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# State Fiscal Year 2018 Pharmacy Annual Trend Report

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## Oklahoma Health Care Authority

### Introduction<sup>1</sup>

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The Oklahoma Medicaid program (SoonerCare) provides pharmacy benefits for its members. In order to provide the best care to as many SoonerCare members as possible, pharmacy claim trends are assessed, and adjustments are implemented where appropriate. Cost containment avenues are deployed to minimize health care cost increases while ensuring access. Annual trends of enrollment, claims, reimbursement, and utilization are monitored for future program planning.

During state fiscal year (SFY) 2018, prescription drugs accounted for \$543 million of the approximate \$5.3 billion in total SoonerCare funding. According to the Centers for Medicare and Medicaid Services (CMS), national health spending is projected to grow at an average rate of 5.5% annually and Medicaid expenditures are expected to grow at a rate of 5.8% annually<sup>1</sup>. Comparing SoonerCare pharmacy data from SFY 2016 and 2017, the total reimbursement increased by 5.4% and increased by 5.7% from SFY 2017 to 2018; both increases are less than the CMS-estimated Medicaid expenditure increases. The pharmacy cost per member per year (PMPY; total pharmacy cost per total members) increased from \$506.47 in SFY 2017 to \$532.62 in 2018, a 4.9% increase. Reimbursement increases per member can largely be attributed to the increase in cost per claim for specialty medications as well as an increase in the number of claims for specialty medications. Recently, the specialty pharmaceutical products total pharmacy reimbursement has been on the incline as a result of orphan drug approvals for rare diseases and the high costs associated with these therapies. During SFY 2017, SoonerCare spent 37.7% of total pharmacy expenditures on 0.84% of claims for medications costing greater than \$1,000 per claim and in SFY 2018, spent 42.6% of total pharmacy expenditures on 0.92% of claims for medications costing greater than \$1,000 per claim. Claims costing greater than \$1,000 per claim are largely specialty medications but may include some traditional claims.

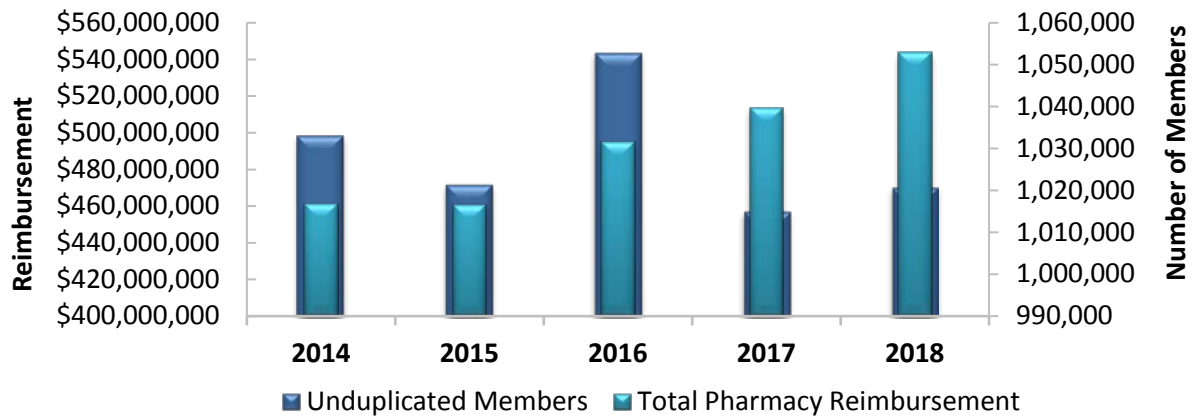
Due to new federal regulations, SoonerCare implemented a new pricing methodology for pharmacy claims reimbursement on January 3, 2017. Ingredient reimbursement changed from an estimated acquisition cost (EAC) to an actual acquisition cost (AAC). In addition, the professional dispensing fee increased from \$3.60 in 2016 to \$10.55 starting in January 2017; professional dispensing fees are included in the reimbursement totals in the following report. The impact of the pricing methodology and dispensing fee change are estimated to be budget neutral. This change in reimbursement should be considered when evaluating reimbursement changes from year to year. Medications with a very low cost per claim and large volume of claims will appear to increase in price due to the increase in dispensing fee; however, these increases will be neutralized by changes in ingredient reimbursement for higher cost medications. Further, Indian Health Service (IHS) reimbursement was updated to the Federal Office of Management and Budget (OMB) encounter rate. In order to more accurately compare SFY 2018 with previous fiscal years, IHS data was excluded from the analysis.

Costs in this report do not reflect the federal and state supplemental rebates that are provided by medication manufacturers. Many products, particularly the anti-infective medications, attention-deficit/hyperactivity disorder (ADHD) medications, antipsychotic medications, endocrine medications, and pain medications are heavily influenced by supplemental rebates and net costs are substantially lower than the total reimbursement to pharmacies shown here.

