

# Coverage Completeness and Treatment Cost Estimation for Administered Drugs in US Commercial Payer Price Transparency Data

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## Objectives

To evaluate whether payer-posted Transparency in Coverage negotiated rates can support reliable, repeatable life sciences analyses for physician-administered drugs. We assessed: 1) coverage completeness across the Part B ASP administered-drug universe, 2) commercial reimbursement variation relative to Medicare ASP, and 3) whether unit-level negotiated rates can be linked to claims-derived utilization to estimate treatment-level and population-level cost burden for specific administered therapies.

## Methods – Data Coverage and Rate Benchmarking

We ingested and normalized payer TIC machine-readable files for 876 administered-drug HCPCS/CPT codes and benchmarked commercial negotiated rates to Medicare Part B ASP payment limits posted by 202 US commercial payers (N=8.3 billion observations), comparing these results. Coverage was assessed against the Part B ASP administered-drug universe, with a related coverage assessment made for corresponding hospital-reported price transparency data. Rates were summarized by payer, network, provider organization, billing class, geography, and code. Claims-derived dosing, visits per year, and treated prevalence were used to estimate per-treatment costs, annual allowed amount per treated member, and modeled exposure per 100K covered lives.

Breadth of Coverage for Part B Drugs Across Payer-, Hospital-, and Matched Price Transparency Data, March 2026

Source	Code	Match Rate	Matched	Unmatched	Matched	Unmatched	Matched	Unmatched	Matched	Unmatched
Commercial Payer	876,000	85%	745,000	131,000	85%	745,000	131,000	85%	745,000	131,000
Hospital	876,000	85%	745,000	131,000	85%	745,000	131,000	85%	745,000	131,000
Matched	876,000	85%	745,000	131,000	85%	745,000	131,000	85%	745,000	131,000

## Methods - Treatment Cost Modeling

We translated HCPCS code-level negotiated rates into three complementary cost views for medical-benefit drugs:

- Per-treatment cost:** In-network negotiated rate per billable unit × units per administration
- Per-member per year (PMPY) spending per treated member:** negotiated rate per billable unit × claims-derived units per visit × visits per treated member per year
- Modeled PMPY spending per 100K covered lives:** annual allowed amount per treated member × treated prevalence

These views distinguish therapies that are economically important because of high unit cost, repeated utilization, or broad treated prevalence.

## Acknowledgements

A multidisciplinary team at Serif Health compiled, enriched, and analyzed the price transparency and claims data utilized in presented analyses. We are also thankful to payer, patient advocacy organization, and US federal government contacts with whom we have discussed these and related findings.

## Tables and Figures

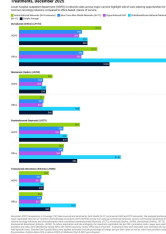
Top Administered Drugs by PMPY Spending among Treated Patients in 2025

HCPCS Code	Drug Name	Brand Name	Medication Class	Therapeutic Area	Share of Total PMPY	Median PMPY	Annual Total PMPY	Median PMPY	Annual Total PMPY
J08B	Trastuzumab	Herceptin	Anticancer	Breast Cancer	10%	\$1,200	\$120,000	\$1,200	\$120,000
J02B	Insulin	Humalog	Antidiabetic	Diabetes	8%	\$100	\$8,000	\$100	\$8,000
J01B	Amoxicillin	Amoxil	Antibiotic	Infectious Disease	5%	\$20	\$2,000	\$20	\$2,000

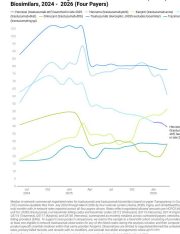
Top Administered Drugs by Estimated PMPY Spending per 100K Lives in 2025

HCPCS Code	Drug Name	Brand Name	Medication Class	Therapeutic Area	Share of Total PMPY	Median PMPY	Annual Total PMPY	Median PMPY	Annual Total PMPY
J08B	Trastuzumab	Herceptin	Anticancer	Breast Cancer	10%	\$1,200	\$120,000	\$1,200	\$120,000
J02B	Insulin	Humalog	Antidiabetic	Diabetes	8%	\$100	\$8,000	\$100	\$8,000
J01B	Amoxicillin	Amoxil	Antibiotic	Infectious Disease	5%	\$20	\$2,000	\$20	\$2,000

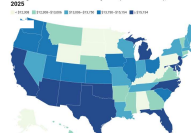
Office of Inspector General: Average Professional Pricing for Select Drugs



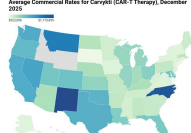
Median In-Network Negotiated Rates for Trastuzumab (J7740) and Insulin, 2014 - 2025 (Four Payers)



Average Commercial Rates for Keytruda (Pembrolizumab), December 2025



Average Commercial Rates for Curvitec (CAR-T Therapy), December 2025



## References

Whaley, CM, et al., Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020.  
Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. Report. January 20, 2022.  
Hernandez, I, et al., Limited utility of price transparency data for drugs. Journal of Managed Care & Specialty Pharmacy. 2025;31(4):338-342. doi:10.18553/jmcp.2025.31.4.338.

## Results

Payer TIC files covered all 876 Part B ASP administered-drug codes in the March 2026 analytic snapshot. Rates were observed across 202 payers, 519 networks, 1.28M billing organizations, and more than 8.3B negotiated rate observations. Commercial rates were generally centered near Medicare Part B ASP, but variation was substantial: 25% of in-network negotiated rates exceeded 112% of Medicare, and the top 5% exceeded 559%. For pembrolizumab, for example, state-level average commercial reimbursement for a standard 200 mg administration ranged from under \$12,000 to over \$30,000. Across selected oncology infusions, office reimbursement exceeded HOPD reimbursement for several branded therapies, but the direction and magnitude vary by payer. When linked to claims-derived dosing and treated prevalence, TIC rates can be scaled from unit reimbursement to treatment episodes, annual allowed amounts per treated member, and modeled plan-level exposure. This approach separates high-cost episodic therapies, such as CAR-T and rare-disease treatments, from chronic infused biologics and high-volume office-administered drugs, which may create meaningful population-level burden despite lower unit prices. In the PMPY spending per 100K lives framework, modeled spending is highly concentrated: the Top 100 administered-drug codes capture approximately 93% of modeled administered-drug exposure, while the Top 10 alone capture approximately 59%, highlighting why a focused high-cost drug universe can support practical prioritization for market access and HEOR teams.

## Conclusions

First released in 2022, payer-reported TIC data has matured into a usable national reimbursement benchmark for physician-administered drugs. Near-complete Part B code coverage, payer/provider specificity, and claims-linked utilization modeling create practical applications for market access, health economics, and other real-world economic evaluation, while ongoing improvements in file consistency and identifier completeness will further strengthen cross-payer comparability.

## Limitations

In-network rates posted by commercial payers under the US Transparency in Coverage regulations represent contracted in-network rates paid to providers and do not directly incorporate rebates, chargebacks, 340B acquisition cost, patient cost sharing requirements, or net manufacturer revenue. Results vary by payer, billing-unit conventions, provider identifier completeness, and the availability of claims-derived utilization inputs. Hospital price transparency files provide useful complementary context but require additional standardization before broad drug-price inference.

## Discussion

Payer-reported price transparency data can now support repeatable commercial reimbursement benchmarks for all administered drugs. When paired with claims-derived utilization, these rates can be used to calculate treatment costs and thus inform budget impact modeling, account planning, site-of-care strategy, payer segmentation, and competitive intelligence for biosimilars and high-cost specialty therapies. TIC should be interpreted as a reimbursement benchmark, not a direct measure of net manufacturer price.

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