# 2016 Drug Trend Report

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Introduction
Keeping care affordable for the most vulnerable

Last year, when we published our Medicaid Drug Trend report, we were fresh off celebrating the 50th anniversary of the Medicaid and Medicare programs. This year, we saw significant pieces of federal Medicaid regulation, which was absent in previous years. Although we normally see a number of regulatory and legislative changes in state Medicaid programs, 2016 was a year of more intense federal focus on Medicaid, specifically on managed care regulations.

Through the Covered Outpatient Drugs Final Rule, the Centers for Medicare & Medicaid Services (CMS), defined Average Manufacturer Price (AMP), which affects the calculation of Medicaid drug rebates – which in turn affects both fee-for-service (FFS) and managed Medicaid claims.\(^1\) In addition, the regulation also shifted FFS reimbursement away from estimated acquisition cost (EAC) methodologies to average acquisition cost (AAC) reimbursement methodologies. While this regulation was designed for FFS programs, we note a few states requiring such methodologies for managed Medicaid claims – signaling a shift away from more traditional pharmacy reimbursement approaches using average wholesale price (AWP).

A major source of federal regulatory change was CMS’ release of the Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Rule, often referred to as the Medicaid Mega Rule or Medicaid Managed Care Oversight Rule.\(^2\) The release of this regulation was significant because managed Medicaid regulations had not been updated since 2002 and it gave CMS an opportunity to align requirements between managed Medicaid programs and other federally-regulated programs, such as Qualified Health Plans and Medicare Advantage plans.

While these federal regulatory changes are important to note, their effects may not be immediately seen as some portions of the regulations do not take effect until mid to late 2018. Within the Medicaid landscape, we know that a good indicator of current and future market dynamics can be observed by watching legislation introduced at the state level – whether successful or not.

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1. Medicaid Program; Covered Outpatient Drugs; Final Rule. 81 Federal Register 20 (1 February 2016), pp 5170-5357.
2. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Federal Register 81 (6 May 2016) 88, pp 27498-27901.
In 2016, we saw two key areas of focus – opioids and formulary management – both of which play an important role in effective management of Medicaid drug spend.

Opioids continue to generate significant focus within the Medicaid population as research shows Medicaid enrollees are prescribed opioids twice as often as those with private health insurance and that opioid-related deaths are estimated to be 10 times higher in Medicaid than in non-Medicaid populations. Despite most Medicaid programs and Medicaid managed care plans having restricted recipient, or lock-in, programs to help try and curb opioid abuse, the pain and inflammation therapy class remains the seventh highest therapy class for Medicaid spend at $59.32 per member per year. Growing concern about how to encourage appropriate prescribing and manage abuse led many states to introduce legislation regarding prescribing guidelines, the quantity of an opioid medication dispensed, and the method for issuing prescriptions for opioids, with an increased focus on electronic prescribing of such medications.

In an increasing effort to maximize Medicaid rebates, we saw a number of states implement or consider state-mandated formularies for their Medicaid managed care programs. With such requirements, managed Medicaid plans are required to follow the state FFS formulary and are prohibited from collecting supplemental rebates, thereby removing two effective tools for pharmacy benefit management from the Medicaid health plan toolkit. While touted as an improvement in provider administrative simplification and a cost savings, Express Scripts research shows that moving to a state-managed preferred drug list (PDL) significantly lowers the generic dispensing rate and increases health plan costs. In addition, such actions cause considerable concern about the timely and adequate adjustment in capitation rates for managed Medicaid plans as rising drug expenditures may not be adequately offset by adjustments in their capitation payments.

In addition to regulatory and legislative changes, we continue to see states move more Medicaid populations to managed care, specifically members that require more complicated care, such as those with intellectual or development disabilities. With such complex populations moving to managed care, it’s more important than ever for Medicaid plans to focus on effective utilization management and innovative solutions to dealing with common problems like adherence, refilling medication on time, and utilizing the most appropriate and cost effective care settings. These things will become critically important if per capita caps or block grants are utilized within Medicaid reform efforts being considered with the new Administration.

