MARCH 2015

THE 2014 DRUG TREND REPORT MEDICAID

THE EXPRESS SCRIPTS LAB®

CONTENT

MEDICAID

MEDICAID YEAR IN REVIEW

During 2014, multiple factors affected trend for health plans that manage pharmacy benefits for Medicaid beneficiaries, including: the expansion of Medicaid coverage and subsequent increase in Medicaid beneficiaries that followed implementation of the 2010 Affordable Care Act (ACA); changes to the Medicaid program by state legislatures, and clinical advances and subsequent treatment guideline updates.

Expansion of Medicaid Coverage

In support of its goal of decreasing the number of uninsured Americans and making health insurance more affordable, the ACA gave states the option of receiving federal funds to offset the costs of raising the Medicaid threshold to households with incomes less than 138% of the federal poverty level. The legislatures in 25 states, along with the government of the District of Columbia, chose to raise eligibility thresholds in 2014. In addition, the ACA extended Medicaid coverage to childless adults, who previously had not been eligible for the program.[1] Consequently, we saw the number of Medicaid beneficiaries over age 19 grow from 40.2% in 2013 to 44.2% in 2014. Also contributing to growth in the Medicaid population was what has been called "the woodwork effect." As some individuals were applying for health insurance coverage through the federal exchange or one of the 25 state exchanges, they discovered that they were eligible for Medicaid coverage and thus were "drawn out of the woodwork." As a result, 8.7 million adults and children were added to the Medicaid program in 2014, bringing the number of Medicaid beneficiaries nationwide to 67.9 million.[2]

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With their numbers of Medicaid beneficiaries increased dramatically but unevenly, states took varying approaches to managing the Medicaid pharmacy benefit. Many that chose Medicaid expansion had previously used some form of managed care to control the operational and medical costs of managing enrollee benefits. A few states implemented managed care tools for their expansion population, using a different care model than they had previously utilized. This resulted in various levels of trend management success across states.

State Legislation

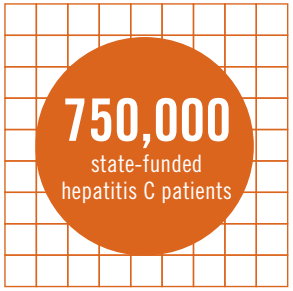
In 2014, some states enacted legislation that changed the requirements for the management of prescription drug benefits, thereby limiting the strategies available to Medicaid plan sponsors to control the cost and utilization of the pharmacy benefit.

As part of Florida's statewide expansion of managed care Medicaid, that state now requires all participating health plans to use a state-mandated formulary for the first year of a contract. The state of Washington took a different approach, enacting regulations that require health plans to maintain an "open" formulary status for patients who continue to fill prescriptions for previously prescribed atypical antipsychotics, antidepressants and medications for attention deficit hyperactivity disorder (ADHD).

Meanwhile, New York made changes to its "Prescriber Prevails" program; implemented in 2012, the program allows a prescriber's professional judgment to prevail in the prior-authorization process, thereby allowing some patients to bypass the prior authorization process usually required for some drugs. Originally focused on medically necessary atypical antipsychotics, the New York program was expanded in 2013 to apply to other drug categories, including transplant medications, antidepressants, specialty inflammatory condition therapies and anti-seizure medications. In 2014, New York continued to add medications to this list, which affects the ability of Medicaid payers to manage costs.

Clinical Advances

The largest impact on trend for Medicaid plans in 2014 stemmed from U.S. Food and Drug Administration (FDA) approval of three expensive new oral hepatitis C treatments: Sovaldi® (sofosbuvir), Olysio® (simeprevir) and Harvoni® (ledipasvir/sofosbuvir). Treatment with these specialty drugs is one of the most expensive therapeutic regimens available, and the cost for a course of therapy can reach as high as $150,000. With more than 750,000 patients with chronic hepatitis C receiving state-funded healthcare through either Medicaid or the prison system, the burden of paying for the cost of these hepatitis C treatment regimens falls disproportionately on state budgets, as opposed to commercial insurance plan budgets.