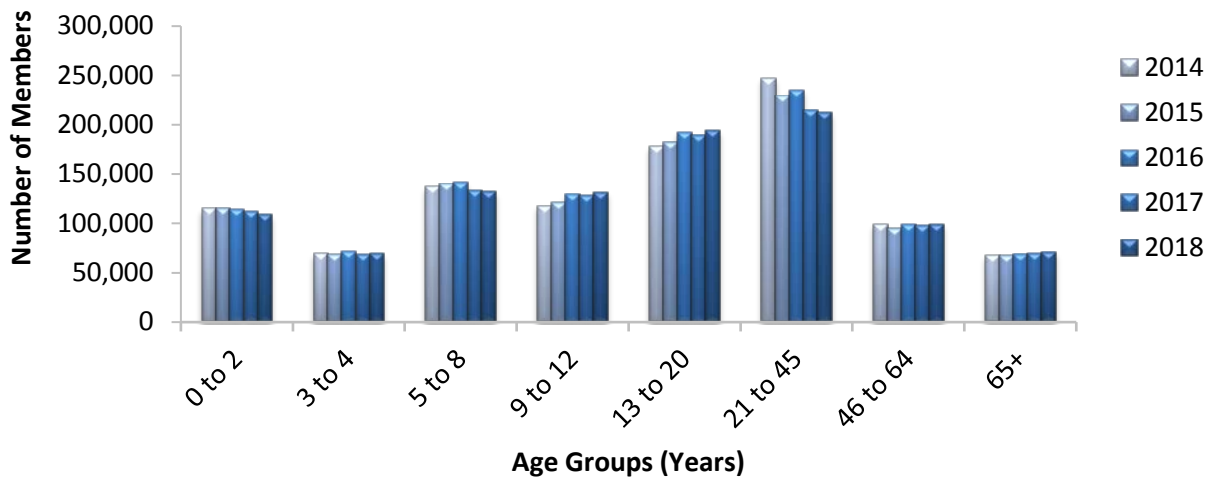
Total Pharmacy State Fiscal Year (SFY) Comparison							
SFY	Claims	Members	Utilizers	Cost	Cost/Claim	Cost/Member	Cost/Day
2014	6,378,863	1,033,114	573,699	\$461,468,656	\$72.34	\$446.68	\$2.93
2015	5,842,175	1,021,359	541,116	\$461,040,790	\$78.92	\$451.40	\$3.19
2016	5,891,156	1,052,826	542,290	\$495,171,030	\$84.05	\$470.33	\$3.32
2017	5,897,218	1,014,983	541,021	\$514,062,768	\$87.17	\$506.47	\$3.40
2018	5,802,025	1,020,726	535,823	\$543,569,067	\$93.70	\$532.62	\$3.61

Costs do not reflect rebated prices or net costs.

**Total Pharmacy Reimbursement and Member Enrollment Comparison**



**Members by Age Group SFY Comparison**



## Traditional Versus Specialty Pharmacy Products

Traditional pharmaceutical products include products which are typically indicated for many common chronic conditions such as diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). Traditional pharmaceuticals carry the bulk of the reimbursement costs, accounting for 83.2% of the total pharmacy reimbursement in 2018. Specialty pharmaceutical products, in contrast, are typically injectable and require special handling such as refrigerated transport and special administration techniques. These products include treatments for hemophilia, rheumatoid arthritis (RA), and genetic deficiencies, for example. Recently, the specialty pharmaceutical products total pharmacy reimbursement has been on the incline due to new emerging therapies.

## Traditional Pharmacy Expenditure Trend

The traditional pharmaceutical products comprised 83.2% of the total pharmacy reimbursement costs and were used by 99.96% of utilizers. In SFY 2014 the traditional pharmacy reimbursement comprised of 88% of the total pharmacy reimbursement however during SFY 2015 to 2017, traditional pharmacy reimbursement decreased to 84.7% and then to 82.5% of the total pharmacy reimbursement, respectively. Compared to SFY 2017, traditional pharmacy spending in SFY 2018 has decreased slightly for members 5 to 12 years of age and has increased for members 13 years of age and older. Traditional spending for those 13 years of age and older increased more than 8% in 2018 from the previous year. This increase in spending in the adolescent and adult population can largely be accounted for by the removal of a minimum fibrosis score requirement for authorization of costly antivirals for the treatment of hepatitis C, resulting in an increase in utilization and a subsequent increase in pharmacy reimbursement.

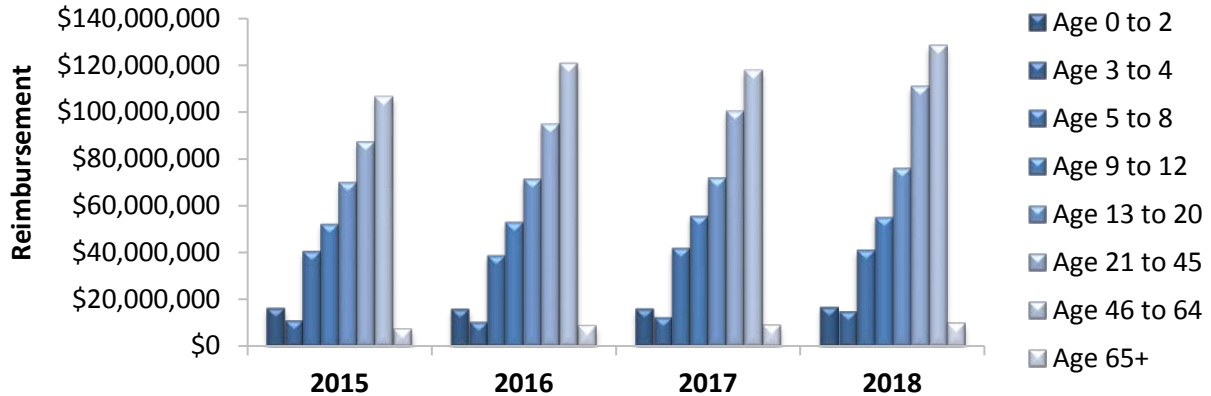
The top traditional pharmaceuticals for members 0 to 4 years of age include antibiotics and anti-asthma products. For members 5 to 20 years of age, top traditional pharmaceuticals include treatments for ADHD and other behavioral health-related conditions. For those members 21 to 45 years of age, the increase in expenditures can be attributed to atypical antipsychotics, hepatitis C therapies, and diabetes medications. Finally, expenditures for members 46 years of age and older include similar therapies to those 21 to 45 years of age, with the addition of COPD medications.

