persons covered by third party governmental entities that are not Medicare and Medicaid,
- persons covered by commercial insurance,
- persons covered by all other third parties.

Table 7 represents PBM rebate information negotiated with manufacturers, while Table 8 depicts PBM rebate information negotiated specifically with pharmacies.

Table 7: Total Reported Rebates Negotiated by PBMs with Manufacturers

Reported Value Description	Value	Percent
Total amount of all rebates that the PBM negotiated with manufacturers	$155,450,317	100.00%
Total amount of all rebates described in Row 1 that were negotiated for use by recipients of Medicaid	$4,616,814	2.97%
Total amount of all rebates described in Row 1 that were negotiated for use by recipients of Medicare	$20,822,109	13.39%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by governmental entities that are not Medicaid or Medicare	$25,942,190	16.69%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by commercial insurers	$103,823,394	66.79%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by all other third parties	$1,593,254	1.02%
Total amount of all rebates described in Row 1 that were retained by the PBM	$9,651,814	6.21%

Table 7 shows us that PBMs negotiated a total of $155,450,317 in rebates with manufacturers.

Rebate Distribution

The rebates were distributed across various sectors:

- Commercial Insurers: The largest portion of rebates, $103,823,394 (66.79% of the total), was negotiated for use by persons covered by commercial insurers
- Medicare: $20,822,109 (13.39% of the total) was negotiated for use by persons covered by Medicare
- Other Governmental Entities: The second-largest share $25,942,190 (16.69%) was negotiated for use by persons covered by governmental entities other than Medicaid or Medicare
- Medicaid: $4,646,814 (2.97%) was allocated for use by Medicaid recipients
- Other Third Parties: A small portion, $1,593,254 (1.02%), was negotiated for use by persons covered by all other third parties

PBM Retention

The PBMs retained $9,651,814, which represents 6.21% of the total rebates negotiated.

Key Observations

- Commercial Dominance: Nearly two-thirds of the rebates were negotiated for commercial insurance, indicating a significant focus on this sector.
- Government Programs: Combined, Medicare and Medicaid account for over 32% of the total rebates, highlighting the importance of these public health programs.
- PBM Profit: The PBM's retention of 6.50% of the total rebates suggests a substantial financial benefit from these negotiations.
- Diverse Allocation: The distribution across various sectors demonstrates the PBM's involvement in multiple healthcare payment systems.

Table 8: Total Reported Fees Negotiated by PBMs with Pharmacies

Reported Value Description	Value	Percent
Total amount of all rebates that the PBM negotiated with pharmacies	$138,881,616	100.00%
Total amount of all rebates described in Row 1 that were negotiated for use by recipients of Medicaid	$778,515	0.56%
Total amount of all rebates described in Row 1 that were negotiated for use by recipients of Medicare	$49,095,830	35.35%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by governmental entities that are not Medicaid or Medicare	$19,998,646	14.40%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by commercial insurers	$68,977,444	49.68%
Total amount of all rebates described in Row 1 that were negotiated for use by persons covered by all other third parties	$31,134	0.02%

Table 8 demonstrates that the total amount of discounts and fees negotiated with pharmacies is $138,881,616.

This data provides insight into the complex rebate negotiation process in the pharmaceutical industry and the role of PBMs in managing these rebates across different healthcare sectors.

Implications

This distribution of negotiated discounts and fees could reflect various factors, including:

- The relative size of each sector's patient population
- Differences in negotiating power among different healthcare payers
- Variations in drug utilization patterns across different patient groups
- Policy and regulatory influences on pharmacy benefit negotiations

Understanding these patterns can be crucial for policymakers, healthcare providers, and insurers in assessing the equity and efficiency of pharmacy benefit negotiations across different healthcare sectors.

Pharmaceutical Representative Reporting

Nevada's pharmaceutical sales representative reporting requirements, as outlined in NRS 439B.660, mandate the following:

Manufacturers must register their sales representatives that conduct business in Nevada. These sales representatives must then submit an annual report detailing their activities in the state. This includes distribution of drug samples as well as any compensation provided in the previous year.

Reportable Recipients

The following individuals must be included in the reports if they received eligible compensation or samples:

- Licensed, certified, or registered health care providers
- Pharmacy employees
- Operators or employees of medical facilities
- Individuals licensed or certified under Title 57 of NRS

Eligible Compensation

Compensation that must be reported includes:

- Any single item valued at $10 or more
- Total compensation with an aggregate value of $100 or more

Reporting Statistics for 2024:

- 296,936 pharmaceutical representatives' events were reported
- 1,569 individuals had activity to report
- 259 different companies were involved

Many reported events involved multiple recipients, such as group lunches.