Based on the pricing strategy offered by drug manufacturers when Sovaldi first launched, Express Scripts projected that states would spend a total of more than $55.2 billion if they provided all these hepatitis C patients with one of the newest therapy regimens that included Sovaldi. Express Scripts estimated that five states would be faced with the highest spend: California, Texas, Florida, New York and Illinois.

Because Sovaldi was released in late 2013, after most state Medicaid agencies had calculated their capitation rates for managed care organizations for 2014, those rates did not take into account the cost of these new, expensive treatment regimens. Neither had most state Medicaid agencies predicted the impact that paying for these therapies would have on their budgets. This concern was raised by state Medicaid agencies in 2014, as they tried to create treatment guidelines while facing high demand for these products and large financial outlays.

The concerns of state agencies were warranted. Hepatitis C medications had a trend of 317.2% for 2014 – a higher trend than that for any other therapy class. In addition, the per-member-per-year (PMPY) spend for this therapy class, at $55.02, was higher than the spend for all but three of the top 10 therapy classes across both traditional and specialty drugs – even though the prevalence of use for hepatitis C medications was dramatically lower than that for other medications in the top 10 classes. This dramatic increase in spend is reminiscent of the staggering increases in price for HIV/AIDS medications that were seen in the early 2000s, when the new subclass of antiretroviral therapy became the standard of care for HIV/AIDS.

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TREND MANAGEMENT STRATEGIES

Tighter Specialty Drug Management and Accredo

While Express Scripts and our clients continue to advocate for more sustainable and fair drug pricing, there are important strategies that Medicaid plans can implement to ensure the most appropriate use of these medications. One recommended strategy is tighter management for high-priced specialty medications to help ensure that the right patients receive the right treatments. This tighter management can occur through updated prior authorization and treatment guidelines, including the use of exclusive specialty drug distribution channels like Accredo, the Express Scripts specialty pharmacy.

We have seen state Medicaid agencies implement various guidelines, such as making viral load testing a requirement for continued authorization of medication; split-fill dispensing, allowing only 14-day dispensing; evaluation of illegal drug use; and retreatment limits. We encourage health plans to review and consider the approaches taken in the marketplace as they create their own guidelines.

Encouraging the use of exclusive specialty drug distribution channels like Accredo – rather than retail pharmacies – can dramatically improve medication adherence. For example, among patients with cancer, our specialized care improved medication adherence by 16 percentage points; among patients with multiple sclerosis, adherence improved 32 percentage points.

Medication adherence is critically important for patients with conditions such as hepatitis C – from the standpoint of both the high costs of the newer therapies being used to treat the condition and concerns about clinical effectiveness and possible future complications due to nonadherence. A recent analysis underlines the importance of Accredo's programs for patients with hepatitis C. It found that hepatitis C patients who do not experience the unique clinical model available through Accredo are nearly twice as likely to fail their therapy.

Smart Formulary Management

Another strategy we recommend is smart formulary management. Today, most therapy classes offer more drug choices than ever. Yet many prescription drugs that cost more deliver no additional health benefit. Smart formulary management is vital to offering a sustainable pharmacy benefit that preserves patient access and choice while helping payers obtain fair and affordable pricing. Express Scripts modeled this type of smart formulary management by excluding a handful of "me-too" products from the Express Scripts National Preferred Formulary. This step created the necessary leverage to negotiate more effectively with manufacturers and ultimately achieve lower drug prices for the clients and patients we serve. To ensure needed access, in the rare instance when a patient has a medical need for an off-formulary drug, we have created a pathway for the excluded drug to be covered for the patient.

Smart formulary management can also include preference for one product over another when the products are clinically equivalent. Throughout 2014, Express Scripts was largely critical of a recent trend of drug manufacturers bringing to market products that, although innovative, were priced at levels that were so high that they were unsustainable for payers. For example, the $84,000 treatment cost for the hepatitis C drug, Sovaldi (sofosbuvir), threatened to bankrupt both private and public plan sponsors around the United States. After a year-long campaign advocating for fairer drug pricing, Express Scripts announced in December a new agreement with AbbVie, makers of the new hepatitis C medication, Viekira Pak™ (ombitasvir/paritaprevir/ritonavir co-packaged with dasabuvir). The unprecedented arrangement expands both payer affordability and patient access. The cost to cure is now low enough that plan sponsors can afford to treat all hepatitis C patients with genotype 1, not just the sickest.