<b>Age Group (Years)</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
<b>Age 0 to 2</b>	\$16,027,845	\$15,562,590	\$15,744,262	\$16,424,744
<b>Age 3 to 4</b>	\$11,010,272	\$10,315,779	\$12,235,383	\$14,869,598
<b>Age 5 to 8</b>	\$40,433,970	\$38,626,102	\$41,724,293	\$40,915,001
<b>Age 9 to 12</b>	\$52,147,080	\$52,983,674	\$55,574,522	\$55,062,826
<b>Age 13 to 20</b>	\$69,812,445	\$71,164,995	\$71,690,506	\$75,829,557
<b>Age 21 to 45</b>	\$87,311,154	\$94,972,118	\$100,407,326	\$110,978,937
<b>Age 46 to 64</b>	\$106,595,795	\$120,681,290	\$117,861,211	\$128,366,280
<b>Age 65+</b>	\$7,262,277	\$8,713,602	\$8,919,979	\$9,760,679
<b>All ages</b>	<b>\$390,600,840</b>	<b>\$413,020,154</b>	<b>\$424,157,485</b>	<b>\$452,207,627</b>

Costs do not reflect rebated prices or net costs.

Totals based on total number of unduplicated members.

### Traditional Pharmacy Reimbursement Trend by State Fiscal Year



### Specialty Pharmacy Expenditure Trend

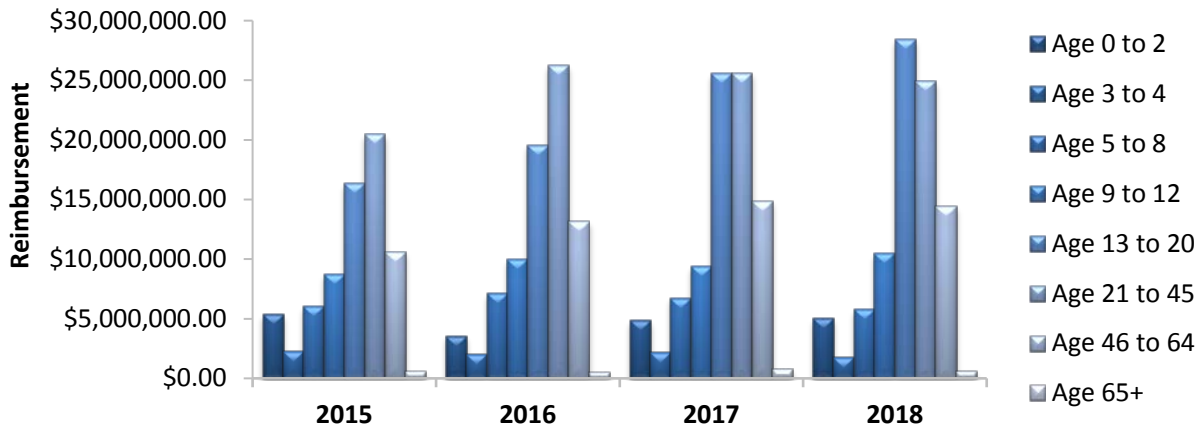
Specialty pharmaceuticals have become a larger part of reimbursement over the last five years, now comprising close to 17% of the total expenditures. Newly U.S. Food and Drug Administration (FDA) approved therapies for RA and dermatological conditions have led to an increase in specialty pharmaceutical expenditures this past year. The top specialty pharmaceuticals for members 0 to 2 years of age in SFY 2018 include anti-infectives, immunizing agents, antihemophilic agents, and respiratory agents including those indicated for cystic fibrosis (CF). The utilization of Synagis® (palivizumab), a specialty medication for the prophylaxis of respiratory syncytial virus (RSV) infection in high risk infants, increased from FY 2017 to FY 2018, attributing to growth in specialty reimbursement in the 0 to 2 year old age group. Some medication reimbursement requirements have minimum age limits for approval, one example being growth hormone, which for most indications requires the member to be 2 years of age or older. For members 5 to 12 years of age, specialty pharmaceuticals include similar examples to the younger children, excluding palivizumab, as well as targeted immunomodulatory agents (e.g., adalimumab, infliximab, etanercept). Teens most commonly utilized growth hormone, antihemophilic agents, and Cinryze®, a C1 esterase inhibitor indicated to prevent hereditary angioedema attacks. For members 18 years of age and older, specialty reimbursement costs are attributed to hydroxyprogesterone for preterm labor, hematologic therapies such as Wilate® (von Willebrand factor/coagulation factor VIII complex), and targeted immunomodulatory agents that are used to treat Crohn's disease, RA, ankylosing spondylitis (AS), and dermatological conditions such as atopic dermatitis and plaque psoriasis. Finally, for members 46 years of age and older, specialty pharmaceuticals include targeted immunomodulatory agents, multiple sclerosis (MS) medications, and cardiovascular specialty pharmaceutical products.

Specialty Pharmacy Reimbursement Age Group Comparison by State Fiscal Year				
Age Group (Years)	2015	2016	2017	2018
Age 0 to 2	\$5,367,199	\$3,565,336	\$4,829,498	\$5,047,000
Age 3 to 4	\$2,297,914	\$2,062,207	\$2,173,300	\$1,785,270
Age 5 to 8	\$6,034,031	\$7,142,948	\$6,732,542	\$5,795,868
Age 9 to 12	\$8,699,756	\$9,983,948	\$9,368,509	\$10,463,091
Age 13 to 20	\$16,358,502	\$19,556,424	\$25,571,310	\$28,454,258
Age 21 to 45	\$20,476,676	\$26,221,851	\$25,622,718	\$24,880,218
Age 46 to 64	\$10,612,463	\$13,128,718	\$14,866,052	\$14,417,546
Age 65+	\$590,395	\$487,184	\$735,502	\$609,601
<b>All ages</b>	<b>\$70,436,940</b>	<b>\$82,148,620</b>	<b>\$89,902,433</b>	<b>\$91,452,855</b>

Costs do not reflect rebated prices or net costs.

Totals based on total number of unduplicated members.

### Specialty Pharmacy Reimbursement Trend by State Fiscal Year



### Per Member Per Year (PMPY) Spending

Overall PMPY spending has increased to \$532.52 during SFY 2018. The increased PMPY spending can be attributed to the rising cost of generic medications with single manufacturers, brand formulation price increases as products approach the end of their patent-life, as well as the significant cost of new therapies upon market entry.