We are proud of the work we do to support our Medicaid health plans – most importantly, holding drug trend to just 5.5%. Our work is not done though; while we saw decreases in specialty medication usage – primarily driven by significant decreases in HIV and hepatitis C medication utilization – we continue to see unit cost increase, both in traditional and specialty therapy classes. In addition, there is always room for improvement in the main Medicaid disease states of diabetes, asthma, and mental/neurological disorders. As we await impending changes to the Medicaid program – whether through the Medicaid Mega Rule or through the use of per capita caps or block grants – diligence in managing the pharmacy benefit is our primary concern. We know our Medicaid health plans count on us for creative solutions to help manage the pharmacy benefit and we eagerly accept the challenge.

Peggy Finn
Vice President, Medicaid
Express Scripts

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Trend analysis
Looking at drug spending in 2016

- In 2016, per-member-per-year (PMPY) spend for Medicaid was $1,196.01, an increase of 5.5% over 2015, as evaluated across the Medicaid beneficiary data examined in this report.

- The rise in spending was mainly attributed to a 4.3% increase in the unit cost of drugs – 3.5% for traditional medications and 12.8% for specialty medications – along with a 1.2% bump in drug utilization.

- Overall spending on traditional medications rose 4.8% in 2016, primarily due to the jump in unit cost, although there was a slight 1.3% increase in utilization.

- The overall 6.6% specialty medication spend increase was due predominantly to the double-digit bump in unit cost, which offset a 6.2% decline in utilization.

- Medicaid health plans continued to implement a diverse set of benefit design, utilization management and formulary administration techniques to contain utilization and costs which had an impact on overall and Medicaid enrollment category trends.

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### PMPY* Spend

<table>
<thead>
<tr>
<th>Year</th>
<th>Traditional</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>2016</td>
<td>$709.85</td>
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### Utilization Trend

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### Total Trend

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<tr>
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*January-December 2016 compared to same period in 2015 for Medicaid members with drug coverage provided by Express Scripts plan sponsors. Reflects total cost for both payers and patients, net of rebates.

*Per member per year
MEDICAID ENROLLMENT CATEGORIES

Our insights and observations are organized around the following enrollment categories within our Medicaid book of business:

- **Temporary Assistance for Needy Families (TANF)** – all TANF members and similar populations including, but not limited to, pregnant women, foster children, the homeless and ACA Medicaid Expansion members
- **Children’s Health Insurance Program (CHIP)** – stand-alone or separate CHIP plans, as well as Medicaid extension CHIP programs
- **Aged, Blind and Disabled (ABD)** – all ABD members or members classified as long-term care (LTC) members

Dual-eligible beneficiaries are excluded as their drug benefits are managed mainly by Medicare Part D drug plans and most of the pharmacy spend is absorbed by those plans.

PMPY spend was highest for TANF recipients ($1,279.17) – higher than the overall Medicaid PMPY spend of $1,196.01 – and up 6.6% from 2015, driven primarily by increases in unit costs.

Drug spend for our CHIP population declined 1.3%, driven by a 4.6% drop in drug utilization.

ABD members had the highest increase in drug spend (8.4%), driven by increases in both utilization (3.5%) and unit cost (4.9%) that topped all Medicaid enrollment categories. The high utilization trend for ABD members was not unexpected as most beneficiaries have multiple comorbidities that typically result in high healthcare spending.

January-December 2016 compared to same period in 2015 for Medicaid members with drug coverage provided by Express Scripts plan sponsors. Reflects total cost for both payers and patients, net of rebates.

*Per member per year
Therapy class review
Top 15 therapy classes and insights

- When ranked by PMPY spend, the top 15 drug therapy classes, including traditional and specialty, contributed 73.4% of the total overall drug spend among Medicaid beneficiaries.

- HIV and diabetes medications, the top two therapy classes by spend, accounted for 27.6% of total Medicaid drug spend.

- Three of the top 15 therapy classes had decreases in spending in 2016, with medications used to treat mental/neurological disorders experiencing the largest decrease of 21.6%.

The top 15 drug therapy classes contributed 73.4% of the total overall drug spend.