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Clinical Solutions

An additional strategy that health plans can implement is Express Scripts clinical solutions that align pharmacists, physicians, patients and case managers to help drive optimal performance against both pharmacy and medical measures. The clinically specialized Therapeutic Resource Centers (TRCs) of the Express Scripts Pharmacy and Accredo Specialty Pharmacies deliver superior treatment outcomes and cost-effectiveness by supporting patients through the challenges of complex and costly diseases. Our specialist pharmacists and nurses each receive clinically specialized training in one disease state, and the work they do focuses almost exclusively on that clinical condition. This specialized expertise and commitment enables an optimal patient experience and ensures the highest performance in pharmacy safety, improved medication adherence and closing gaps in care. With their highly specialized knowledge of the complex disease states and complicated treatment protocols they manage, these TRC pharmacists and nurses often have more experience in rare conditions than some of the physicians who prescribe the treatments.

Because each Medicaid health plan's needs are unique, our menu of available programs is designed to meet varying needs – from ScreenRx® for predictive modeling and tailored interventions to drive adherence; to RationalMed® using proprietary clinical analysis of prescription, medical and lab data to identify safety risks; to targeted diabetes treatment initiatives supporting physician prescribing best practices.

A LOOK AT MEDICAID OVERALL DRUG TREND FOR 2014

Overall trend for Medicaid plans was 10.2% in 2014, due primarily to a 10.7% increase in unit cost. Utilization was marginally negative (-0.5%), reflecting the influx of new, adult beneficiaries less likely to use medications for chronic conditions. Because the number of prescriptions remained similar from 2013 to 2014, but the number of beneficiaries across which to divide the costs grew, a decrease in utilization was reflected. Overall per-member-per-year (PMPY) spend was $882.43 (vs. $800.65 in 2013).

Traditional trend was 2.8% – far below that observed in either the commercially insured or Medicare populations – reflecting a 3.2% increase in unit cost, offset somewhat by a 0.5% decrease in utilization. Spend for traditional medications contributed 72.2% of total PMPY spend in 2014 – a lower share than the 77.7% observed in 2013. The decrease in share of spend for traditional medications was due to the impact of the new, expensive specialty medications, Sovaldi, Olysio and Harvoni among them, which contributed significantly to a 35.8% increase in PMPY spend for specialty drugs in 2014 – three times that in 2013.

PMPY spend and trend varied across age groups. For beneficiaries age 20 to 34, total trend was -2.5% – the drop due largely to the increase in the number of younger adult beneficiaries in this age range. PMPY spend for these beneficiaries was $828.78. As in 2013, PMPY spend for beneficiaries age 35 to 64, at $2,222.82, was higher than that for all other age groups. The 4.1% trend for this age group was driven entirely by an increase in unit cost for specialty medications. The highest trend, 12.4%, was among beneficiaries age 65 and older, again driven by increased unit costs for specialty medications.

COMPONENTS OF MEDICAID TREND

2014

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$637.42	-0.5%	3.2%	2.8%
Specialty	$245.01	-0.9%	36.7%	35.8%
TOTAL OVERALL	$882.43	-0.5%	10.7%	10.2%

January-December 2014 compared to same period in 2013

AGES 0 TO 19, 2014

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$266.52	-1.8%	7.2%	5.3%
Specialty	$56.49	0.2%	11.6%	11.7%
TOTAL OVERALL	$323.01	-1.8%	8.2%	6.4%

January-December 2014 compared to same period in 2013

AGES 20 TO 34, 2014

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$583.57	-9.6%	1.1%	-8.6%
Specialty	$245.22	-8.7%	24.6%	16.0%
TOTAL OVERALL	$828.78	-9.6%	7.1%	-2.5%

January-December 2014 compared to same period in 2013

AGES 35 TO 64, 2014

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$1,534.93	-7.5%	2.6%	-4.9%
Specialty	$687.89	-9.9%	41.8%	31.9%
TOTAL OVERALL	$2,222.82	-7.5%	11.6%	4.1%