Spending Per Member Per Year (PMPY) by State Fiscal Year (SFY)				
SFY	2015	2016	2017	2018
<b>Overall PMPY</b>	\$382.43	\$470.32	\$506.47	\$532.52

Costs do not reflect rebated prices or net costs.

The traditional pharmaceutical products PMPY overall total (all ages) has increased every year since 2015. The 46 to 64 years age group was the only age group's PMPY to have decreased in 2017 from 2016; however, then increased again in 2018. There are two groups that have increased each year: the 21 to 45 years and the 65 years and older age groups, with the 21 to 45 years age group having the biggest increase over time, increasing by 27.25% since 2015. These

increases in adult age groups can be attributed to the removal of the minimum fibrosis score for hepatitis C medication authorization, along with newer treatments for chronic conditions such as diabetes and COPD. The 2018 PMPY for the 9 to 12 years age group was less than 2017's and 2015's PMPY. In addition, the 13 to 20 years age group has increased less than 2% since 2015, increasing by \$7.39 over the last four years. This may be due to new generic availability of some commonly used medications in that age group for ADHD and atypical antipsychotic therapies.

<b>Traditional Per Member Per Year Age Group Comparison by State Fiscal Year</b>				
<b>Age Group (Years)</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Age 0 to 2	\$139.26	\$135.73	\$140.55	\$150.48
Age 3 to 4	\$158.94	\$144.15	\$177.62	\$214.30
Age 5 to 8	\$288.25	\$272.95	\$311.91	\$308.18
Age 9 to 12	\$430.09	\$409.04	\$431.66	\$417.52
Age 13 to 20	\$382.09	\$369.44	\$379.09	\$389.46
Age 21 to 45	\$380.44	\$403.49	\$466.63	\$522.99
Age 46 to 64	\$1,117.05	\$1,220.72	\$1,205.96	\$1,291.61
Age 65+	\$107.06	\$126.87	\$128.26	\$136.99
<b>All ages</b>	<b>\$382.43</b>	<b>\$392.30</b>	<b>\$402.88</b>	<b>\$443.00</b>

Costs do not reflect rebated prices or net costs.

The specialty pharmaceutical products PMPY overall total (all ages) has increased similarly to the traditional pharmaceutical products PMPY since 2015. From SFY to SFY, the 13 to 20 years age group has increased steadily; this upward incline may be due to the new dermatological therapies, hemophilia medications, and CF products introduced within the last several years. Meanwhile, members younger than 9 years of age either were close to the same as 2015 PMPY spending or less, as in the case of the 3 to 4 years age group. The 3 to 4 years age group decreased by 22.62% from 2017. Members younger than 9 years of age were the majority of users of inhaled anti-infective medications; cost per claim dropped by 5.40% from 2017.

<b>Specialty Per Member Per Year Age Group Comparison by State Fiscal Year</b>				
<b>Age Group (Years)</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Age 0 to 2	\$46.63	\$31.09	\$43.11	\$46.24
Age 3 to 4	\$33.17	\$28.82	\$31.55	\$25.73
Age 5 to 8	\$43.02	\$50.47	\$50.35	\$43.66
Age 9 to 12	\$71.75	\$77.08	\$72.77	\$79.34
Age 13 to 20	\$89.53	\$101.52	\$135.22	\$146.14
Age 21 to 45	\$89.22	\$111.40	\$119.08	\$117.25
Age 46 to 64	\$111.21	\$132.80	\$152.11	\$145.07
Age 65+	\$8.70	\$7.09	\$10.58	\$8.56
<b>All ages</b>	<b>\$68.96</b>	<b>\$78.03</b>	<b>\$85.39</b>	<b>\$89.52</b>

Costs do not reflect rebated prices or net costs.

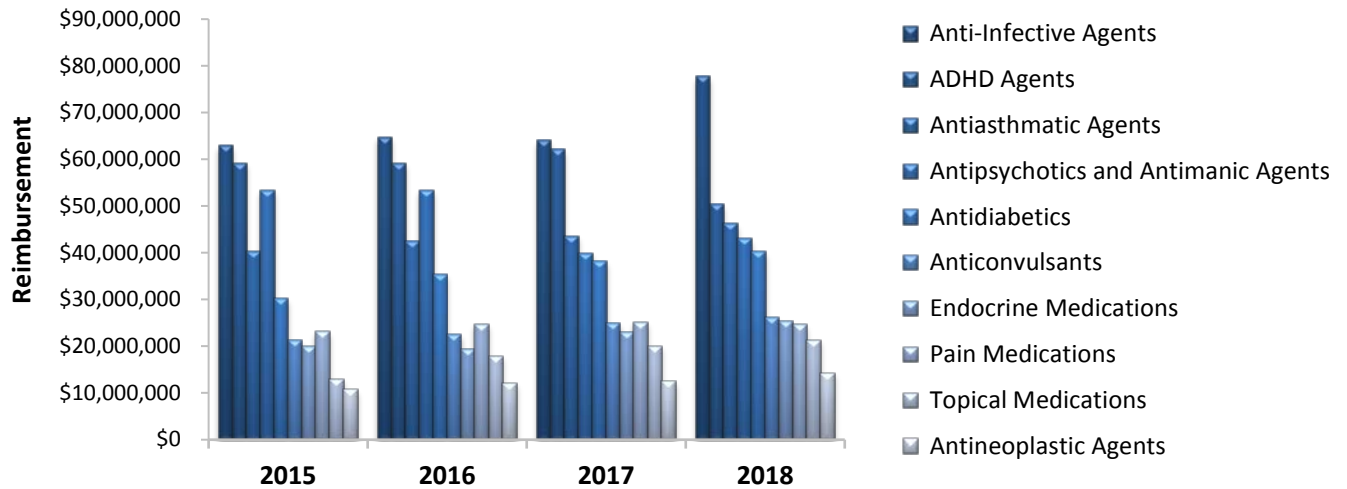
## Traditional Therapeutic Class Reimbursement Trend<sup>2</sup>