### MEDICAID: COMPONENTS OF TREND FOR TOP 15 THERAPY CLASSES

#### RANKED BY 2016 PMPY* SPEND

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<thead>
<tr>
<th>RANK</th>
<th>TYPE</th>
<th>THERAPY CLASS</th>
<th>PMPY SPEND</th>
<th>UTILIZATION</th>
<th>UNIT COST</th>
<th>TOTAL</th>
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<td>0.1%</td>
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<td>-20.0%</td>
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<td>4.5%</td>
<td>3.9%</td>
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<td>T</td>
<td>Attention disorders</td>
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<td>2.3%</td>
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<td>15.8%</td>
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<td>2.8%</td>
<td>10.9%</td>
<td>13.7%</td>
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<td>T</td>
<td>Seizures</td>
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<td>2.1%</td>
<td>12.4%</td>
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<td>12</td>
<td>T</td>
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<td>10.3%</td>
<td>0.5%</td>
<td>10.8%</td>
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<td>T</td>
<td>High blood pressure/heart disease</td>
<td>$16.07</td>
<td>1.9%</td>
<td>0.5%</td>
<td>2.4%</td>
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</tbody>
</table>

**TOTAL FOR ALL THERAPY CLASSES**  
$1,196.01  
1.2%        
4.3%        
5.5%

S = Specialty, T = Traditional  
*Per member per year
HIGHLIGHTS

• For the second year, PMPY spend for HIV treatments ($197.07) topped all other therapy classes. Despite a utilization trend of -11.5%, unit cost increases of 16.0% resulted in a 4.5% trend for HIV. Brand medications continued to dominate this class, comprising the top 17 drugs by market share. Despite a few upcoming patent expirations, the HIV drug pipeline is being replenished with newer drugs that tackle the continuously mutating virus strains, offer broader control or produce fewer side effects.

• Truvada® (emtricitabine/tenofovir disoproxil fumarate) had the highest PMPY drug spend ($31.99) in the HIV class, followed by Stribild® (cobicistat/elvitegravir/emtricitabine/tenofovir disoproxil fumarate) at $19.36 and Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) at $18.77. The only drug approved by the U.S. Food and Drug Administration (FDA) for pre-exposure prophylaxis (PrEP), Truvada also had the highest market share, with 16.6% of all HIV drug claims among Medicaid members. Recently approved drugs containing the improved chemical form, tenofovir alafenamide, are expected to replace some of the established HIV drugs that contain an older chemical compound, tenofovir disoproxil fumarate. They include Vemlidy® (tenofovir alafenamide) replacing the single agent Viread® (tenofovir disoproxil fumarate), Odefsey® (emtricitabine/rilpivirine/tenofovir alafenamide) succeeding Complera® (emtricitabine/rilpivirine/tenofovir disoproxil fumarate), Genvoya® (cobicistat/elvitegravir/emtricitabine/tenofovir alafenamide) replacing Stribild, and Descovy® (emtricitabine/tenofovir alafenamide) for Truvada.

• For the fourth year in a row, diabetes drugs had the highest PMPY spend ($133.07) of all traditional therapy classes among Medicaid beneficiaries. The 16.4% total trend for diabetes was attributed mainly to a 13.2% jump in unit cost coupled with a healthy 3.2% rise in utilization. Continued brand inflation for insulins, such as Humalog® (insulin lispro) and NovoLog® FlexPen® (insulin aspart), was a big contributor. Although metformin was the most widely used diabetes drug, Lantus® (insulin glargine) continued to have the highest PMPY spend in Medicaid ($33.96). However, the unit cost trend for Lantus was only 0.6% in 2016; with most of its rise in spend resulting from a 4.3% increase in utilization. Launched in December 2016, Basaglar® (insulin glargine), the first follow-on, long-acting insulin, is expected to add further pricing pressure on Lantus moving forward.