January-December 2014 compared to same period in 2013

AGES 65 AND OLDER, 2014

		TREND		
	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
Traditional	$680.89	-2.1%	5.9%	3.8%
Specialty	$180.94	-2.4%	65.6%	63.2%
TOTAL OVERALL	$861.83	-2.1%	14.5%	12.4%

January-December 2014 compared to same period in 2013

MEDICAID: TRADITIONAL THERAPY CLASSES AND INSIGHTS

COMPONENTS OF TREND FOR THE TOP 10 MEDICAID TRADITIONAL THERAPY CLASSES

RANKED BY 2014 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Diabetes	$106.13	1.4%	17.0%	**18.4%**
2	Mental/Neurological Disorders	$81.60	-7.2%	7.0%	**-0.2%**
3	Asthma	$67.95	-5.1%	1.1%	**-4.1%**
4	Pain/Inflammation	$52.38	-3.2%	12.3%	**9.1%**
5	Attention Disorders	$44.05	-4.1%	5.1%	**1.0%**
6	Seizures	$22.15	-3.0%	5.2%	**2.1%**
7	Infections	$20.82	-6.6%	2.2%	**-4.4%**
8	Chemical Dependence	$19.29	6.4%	-14.0%	**-7.6%**
9	Depression	$18.10	5.7%	-22.1%	**-16.4%**
10	High Blood Pressure/Heart Disease	$17.24	4.2%	-9.6%	**-5.5%**
	TOTAL TRADITIONAL	**$637.42**	**-0.5%**	**3.2%**	**2.8%**

Ranked by per-member-per-year (PMPY) spend, the top 10 traditional therapy classes accounted for **70.6%** of Medicaid traditional spend.

Ranked by PMPY spend, the top 10 traditional therapy classes accounted for 70.6% of Medicaid traditional spend. For the second year in a row, medications used to treat diabetes were the most-expensive traditional therapy class, contributing 16.6% of overall Medicaid traditional drug spend. Six of the top 10 traditional therapy classes had negative total trend, with the largest decline seen in spend for antidepressants.

HIGHLIGHTS

- PMPY spend for diabetes in 2014 was higher than that for any other traditional therapy class. Total trend for diabetes medications was 18.4%, resulting mainly from a significant increase in unit cost (17.0%). Brand inflation for insulin therapies contributed heavily to the unit-cost increase. For example, the unit cost for Lantus® (insulin glargine [rDNA origin]) increased 32.8% – likely in anticipation of biosimilar insulin glargine expected in 2017 and probable competition from ultra-long acting insulins that are in the pipeline for approval in the next few years. Costs for other insulins, like Humalog® (insulin lispro [rDNA origin]), also went up.

- Despite a 3.2% decrease in utilization, trend for pain/inflammation treatments was 9.1% in 2014. The class, which includes a variety of treatments for pain – including not only opioids like hydrocodone, but also GABA receptor agonists like gabapentin and NSAIDs like naproxen – is almost exclusively generic; the generic fill rate (GFR) for the class was 97.5% in 2014. However, market dynamics in 2014 led to double-digit increases in unit costs for two of the most commonly used treatments among Medicaid beneficiaries, lidocaine and oxycodone/acetaminophen.

- Total trend for medications used to treat attention disorders was a modest 1.0%, mostly as a result of a 4.1% decrease in utilization. This decrease may be partly related to increased scrutiny of medications for attention deficit hyperactivity disorder (ADHD) that are used by Medicaid beneficiaries.[3] The decrease in utilization of therapies for attention deficit – which are prescribed most often for children – may also be attributable to age shifts in the Medicaid population following implementation of the ACA.

- Although utilization of depression medications increased 5.7% in 2014, the 22.1% decrease in unit cost led the class to the largest negative total trend (-16.4%) among the top 10 traditional therapy classes. The biggest reason for the decline in the unit cost was an increase in the GFR from 94.0% in 2013 to 98.6% in 2014. One of the last remaining brand serotonin norepinephrine reuptake inhibitors (SNRIs), Cymbalta® (duloxetine), lost patent protection at the end of 2013, with the result that all of the top 10 most commonly used antidepressants in 2014 were generics.