The top 10 traditional pharmaceutical classes that show the most significant change include the anti-infective agents and ADHD agents. The anti-infective agent reimbursement increased by \$13 million; \$3 million of which is from an increase in utilization of anti-influenza treatments alone (see following oseltamivir utilization table). According to the Centers for Disease Control and Prevention (CDC), the 2017 to 2018 influenza season was considered “high severity” with Oklahoma being one of the first states to have positive influenza cases in the United States that season. The other \$10 million comes from the newer hepatitis C treatments, and the aforementioned removal of the minimum fibrosis score requirement resulting in substantial increases in utilization. Cost reductions in the ADHD class are due to multiple manufacturers of generic atomoxetine getting FDA approval for marketing in May 2017, along with increased availability of other generic stimulant medications. Reimbursement for topical medications has increased this past SFY, a result of FDA approval of new medications for the treatment of atopic dermatitis. Lung cancer medications increased by \$2 million since 2017, accounting for the increase in antineoplastic agents. Costs in this report do not reflect the federal and state supplemental rebates that are provided by medication manufacturers. Many branded products, particularly the anti-infective agents, ADHD agents, antipsychotic medications, endocrine medications, and pain medications are heavily influenced by supplemental rebates and net costs are substantially lower than the total reimbursement paid to pharmacies shown here. The antidiabetic medications class has increased in price significantly, resulting in a large spending increase in the antidiabetic medications class since 2015. These products have significant federal rebates designed to keep the Medicaid net cost relatively flat; however, rebates are not accounted for in this analysis.

<b>Traditional Top 10 Classes by Reimbursement</b>				
<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>Therapeutic Class</b>
\$62,972,086	\$64,753,193	\$63,996,676	\$77,754,042	<b>Anti-Infective Agents</b>
\$59,222,643	\$59,210,124	\$62,118,533	\$50,326,685	<b>ADHD Agents</b>
\$40,250,424	\$42,407,875	\$43,565,926	\$46,258,925	<b>Antiasthmatic Agents</b>
\$53,508,208	\$53,434,190	\$39,977,374	\$43,111,772	<b>Antipsychotics</b>
\$30,259,419	\$35,416,629	\$38,298,122	\$40,247,671	<b>Antidiabetics</b>
\$21,264,626	\$22,587,039	\$24,851,122	\$26,190,057	<b>Anticonvulsants</b>
\$20,090,703	\$19,378,355	\$22,954,966	\$25,402,170	<b>Endocrine Medications</b>
\$23,157,175	\$24,729,391	\$25,210,044	\$24,633,644	<b>Pain Medications</b>
\$12,977,166	\$17,927,089	\$20,067,381	\$21,345,644	<b>Topical Medications</b>
\$10,780,515	\$12,125,906	\$12,518,084	\$14,310,913	<b>Antineoplastic Agents</b>

Costs do not reflect rebated prices or net costs.

### Top 10 Traditional Therapeutic Classes Reimbursement by State Fiscal Year



Tamiflu® (Oseltamivir) Utilization Compared by State Fiscal Year (SFY)						
SFY	Claims	Members	Cost	Cost/Claim	Cost/Member	Cost/Day
2015	43,104	41,434	\$7,527,603	\$174	\$181	\$29.04
2016	11,108	10,613	\$2,091,808	\$188	\$197	\$31.19
2017	47,823	45,845	\$8,730,429	\$182	\$190	\$30.72
2018	78,069	73,694	\$11,640,926	\$149	\$157	\$25.58
<b>% Change</b>	<b>81.1%</b>	<b>77.9%</b>	<b>54.6%</b>	<b>-14.6%</b>	<b>-13.3%</b>	<b>-11.9%</b>
<b>Change*</b>	<b>34,965</b>	<b>32,260</b>	<b>\$4,113,323</b>	<b>-\$25</b>	<b>-\$24</b>	<b>-\$3.46</b>

\*Change calculated from 2015 to 2018.

Costs do not reflect rebated prices or net costs.

### Specialty Therapeutic Class Reimbursement Trend<sup>3</sup>

Specialty therapeutic products costs are high largely in part due to the therapies focused on rare diseases. Specialty pharmaceutical respiratory agents include medications for CF, idiopathic pulmonary fibrosis (IPF), and emphysema. Orkambi® (lumacaftor/ivacaftor) is a medication approved by the FDA in July 2015 for patients with CF with two copies of the *F508del* mutation in their cystic fibrosis transmembrane regulator (CFTR) gene<sup>2</sup>.

The cost of specialty pain products has increased by \$5 million within the last SFY. The cost increase can be attributed to the cost inflation of targeted immunomodulatory agents such as Humira® (adalimumab), Enbrel® (etanercept), Ilaris® (canakinumab), Orencia® (abatacept), Simponi® (golimumab), Xeljanz® (tofacitinib), Otezla® (apremilast), and Kineret® (anakinra). With the emergence of biosimilar FDA approvals, current branded product manufacturers raised their prices in anticipation of larger market share for the biosimilars. All of the above mentioned products have increased cost per claim prices by a minimum of \$400 per claim. The average price increase per claim of the aforementioned products this SFY was \$617 per claim. This cost increase was seen while utilization remained relatively flat. This class will soon face biosimilar competition similar to generic competition for branded patent expirations. The consumer price index (CPI) penalty of the federal rebate is designed to keep Medicaid net cost