• Asthma was among the top three therapy classes, although PMPY spending of $70.28 was well below that for the top two classes. Spending was up 7.7% from 2015, primarily due to an 8.2% rise in unit cost. Advair Diskus® (fluticasone/salmeterol) had the highest PMPY drug spend for an asthma drug at $17.06, followed by $11.41 for Ventolin® HFA (albuterol sulfate) and $10.12 for Symbicort® (budesonide/formoterol). Each of these drugs also had unit cost trends over 9.0% in 2016, with Ventolin HFA having the highest of the three at 14.2%. Ventolin HFA was also the most utilized drug, with its 30.7% share of the Medicaid asthma market nearly double that of the next most utilized asthma drug, montelukast (18.6%), the generic form of Singulair®. Over the past two years, several asthma drugs gained approvals for expanded indications, which affected trend. In 2016, both ProAir® RespiClick® (albuterol) powder and Xolair® (omalizumab) got expanded indications for pediatric use, while Breo® Ellipta® (fluticasone/vilanterol) and Spiriva® Respimat® (tiotropium bromide) were newly approved for adult asthma in 2015.

• PMPY spend for hepatitis C ($65.14) continued to decline for the second straight year. Its 20.0% decrease was influenced heavily by a 20.1% drop in utilization. Harvoni® (ledipasvir/sofosbuvir) still dominated the Medicaid hepatitis C market with the highest market share (31.5%) and highest PMPY spend ($28.82). Sovaldi® (sofosbuvir) and Viekira Pak™ (ombitasvir/paritaprevir/ritonavir; with dasabuvir) were a distant second and third at $10.43 and $7.78 PMPY, respectively. Increased pressure from CMS to allow broad access for these medications for state Medicaid enrollees caused a number of states to instruct plans to ease clinical coverage requirements. Despite factors that should seemingly drive up utilization, the 20.1% decline may be due to decreased demand for treatment after the initial wave of patients was cured.

For the fourth year in a row, diabetes drugs had the highest PMPY spend of all traditional therapy classes.
Spend for inflammatory conditions drugs surged by 39.0%, the highest trend for the top 15 Medicaid therapy classes.

Drugs to treat attention disorders had the fifth-highest spend ($54.82) among traditional therapy classes in Medicaid. The 6.5% total trend in spending resulted mostly from a 4.2% rise in drug utilization. While two generics, methylphenidate and dextroamphetamine/amphetamine, comprise more than half of the market share for this therapy class, the brand drug Vyvanse® (lisdexamfetamine) continued to have double-digit increases in both utilization (15.4%) and unit cost (13.2%) in 2016. Vyvanse gained an additional FDA approval in January 2015 for treatment of binge eating disorders, which could also be responsible for some of its increased utilization.\(^6\)\(^7\)

In 2016, PMPY spend for oncology medications increased by 22.7% to $40.70 for the Medicaid population. Positive trends of 6.9% in utilization and 15.8% in unit cost led to the overall increase in trend. Brand drugs continue to dominate this class, comprising 78.8% of all oncology prescriptions and 88.9% of oncology drug spend, despite the launch of generic Gleevec® (imatinib) in February 2016. Revlimid® (lenalidomide), an oral therapy used to treat multiple myeloma, had the highest PMPY spend ($4.18), while Lupron Depot® (leuprolide), used in the treatment of prostate cancer, had the highest market share (10.3%) in this therapy class. The immuno-oncology (I-O) drug, Opdivo® (nivolumab), which treats certain types of skin and non-small cell lung cancers while also having a number of other indications, had a total trend increase of over 200%, boosted by a jump in utilization that surpassed 270%. The generic form of Gleevec (imatinib) captured a significant portion of the class market share from its brand counterpart (3.8% vs. 2.2%) to rank third among oncology drugs with the highest PMPY spend in the Medicaid population ($2.37).

Spend on multiple sclerosis (MS) medications trended upward by 13.7%, mainly from a unit cost increase of 10.9%. Due to growth in both its utilization (7.8%) and unit cost (12.3%), Tecfidera® (dimethyl fumarate) displaced Copaxone® (glatiramer) as the MS drug most widely

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used by Medicaid members. It also had the highest PMPY spend ($9.64) for the class. Tecfidera, an oral twice-a-day capsule and the only drug approved in its subclass, offers convenience over injectable MS drugs, such as Copaxone. Launched in June 2015, Glatopa™, a generic alternative for Copaxone's 20 mg/mL strength, is gaining market share, with utilization increasing by more than 198% in 2016. The longer-acting, 40 mg/mL form of Copaxone does not yet have generic competition.