Brand inflation for insulin therapies contributed heavily to the **17.0%** increase in unit cost for diabetes treatments.

TOP 10 MEDICAID TRADITIONAL DRUGS

Nine of the top 10 traditional drugs used by Medicaid beneficiaries in 2014 were brands, which contributed 25.8% of per-member-per-year (PMPY) spend for all traditional therapy drugs. The only generic medication in the top 10, methylphenidate, is used to treat attention deficit hyperactivity disorder (ADHD). As in 2013, the Medicaid traditional therapy drug with the highest PMPY spend was the antipsychotic Abilify. Total trend was 6.0% for Abilify, as the decrease in utilization was offset by an increase in unit cost; the increase in unit cost likely occurred in anticipation of the expiration of the drug's patent in April 2015. The highest trend, for Symbicort (53.2%) was driven mostly by a 42.7% increase in utilization.

As in 2013, the Medicaid traditional therapy drug with the highest PMPY spend was the antipsychotic Abilify. Total trend was **6.0%** for Abilify.

TOP 10 MEDICAID TRADITIONAL THERAPY PRODUCTS

RANKED BY 2014 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL TRADITIONAL SPEND	UTILIZATION	UNIT COST	TOTAL
1	Abilify® (aripiprazole)	Mental/Neurological Disorders	$40.99	6.4%	-11.3%	17.2%	**6.0%**
2	Lantus® (insulin glargine injection)	Diabetes	$27.30	4.3%	2.5%	32.8%	**35.3%**
3	Humalog® (insulin lispro injection)	Diabetes	$18.77	2.9%	19.1%	25.5%	**44.6%**
4	OneTouch Ultra® Test Strips	Diabetes	$16.93	2.7%	-2.5%	2.0%	**-0.5%**
5	Suboxone® (buprenorphine/ naloxone)	Chemical Dependence	$14.08	2.2%	-15.6%	-4.9%	**-20.5%**
6	Symbicort® (budesonide/ formoterol)	Asthma	$13.10	2.1%	42.7%	10.5%	**53.2%**
7	methylphenidate extended release	Attention Disorders	$12.24	1.9%	-3.9%	-1.0%	**-4.9%**
8	Ventolin® HFA (albuterol)	Asthma	$11.95	1.9%	4.2%	5.6%	**9.8%**
9	Spiriva® (tiotropium)	Chronic Obstructive Pulmonary Disease	$10.86	1.7%	-3.0%	7.2%	**4.1%**
10	Advair Diskus® (fluticasone/ salmeterol)	Asthma	$10.27	1.6%	-34.0%	6.3%	**-27.7%**

MEDICAID: SPECIALTY THERAPY CLASSES AND INSIGHTS

COMPONENTS OF TREND FOR THE TOP 10 MEDICAID SPECIALTY THERAPY CLASSES

RANKED BY 2014 PMPY SPEND

			TREND		
RANK	THERAPY CLASS	PMPY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Hepatitis C	$55.02	4.6%	317.2%	**321.8%**
2	HIV	$48.28	0.7%	10.3%	**11.0%**
3	Inflammatory Conditions	$30.63	14.4%	21.5%	**35.9%**
4	Oncology	$25.50	11.2%	11.8%	**23.0%**
5	Multiple Sclerosis	$24.52	0.2%	11.3%	**11.5%**
6	Miscellaneous Specialty Conditions	$9.66	39.4%	26.6%	**66.0%**
7	Growth Deficiency	$8.20	-9.2%	4.2%	**-5.0%**
8	Cystic Fibrosis	$7.29	1.7%	6.7%	**8.5%**
9	Pulmonary Arterial Hypertension	$5.60	7.5%	-2.8%	**4.8%**
10	Anticoagulants	$4.92	-2.0%	-13.2%	**-15.2%**
	TOTAL SPECIALTY	**$245.01**	**-0.9%**	**36.7%**	**35.8%**

Hepatitis C medications contributed **65.0%** of the total increase in specialty spend.