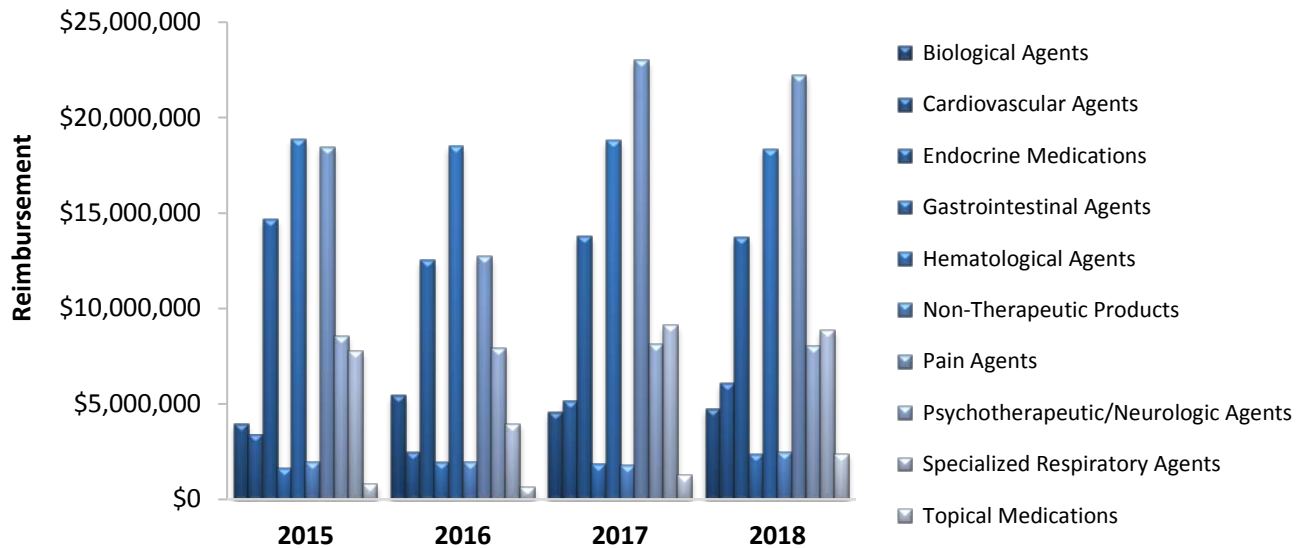


relatively flat despite price increases in medications that pay the brand penalty. The cost increases in the report do not reflect the net cost increases. Additionally, the majority of utilization was seen in Tier-2 medications, which are supplemental rebated medications. The supplemental rebated prices are also not reflected in this analysis.

Specialty Top 10 Classes by Reimbursement				
2015	2016	2017	2018	Therapeutic Class
\$12,732,939	\$18,481,116	\$22,988,676	\$22,236,627	Pain Agents
\$18,497,494	\$18,852,788	\$18,813,132	\$18,339,418	Hematological Agents
\$12,528,464	\$14,684,343	\$13,782,182	\$13,738,382	Endocrine Medications
\$3,959,014	\$7,754,987	\$9,093,408	\$8,860,036	Specialized Respiratory Agents
\$7,930,952	\$8,540,617	\$8,139,124	\$8,035,140	Psychotherapeutic/Neurologic Agents
\$2,441,564	\$3,387,174	\$5,143,843	\$6,071,976	Cardiovascular Agents
\$5,459,825	\$3,935,198	\$4,581,237	\$4,745,569	Biological Agents
\$1,930,027	\$1,928,230	\$1,780,090	\$2,473,095	Non-Therapeutic Products
\$638,208	\$793,104	\$1,253,685	\$2,380,074	Topical Medications
\$1,962,601	\$1,642,701	\$1,856,032	\$2,360,853	Gastrointestinal Agents

Costs do not reflect rebated prices or net costs.

Top 10 Specialty Therapeutic Classes By Reimbursement



Specialty Therapeutic Medications with Increased Reimbursement from SFY 2017		
Medication Class	% Change from SFY 2017	Change from SFY 2017
Cystic fibrosis (CFTR modulators)	26.30%	\$2,097,571.80
Dermatological immune modulators	18.79%	\$718,147.96
Lung cancer	19.01%	\$2,053,926.23

Costs do not reflect rebated prices or net costs.

## Hepatitis C Medication Management Program

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The hepatitis C medication management program has been operating since 2014 to improve adherence and clinical cure rates [sustained virologic response (SVR)] while maintaining minimal cost increases in regimens. At this time, therapy initiation forms, intent to treat contracts, therapy continuation forms, and SVR response forms are required to obtain SVR data, start dates, and member compliance. This program analyzes therapy options for effectiveness and tolerability to determine optimal treatments with cost-effective outcomes.

Hepatitis C Medications Utilization Compared by State Fiscal Year (SFY)						
SFY	Claims	Members	Cost	Cost/Claim	Cost/Member	Cost/Day
2015	432	174	\$13,664,658	\$31,631	\$78,532	\$1,132
2016	1,009	353	\$31,148,335	\$30,870	\$88,239	\$1,102
2017	900	366	\$25,300,197	\$28,111	\$69,126	\$1,003
2018	1,576	680	\$36,230,952	\$22,989	\$53,281	\$821
% Change	264.8%	290.8%	165.1%	-27.3%	-32.2%	-7.5%
Change*	1,144	506	\$22,566,294	-\$8,642	-\$25,251	-\$311

\*Change calculated from 2015 to 2018.

Costs do not reflect rebated prices or net costs.

The increase in hepatitis C medication spending is likely due to the increase in utilization as a result of the removal of the minimum fibrosis score requirement in January 2018. The cost increase could also be accounted for by the use of two direct-acting antiviral (DAA) agents in combination, as recommended by treatment guidelines for some less common hepatitis C viral genotypes. Combination regimen use should decrease as they are no longer preferred regimens due to increased availability of new regimens that treat multiple genotypes. Continual efforts are made to ensure appropriate use for efficacy and cost containment.

## Top 10 Medications by Reimbursement

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Most of the top 10 medications by reimbursement are still branded at this time and not available in a generic formulation. Oseltamivir jumped from the 9th spot to the 6th ranking in SFY 2018 due to the influenza epidemic as mentioned earlier in this report. Insulin glargine has decreased in ranking due to market competition. Aripiprazole and atomoxetine have fallen out of the top 10 due to generic availability and subsequent lower costs. The top products typically come from highly utilized classes such as atypical antipsychotics, ADHD therapies, respiratory medications, including rescue and maintenance therapies, and the anti-infective class, including antiviral medications for hepatitis C. Top drug reimbursement rankings change from year to year only slightly for several reasons: high use, broad use between age demographics, and high costs of new therapies such as those indicated for hepatitis C.