Compensation Provided by Pharmaceutical Representatives

Nevada healthcare providers and their staff received a total of $6,775,548 in compensation from pharmaceutical representatives during the reporting year (Table 9). The average compensation per person was $22.09, indicating that most interactions involved small-value transactions, as was the case in previous years. The reported compensation was categorized into two types:

- Meal-related compensation: This category accounted for over 95% of the total compensation dollars, consistent with the previous year's results. The average meal-related compensation was $21.12.
- Other compensation: The remainder of the total compensation fell into this category. This includes, but is not limited to consultation, education and promotional materials.

This data suggests that most pharmaceutical representative interactions with healthcare providers, support staff, and administration primarily involved providing meals or food-related compensation.

Table 9: Pharmaceutical Representatives Compensation by Compensation Type

Year	Total	Average Per Person
2021	$3,360,479	$21.12
2022	$5,032,398	$21.05
2023	$5,961,471	$19.61
2024	$6,775,448	$22.09

Aggregate reported compensation values were categorized by recipient type in Table 10. Compensation is a blanket term for items of value transferred to a recipient and only rarely (less than 1% of events) refer to an actual transfer of money.

Some activity was reported that was not specific to a Nevada representative. This included 3,459 more “events.” 76% of these were sampling events and 18% were meals, as well as a few cases of education or educational materials provided. This activity is not included in charts and figures that represent activity specific to Nevada registered representatives.

Table 10: Compensation by Recipient Type

	2022		2023		2024	
Recipient Type	*Total*	*Average*	*Total*	*Average*	*Total*	*Average*
Pharmacist	$110,206	$27.06	$108,895	$27.67	$120,893	$28.50
Physician Assistant	$80,636	$21.67	$87,646	$19.46	$96,357	$20.81
RN/LPN	$225,957	$23.68	$289,640	$23.65	$301,736	$24.81
Nurse Practitioner	$173,710	$24.21	$196,676	$21.96	$236,317	$21.88
Office Staff*	$2,468,127	$19.77	$3,349,964	$18.27	$3,445,291	$22.86
Other Healthcare Provider	$1,051,671	$19.52	$807,464	$18.58	$1,333,718	$19.67
Other Non-Healthcare Provider	$418,752	$18.61	$490,445	$18.55	$485,500	$22.85
Doctor (MD or DO)	$556,495	$33.78	$628,486	$29.73	$755,634	$31.16

*includes not specified and “other”

Compensation Overview by *Recipient Type*

Overall, many recipient types experienced an increase in total compensation over the years. However, this did not always translate into higher average compensation.

- Office staff saw the most significant increase in total compensation.
- Doctors continue to have the highest average compensation among all recipient types listed.

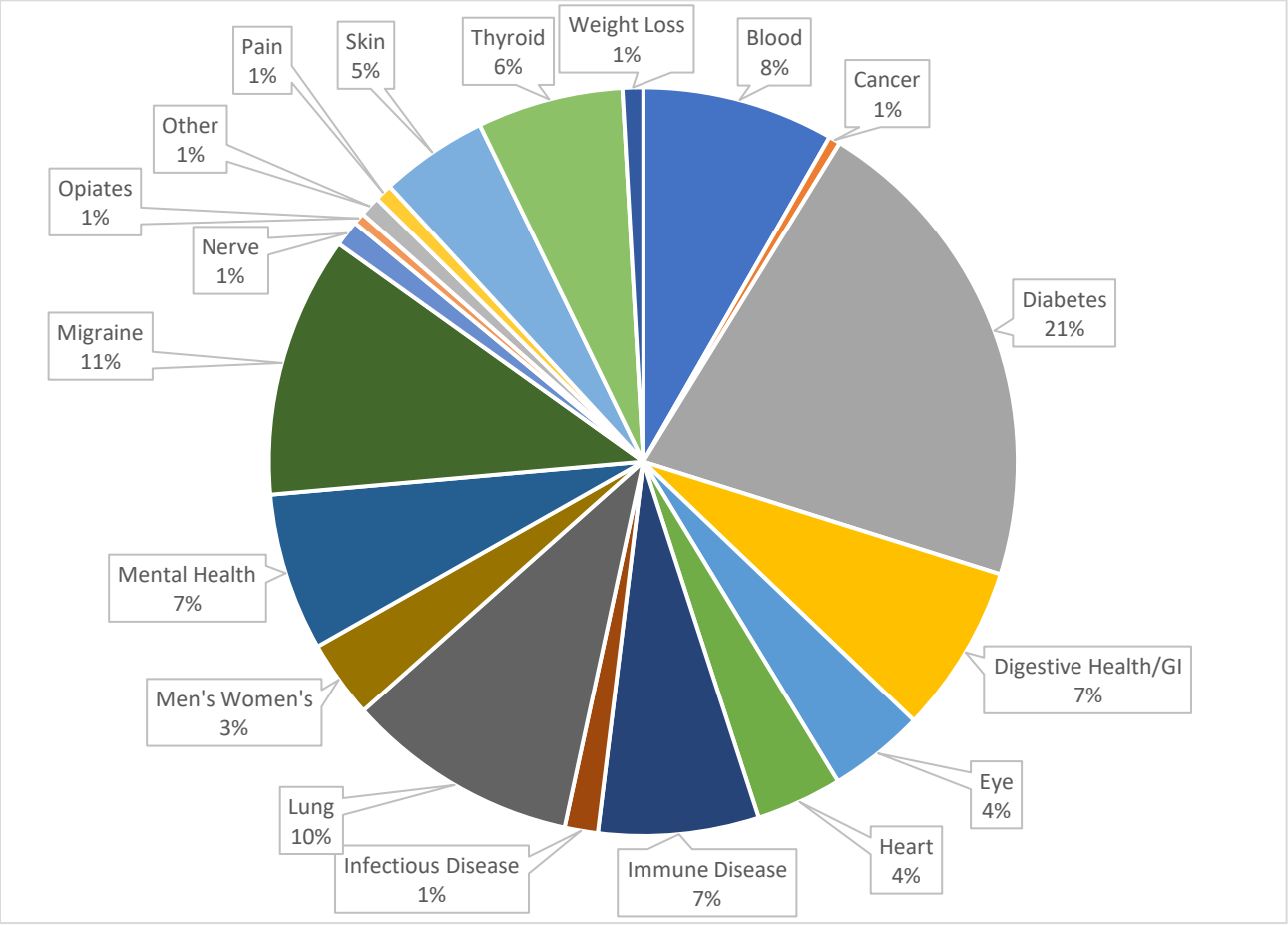
This analysis provides insights into the changes in financial distribution across different healthcare roles over the years and highlights trends that might be useful for policy-making decisions within healthcare organizations.