Overall trend for specialty medications used by Medicaid beneficiaries was 35.8% in 2014, fueled by the significant increase in unit cost related to the launch of three new hepatitis C treatments – Sovaldi® (sofosbuvir), Olysio® (simeprevir) and Harvoni® (ledipasvir/sofosbuvir). Hepatitis C medications contributed 65.0% of the total increase in specialty spend. Accordingly, hepatitis C medications were the most-expensive Medicaid specialty therapy class when ranked by PMPY spend. The top three therapy classes – hepatitis C, HIV and inflammatory conditions – together contributed 54.7% of total specialty PMPY spend. Two of the top 10 therapy classes – growth deficiency and anticoagulants – had negative total trend in 2014. Only pulmonary arterial hypertension and anticoagulants had a decrease in unit cost from 2013 to 2014.

HIGHLIGHTS

- Total trend for HIV medications was 11.0%, almost exclusively from an increase in unit cost. Although the wave of patent expirations in this class continues, generic availability may not reduce the cost of HIV therapy because a constantly changing pipeline is needed to address mutations in virus strains that cause resistance to drugs. Additionally, older HIV drugs that may have generic equivalents must be taken several times a day in combination with other drugs, and newer treatments that combine multiple medications into one-dose form offer more convenient dosing regimens. For example, Stribild®(elvitegravir/cobicistat/emtricitabine/tenofovir) is taken only once a day; and although Tivicay® (dolutegravir), another relatively recent FDA approval, must be taken with other drugs, dosage is only twice a day. Both brand medications gained significant market share in 2014, but both come with much higher price tags than generics.

- A 9.2% decrease in utilization was offset by a 4.2% increase in unit cost, resulting in a -5.0% trend for growth deficiency treatments among Medicaid beneficiaries. Growth hormone treatments are another class of medications that is primarily used by children, so a shift in the age structure of the Medicaid population following the expansion of the Medicaid program in some states could be contributing to the decrease in utilization.

- Both the cost and the utilization of cystic fibrosis (CF) treatments increased in 2014. However, utilization of Kalydeco® (ivacaftor), the first drug to treat the underlying cause of disease in patients with a rare form of CF, dropped 6.7%. The annual price tag for Kalydeco, an oral drug, can exceed $300,000. A new drug, lumacaftor, is in development; if approved, it will be taken in combination with Kalydeco to treat underlying genetic mutations that cause the most common form of CF.

- Medicaid spend for specialty anticoagulant medications continued to decline, spurred by a 13.2% decrease in unit cost. The 99.6% generic fill rate (GFR) and its associated lower costs far outweighed the 2014 price increases observed for the few remaining brands in the class.

Utilization of Kalydeco® (ivacaftor), the first drug to treat the underlying cause of disease in patients with a rare form of CF, dropped **6.7%**.

THE TOP 10 MEDICAID SPECIALTY DRUGS

For Medicaid plans, the top 10 specialty drugs accounted for 44.5% of per-member-per-year (PMPY) spend for all specialty drugs in 2014. PMPY spend ranged from $43.13 for Sovaldi to $4.32 for generic enoxaparin. Sovaldi captured 17.6% of PMPY spend for all specialty drugs in 2014. The PMPY spend for Sovaldi was also more than triple the PMPY spend for the second-most-expensive drug, Humira, which had almost three times the utilization Sovaldi did in 2014. Three HIV medications captured spots in the top 10: Atripla, Truvada and Viread, which ranked fourth, fifth and seventh, respectively. Aside from Sovaldi, the oral MS treatment, Tecfidera, had the highest trend (247.7%), driven by a triple-digit increase in utilization, likely spurred by the added convenience of administration for an oral medication over an injectable treatment.

PMPY spend ranged from **$43.13** for Sovaldi to **$4.32** for generic enoxaparin.