<b>Top 10 Medications by Reimbursement</b>				
<b>Rank</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
<b>1</b>	aripiprazole	lisdexamfetamine	lisdexamfetamine	lisdexamfetamine
<b>2</b>	lisdexamfetamine	aripiprazole	ledipasavir/sofosbuvir	paliperidone inj
<b>3</b>	albuterol	ledipasavir/sofosbuvir	paliperidone inj	ledipasavir/sofosbuvir
<b>4</b>	methylphenidate	methylphenidate	methylphenidate	albuterol
<b>5</b>	sofosbuvir	albuterol	albuterol	adalimumab
<b>6</b>	oseltamivir	paliperidone inj	adalimumab	oseltamivir
<b>7</b>	ledipasavir/sofosbuvir	atomoxetine	atomoxetine	methylphenidate
<b>8</b>	insulin glargine	adalimumab	insulin glargine	lurasidone
<b>9</b>	guanfacine ER	insulin glargine	oseltamivir	sofosbuvir/velpatasvir
<b>10</b>	atomoxetine	sofosbuvir	somatropin inj	insulin glargine

Rank does not reflect rebated prices or net costs.

Medications are listed by generic name, but may include both generic and brand formulations.

ER = extended-release; inj = injection

### **Total Enrollment<sup>4,5,6,7</sup>**

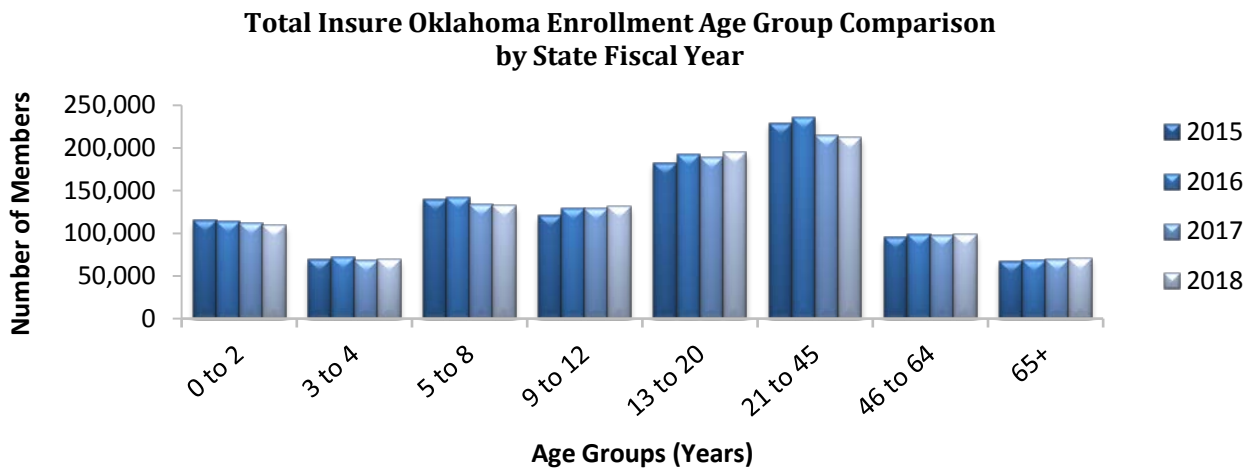
Total annual enrollment of SoonerCare members has reached over 1 million for the past five years. It is likely that SoonerCare enrollment will remain high due to several reasons including: 3.1% of Oklahoma hourly paid workers earning at or below the federal minimum wage (ranked 12<sup>th</sup> highest among the 50 states), the percent of Oklahomans below the federal poverty level is 15.8%, and poor overall health of Oklahomans (Oklahoma ranked 46<sup>th</sup> in the nation in overall health). Total enrollment encompasses a diverse group of programs including the following: Program of all-Inclusive Care for the Elderly (PACE), Home and Community-Based Services (HCBS), Soon to be Sooners (STBS), Care for Children with Disabilities: Tax Equity and Fiscal Responsibility Act (TEFRA), Family Planning (SoonerPlan), Breast and Cervical Cancer (Oklahoma Cares), Tuberculosis (TB) patients, and Insure Oklahoma (IO).

- Oklahoma Cares is the Breast and Cervical Cancer Treatment Program that provides SoonerCare benefits to uninsured women younger than 65 years of age, who need treatment for breast or cervical cancer (including pre-cancerous conditions and early-stage cancer).
- SoonerPlan is a benefit plan covering limited services related to family planning, to women and men 19 years of age and older, in an effort to reduce unwanted pregnancies.
- TEFRA Care for Children with Disabilities allows members younger than 19 years of age with special health care needs or disabilities to be cared for at home instead of in an institution.
- Children's Health Insurance Program (CHIP) provides benefits to children younger than 19 years of age and who have income between the maximum for standard eligibility and the expanded Federal Poverty Level (FPL) income guidelines.
- IO is a program to bridge the gap in health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60%), the employer (25%), and the employee (15%). The Individual Plan (IP) allows people who cannot access benefits through their employer, including those who

are self-employed or may be temporarily unemployed, to buy health insurance directly through the state<sup>3</sup>. Several reasons for the unstable IO enrollment: in January 2014 IO IP qualifying income guidelines decreased from 200 to 100% of the FPL, in July 2015 CMS approved a 1-year extension (January 1, 2016 to December 31, 2016) for the IO Premium Assistance Program without any modifications, in September 2015 ESI became available to any small business with up to 250 employees, and lastly, in March 2016 IO moved to online enrollment.