- The 10.3% increase in utilization for the chemical dependence therapy class was not surprising, as substance abuse disorders are prevalent in the Medicaid population. For Medicaid, Suboxone® (buprenorphine/naloxone) had the highest PMPY spend ($17.88) and was the most commonly used drug in the class. Far behind in second place was its generic, buprenorphine/naloxone, at $2.88. Combined, the brand and generic versions of all buprenorphine/naloxone dose forms captured more than 94% of the chemical dependence market share in 2016 among the Medicaid population.


Suboxone had the highest PMPY spend and was the most commonly used drug in the chemical dependence therapy class.
In 2016, the top two traditional drugs ranked by PMPY spend for Medicaid were insulins. Lantus once again was the most expensive, while Humalog jumped to second place this year. Eighth-ranked NovoLog FlexPen rounded up the trio of insulins that were among the 10 most-expensive traditional Medicaid therapies in 2016.

Combined with the seventh-ranked OneTouch Ultra® Test Strips, the top 10 drugs and supplies associated with diabetes contributed 12.3% of the total Medicaid traditional drug spend.

| RANK | DRUG NAME                         | THERAPY CLASS          | PMPY SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL TRADITIONAL SPEND | % OF TOTAL 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• Aripiprazole and methylphenidate extended release were the only two generics in the top 10 traditional drug classes for Medicaid. Although aripiprazole had a 51.5% upward trend in utilization, its unit cost declined by 56.7%. As a result, aripiprazole took a significant chunk of market share from its brand counterpart Abilify, which was knocked out of the top 10 traditional drugs in 2016.

• The chemical dependence drug Suboxone was the fourth most-expensive traditional drug in Medicaid due to a 16.8% increase in drug spend on the back of a 17.0% rise in utilization.

• The 11.3% jump in spend for Advair Diskus was fueled largely by 9.7% brand inflation.

• NovoLog FlexPen and Ventolin HFA had substantial positive trends of 35.6% and 21.8%, respectively, due to large increases for each in both utilization and unit cost trends.

• The 28.6% total trend for the attention disorders drug Vyvanse was due in nearly equal parts to a rise in both utilization (15.4%) and unit cost (13.2%).
In 2016, the 10 most expensive specialty drugs comprised only three therapy classes – HIV, hepatitis C and inflammatory conditions.

Seven of the top 10 specialty drugs for Medicaid were HIV medications, six of which were combination products containing two or more different drugs in one dosage form. Together, these seven HIV drugs contributed 27.2% of the total specialty drug spend in Medicaid.