TOP 10 MEDICAID SPECIALTY THERAPY DRUGS

RANKED BY 2014 PMPY SPEND

					TREND		
RANK	DRUG NAME	THERAPY CLASS	PMPY SPEND	% OF TOTAL SPECIALTY SPEND	UTILIZATION	UNIT COST	TOTAL
1	Sovaldi® (sofosbuvir)	Hepatitis C	$43.13	17.6%	33131.0%	-503.2%	**32627.8%**
2	Humira® (adalimumab)	Inflammatory Conditions	$12.78	5.2%	11.4%	19.9%	**31.3%**
3	Enbrel® (etanercept)	Inflammatory Conditions	$9.35	3.8%	10.4%	18.7%	**29.2%**
4	Atripla® (efavirenz/emtricitabine/ tenofovir)	HIV	$8.82	3.6%	-7.4%	7.0%	**-0.3%**
5	Truvada® (emtricitabine/tenofovir)	HIV	$8.77	3.6%	-0.5%	4.3%	**3.8%**
6	Copaxone® (glatiramer)	Multiple Sclerosis	$6.51	2.7%	-11.7%	9.0%	**-2.7%**
7	Viread® (tenofovir)	HIV	$5.58	2.3%	-2.2%	4.0%	**1.8%**
8	Tecfidera® (dimethyl fumarate)	Multiple Sclerosis	$5.19	2.1%	216.3%	31.4%	**247.7%**
9	Avonex® (interferon beta 1-a)	Multiple Sclerosis	$4.61	1.9%	-28.4%	8.3%	**-20.1%**
10	enoxaparin	Anticoagulants	$4.32	1.8%	1.2%	-13.0%	**-11.7%**

APPENDIX

THE DRUG TREND REPORT METHODOLOGY

Prescription drug use for members with drug coverage provided by Express Scripts plan sponsors[4] was analyzed for the Drug Trend Report. The plan sponsors providing the pharmacy benefit paid at least some portion of the cost for the prescriptions dispensed to their members, providing what is known as a funded benefit.

Both traditional and specialty drugs are included. Specialty medications include injectable and noninjectable drugs that are typically used to treat chronic, complex conditions and may have one or more of the following qualities: frequent dosing adjustments or intensive clinical monitoring; intensive patient training and compliance assistance; limited distribution; and specialized handling or administration. Nonprescription medications (with the exception of diabetic supplies billed under the pharmacy benefit) and prescriptions that were dispensed in hospitals, long-term care facilities and other institutional settings, or billed under the medical benefit are not included.

Trend and other measures are calculated separately for those members with commercial insurance coverage, for Medicaid recipients and for Medicare beneficiaries receiving prescription benefits through Employer Group Waiver Plans (EGWPs), managed Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MAPDs). Members used Express Scripts for retail and home delivery pharmacy services; they used Accredo, the Express Scripts specialty pharmacies, for specialty drug prescriptions.

Total trend measures the rate of change in plan costs, which include ingredient costs, taxes, dispensing fees and administrative fees. Rebates are not included as a component of cost. Total trend comprises utilization trend and unit cost trend. Utilization trend is defined as the rate of change in total days' supply of medication per member, across prescriptions. Unit cost trend is defined as the rate of change in costs due to inflation, discounts, drug mix and member cost share. Utilization and cost are determined on a per-member-per-year (PMPY) basis. Metrics are calculated by dividing totals by the total number of member-months, which is determined by adding the number of months of eligibility for all members in the sample.

The Express Scripts Prescription Price Index (PPI) measures inflation in prescription drug prices by monitoring changes in consumer prices for a fixed market basket of commonly used prescription drugs. Separate market baskets are defined for brand drugs and for generic drugs, and are based on the top 80% of utilized drugs.

Please Note: Although up to nine decimal places were allowed in making all calculations, in most cases the results were rounded down to one or two decimals for easier reading. Therefore, dollar and percentage calculations may be slightly off due to rounding.

CITATIONS

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4. Plan sponsors were excluded if they were not Express Scripts clients in both periods, if they had less than 12 months of claims data in either period, if they had retail-only benefits, if they had 100% or 0% copayment benefits, if they had eligibility shifts exceeding 20% for commercial plans (eligibility shifts exceeding 50% for Medicare and Medicaid plans), or if they were contractually prohibited from inclusion. Individual members might be covered, and thus included, for only a portion of the time periods of interest.