The following are examples of professions grouped into select recipient categories:

- Office Staff: receptionists, general office staff, scribe, scheduler

- Other Non-Healthcare Provider: administration, technician, optical technician, pharmacy technician
- Other Healthcare Provider: clinical social worker, therapist, psychologist, social worker, doctor of podiatric medicine, optometrist, dentist

Figure 7: Percentage of Drug Samples Distributed by Targeted Health Condition



(Values of less than 1.0% were included in "other" category in the figure above.)

Figure 7 depicts drug sample distribution broken down by health condition. Those conditions are grouped and further explained below.

The drug samples most frequently provided were to treat diabetes (21%). This has been the case in all years the program has monitored this activity. The following includes health conditions grouped into each major category utilized in Figure 8:

- Blood Disorder: Anemia, Venous Thromboembolism, Kidney Conditions, Blood Clots
- Cancer: Cancer, Carcinoid Syndrome Diarrhea, Cancer-related Nausea and Vomiting
- Diabetes

- Digestive Health: Acid Reflux, Bowel Prep, Crohn's Disease, Ulcerative Colitis, Exocrine Pancreatic Insufficiency, Heartburn, Hemorrhoids, Irritable Bowel Syndrome, Overactive Bladder, Pancreatic Insufficiency, Ulcer
- Eye Health: Conjunctivitis, Dry Eye, Eye Pain and Swelling, Glaucoma, Macular Degeneration
- Heart: Angina, Atrial Fibrillation, Cardiovascular Disease, Heart Attack, Stroke, Heart Disease, Heart Failure, High Cholesterol, Hypertension
- Infectious Disease: Hep C, Systemic Bacterial Infections, HIV
- Immune Disorder: Auto Immune Diseases, Osteoarthritis, Psoriatic Arthritis, Rheumatoid Arthritis
- Lung Health: Asthma, Chronic Obstructive Pulmonary Disease
- Men's & Women's Health: Birth Control, Endometriosis, Erectile Dysfunction, Fertility, Infection - Women's Health, Menopause, Prostate, Low-Testosterone, Vaginal Dryness, Osteoporosis, Urinary Tract Infection
- Mental Health: Attention Deficit Hyperactivity Disorder, Binge Eating Disorder, Alzheimer's Disease, Bipolar Disorder, Depression, Schizophrenia, Pseudobulbar Affect
- Nerve Disorder: Multiple Sclerosis, Epilepsy, Parkinson's Disease, Neuropathy, Narcolepsy, Tardive Dyskinesia
- Opioid & Opioid Abuse Treatment: Drug Withdrawal, Opioid Managed Pain, Opioid-Induced Constipation
- Other: Allergies, Botox and similar products (multiple indications), Oral or Injectable Steroids (multiple indications), drugs that fit no other listed category
- Migraine
- Pain Relief: Gout, Pain Treated with Topical NSAIDs, Topical Lidocaine and Oral NSAIDs
- Skin conditions: Acne, Actinic Keratosis, Angioedema, Fungal Skin Infections, Parasitic Skin Infections, Antipruritic, Athlete's Foot, Dermatitis, Eczema, Psoriasis, Rosacea/Severe Acne, Seborrheic Dermatitis, Itchy Skin
- Weight Loss

Wholesalers

Sixteen wholesalers reported paying rebates this reporting period. Many wholesalers reported no rebates paid and those reports are not included here. Data reported included 892,859 units shipped into Nevada, $35,367,830 in rebates paid to manufacturers and $33,471,629 in rebates paid to pharmacies or PBMs.