**MEDICAID: TOP 10 SPECIALTY DRUGS**

**RANKED BY 2016 PMPY* SPEND**

<table>
<thead>
<tr>
<th>RANK</th>
<th>DRUG NAME</th>
<th>THERAPY CLASS</th>
<th>PMPY SPEND</th>
<th>% OF TOTAL SPECIALTY SPEND</th>
<th>UTILIZATION</th>
<th>UNIT COST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Truvada® (emtricitabine/tenofovir disoproxil fumarate)</td>
<td>HIV</td>
<td>$31.99</td>
<td>6.6%</td>
<td>-16.4%</td>
<td>7.0%</td>
<td>-9.4%</td>
</tr>
<tr>
<td>2</td>
<td>Harvoni® (ledipasvir/sofosbuvir)</td>
<td>Hepatitis C</td>
<td>$28.82</td>
<td>5.9%</td>
<td>-48.3%</td>
<td>0.2%</td>
<td>-48.1%</td>
</tr>
<tr>
<td>3</td>
<td>Humira® Pen (adalimumab)</td>
<td>Inflammatory conditions</td>
<td>$25.70</td>
<td>5.3%</td>
<td>14.9%</td>
<td>30.8%</td>
<td>45.7%</td>
</tr>
<tr>
<td>4</td>
<td>Stribild® (cobicistat/elvitegravir/emtricitabine/tenofovir disoproxil fumarate)</td>
<td>HIV</td>
<td>$19.36</td>
<td>4.0%</td>
<td>-10.0%</td>
<td>7.3%</td>
<td>-2.7%</td>
</tr>
<tr>
<td>5</td>
<td>Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)</td>
<td>HIV</td>
<td>$18.77</td>
<td>3.9%</td>
<td>-30.0%</td>
<td>6.3%</td>
<td>-23.7%</td>
</tr>
<tr>
<td>6</td>
<td>Triumeq® (abacavir/dolutegravir/lamivudine)</td>
<td>HIV</td>
<td>$18.23</td>
<td>3.7%</td>
<td>119.4%</td>
<td>14.1%</td>
<td>133.5%</td>
</tr>
<tr>
<td>7</td>
<td>Complera® (emtricitabine/ritpivirine/tenofovir disoproxil fumarate)</td>
<td>HIV</td>
<td>$16.59</td>
<td>3.4%</td>
<td>-17.7%</td>
<td>9.4%</td>
<td>-8.3%</td>
</tr>
<tr>
<td>8</td>
<td>Enbrel® (etanercept)</td>
<td>Inflammatory conditions</td>
<td>$14.52</td>
<td>3.0%</td>
<td>3.3%</td>
<td>24.8%</td>
<td>28.1%</td>
</tr>
<tr>
<td>9</td>
<td>Genvoya® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)</td>
<td>HIV</td>
<td>$13.48</td>
<td>2.8%</td>
<td>13,817.2%</td>
<td>-90.0%</td>
<td>13,727.2%</td>
</tr>
<tr>
<td>10</td>
<td>Prezista® (darunavir)</td>
<td>HIV</td>
<td>$13.39</td>
<td>2.8%</td>
<td>-25.3%</td>
<td>5.5%</td>
<td>-19.8%</td>
</tr>
</tbody>
</table>

*Per member per year
• Truvada had the highest PMPY spend for Medicaid in 2016 ($31.99). Despite it being the only drug approved and marketed for pre-exposure prophylaxis (PrEP, or prevention of HIV), its utilization dropped 16.4%, leading to its -9.4% total trend. Triumeq® (abacavir/dolutegravir/lamivudine) and Genvoya were the only two HIV drugs with positive total trends. Triumeq had a 133.5% total trend. This rise was mainly due to a 119.4% growth in utilization coupled with a 14.1% rise in unit cost. Because Genvoya was launched in November 2015, its total trend does not provide a complete picture of the year-over-year trend.

• While Harvoni had the second highest PMPY spend in 2016 ($28.82), it had the lowest total trend (-48.1%) due to a 48.3% fall in drug utilization and only a slight rise in unit cost. The decline in trend may be due to the initial wave of hepatitis C patients already receiving their fixed-duration treatments and getting cured.

• Spending for the number three drug, Humira Pen, continued to rise in double digits to a total trend of 45.7%, mainly due to 30.8% brand inflation. The other anti-inflammatory drug in the top 10, Enbrel, had a PMPY spend of $14.52, which was up by 28.1% from 2015, mainly due to an increase of 24.8% in unit cost.

While Harvoni had the second highest PMPY spend in 2016, it had the lowest total trend due to a 48.3% fall in drug utilization.
Methodology
Methodology

Prescription drug use data for Medicaid members with drug coverage provided by Express Scripts plan sponsors was analyzed for the 2016 Drug Trend Report. The Medicaid 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 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 medical 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 members with coverage for Medicaid enrollees. Medicaid enrollees included in this analysis were enrolled in the following programs: Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD).

Total trend measures the rate of change in gross costs, which include ingredient costs, taxes, dispensing fees and administrative fees. Gross cost includes member cost share, and is net of rebates. 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) multiplied by the number of months per period.

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 vary slightly due to rounding.

Methodology

Plan sponsors were excluded if they were not Express Scripts clients in both 2015 and 2016, if they had less than 12 months of claims data in either year, if they had retail-only benefits or home delivery-only benefits, if they had 100% or 0% copayment benefits, if they had eligibility shifts exceeding 50%, 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.
2016 Drug Trend Report

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