Report Methodology and Reporting Compliance

This report complies with NRS 439B.650 requirements, presenting only aggregated data that safeguards the identity of specific drugs, manufacturers, and PBMs, as stipulated by Nevada Administrative Code 439.740. Unless otherwise specified, the information pertains to the 2024 calendar year.

Data Analysis Methodology

To enhance the accuracy of our analysis, manufacturer responses to price increase justifications were weighted. This approach ensures that the results more precisely represent the studied information:

- Each manufacturer's response is counted for every NDC it represents, rather than per respondent.
- For instance, a manufacturer with one NDC is counted once, while a manufacturer with 10 NDCs is counted 10 times.

Summary of Reports Provided and Analysis

- Reports Provided
    - Essential Diabetic and Over $40 Report
        - Total manufacturer reports: 102
        - Reports indicating price increases in the past five years: 63
    - Significant Price Increase Report
        - Total manufacturer reports: 55
- Essential Diabetic and Over $40 Report Drug Manufacturer Reporting
    - The manufacturer reported values for costs, profits, and rebates attributable to Essential Medications and medications that appeared on the Over $40 List were aggregated.
    - Manufacturers provided justifications for all price increases over the last five years. This contrasts with the price increase report as five years are included, and it includes all increases, even if it does not meet the criteria of NRS439B.640.
    - This reporting was required for drugs on Nevada Lists #2 and #4.
- Price Increase Justification
    - Drug manufacturers reported justifications for price increases of drugs on Nevada Lists #3 and #4. Responses were standardized into categories as described in this report so that they could be quantified and compared for their relative frequency. Manufacturers often reported one or more justifications for the drug price increases. They provided a percentage of influence on price increase for each factor. Scoring was completed at NDC level rather than at manufacturer level.
- PBM Rebates
    - PBMs submitted rebate information for all drugs on List #2 and #4. Some PBMs reported zero dollars for rebates negotiated with manufacturers. In those cases, they only reported negotiated rebates with pharmacies. All PBM reported rebates were totaled to create Tables 7 and 8.
- Pharmaceutical Representative Compensation and Samples Data

- All pharmaceutical drug representative compensation and samples reports received were standardized and merged into one dataset. DHHS received 296,936 pharmaceutical representative compensation and samples records.

Key Findings

- Medicaid Prescription Spending
  - Total Medicaid spending on medications increased by 109.7% since program inception in 2017.
  - The average cost per claim rose by 43.5% during this period.
  - In 2024, a notable 5.61% decrease in the average cost per claim was observed, the first such decrease since program inception.
- Essential Diabetes Drugs
  - 123 out of 1,019 essential diabetes drugs (12.1%) experienced price increases that exceeded medical inflation.
- Manufacturer Price Increase Justifications
  - Research and development costs (20%), inflation (18%), and comparative drug value (18%) were the most cited justifications for price increases.
- Pharmacy Benefit Managers (PBMs)
  - PBMs reported $155,450,317 in rebates with manufacturers.
  - 66.79% of these rebates were allocated to commercial insurers.
  - PBMs retained 6.21% ($9,651,814) of the total rebates.
- Pharmaceutical Representative Activity
  - 296,936 pharmaceutical representative events were reported.
  - Healthcare providers received $6,775,548 in total compensation.
  - Over 95% of compensation was meal-related, with an average value of $21.12.
  - Diabetes medications accounted for 21% of all drug samples distributed to healthcare providers.
- Wholesaler
  - Sixteen wholesalers reported $35,367,830 in rebates paid to manufacturers.
  - $33,471,629 in rebates were paid to pharmacies or PBMs.

Conclusion

This report aims to improve transparency in pharmaceutical pricing for Nevada policymakers, healthcare providers, and consumers. It highlights the complex financial relationships between various stakeholders in the pharmaceutical supply chain and identifies potential areas for policy intervention to improve medication affordability and access.

More Information

The DHHS Drug Transparency website is available at drugtransparency.nv.gov

For email notifications and Nevada Drug Transparency information and updates, subscribe to the LISTSERV online at Drug Transparency - LISTSERV (nv.gov).

Feedback and questions can be directed to drugtransparency@dhhs.nv.gov