<b>Total Insure Oklahoma Enrollment Age Group Comparison by State Fiscal Year</b>				
<b>Age Group (Years)*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
<b>Age 0 to 2</b>	115,097	114,661	112,020	109,150
<b>Age 3 to 4</b>	69,274	71,565	68,881	69,388
<b>Age 5 to 8</b>	140,272	141,516	133,771	132,765
<b>Age 9 to 12</b>	121,246	129,533	128,747	131,882
<b>Age 13 to 20</b>	182,714	192,629	189,110	194,703
<b>Age 21 to 45</b>	229,498	235,377	215,176	212,200
<b>Age 46 to 64</b>	95,426	98,861	97,732	99,385
<b>Age 65+</b>	67,832	68,684	69,546	71,253
<b>All Ages</b>	<b>1,021,359</b>	<b>1,052,826</b>	<b>1,014,983</b>	<b>1,020,726</b>

\*Includes Insure Oklahoma members



## Market Projections<sup>8</sup>

Recently approved medications in the third and fourth quarter of calendar year 2018 for various types of oncology indications (see following table) will likely influence future reimbursement trends in SFY 2019. With new oncology agents continually flooding the market, assessment of oncology medication classes will need frequent reevaluation.

<b>FDA Approved Oncology Medications in State Fiscal Year 2018</b>			
<b>Brand</b>	<b>Generic</b>	<b>Indication</b>	<b>Date of Approval</b>
<b>Copiktra™</b>	duvelisib	chronic lymphocytic leukemia (CLL)	September 2018
<b>Daurismo™</b>	glasdegib	acute myeloid leukemia (AML)	November 2018
<b>Libtayo®</b>	cemiplimab-rwlc	cutaneous squamous cell carcinoma (CSCC)	September 2018
<b>Lorbrena®</b>	lorlatinib	non-small cell lung cancer (NSCLC)	November 2018
<b>Lumoxiti™</b>	moxetumomab	hairy cell leukemia	September 2018
<b>Talzenna®</b>	talazoparib	breast cancer	October 2018
<b>Vitrakvi®</b>	larotrectinib	NTRK gene fusion tumor	November 2018
<b>Vizimpro®</b>	dacomitinib	NSCLC	September 2018
<b>Xospata®</b>	gilteritinib	AML	November 2018

Table information sourced from: [www.centerwatch.com/drug-information/fda-approved-drugs/](http://www.centerwatch.com/drug-information/fda-approved-drugs/).

## **Conclusions**

New prior authorization categories and continuous evaluation of the lung cancer medications, chronic lymphocytic leukemia medications, breast and prostate cancer medications, and hemophilia medications, along with new respiratory and diabetic medications that continue to be FDA approved, ensure the most clinically appropriate, cost-effective measures are taken. Modifications to the topical corticosteroid tier structure and other generic categories reduced elevated spending on high-priced generic products. When new drugs are FDA approved and available on the market, a cost-effective analysis is performed to ensure spending is minimized while ensuring appropriate clinical care. The goal of the SoonerCare program is to provide members with the most appropriate health care in a fiscally responsible manner. For the pharmacy benefit, this is accomplished using a robust prior authorization program, limiting the number of total prescriptions and the number of brand name prescriptions allowed each month for non-institutionalized adult members, continuous product pricing maintenance, and provider outreach and education. Constant market review and response to changes, such as the introduction of new hepatitis C treatments, growth of the specialty market, and introduction of biosimilars, is necessary. SoonerCare will continue to strive to bring value-based pharmacy services to its members.

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- <sup>1</sup> Centers for Medicare and Medicaid Services (CMS). National Health Expenditure Projections 2017-2026, forecast summary. Available online at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/nhe-fact-sheet.html>. Last revised 12/06/2018. Last accessed 01/02/2019.
- <sup>2</sup> Brooks M. FDA Clears First Generic Versions of Strattera for ADHD. *Medscape*. Available online at: <https://www.medscape.com/viewarticle/880860>. Issued 05/30/2017. Last accessed 01/02/2019.
- <sup>3</sup> Vertex Pharmaceuticals, Inc. FDA Approves ORKAMBI™ (lumacaftor/ivacaftor) - the First Medicine to Treat the Underlying Cause of Cystic Fibrosis for People Ages 12 and Older with Two Copies of the F508del Mutation. *Business Wire*. Available online at: <https://investors.vrtx.com/news-releases/news-release-details/fda-approves-orkambitm-lumacaftorivacaftor-first-medicine-treat>. Issued 07/02/2015. Last accessed 01/02/2019.
- <sup>4</sup> Oklahoma Health Care Authority. Enrollment Fast Facts. Available online at: <http://www.okhca.org/research/data>. Last revised 12/10/2018. Last accessed 01/02/2019.
- <sup>5</sup> Cosgrove J. Oklahoma ranks 46th in overall health, new study says. *Tulsa World*. Available online at: [https://www.tulsaworld.com/homepagelatest/oklahoma-ranks-th-in-overall-health-new-study-says/article\\_3700da41-4cba-5f68-b550-ba18f83eb549.html](https://www.tulsaworld.com/homepagelatest/oklahoma-ranks-th-in-overall-health-new-study-says/article_3700da41-4cba-5f68-b550-ba18f83eb549.html). Issued 12/16/2016. Last accessed 01/02/2019.
- <sup>6</sup> Cullison C. Oklahoma Poverty Profile. Oklahoma Policy Institute. Available online at: <https://okpolicy.org/2017-oklahoma-poverty-profile/>. Issued 10/31/2018. Last accessed 01/23/2019.
- <sup>7</sup> United States Department of Labor: Bureau of Labor Statistics. Minimum Wage Workers in Oklahoma – 2017. Available online at: [https://www.bls.gov/regions/southwest/news-release/minimumwageworkers\\_oklahoma.htm](https://www.bls.gov/regions/southwest/news-release/minimumwageworkers_oklahoma.htm). Last revised 07/26/2018. Last accessed 01/23/2019.
- <sup>8</sup> CenterWatch. 2018 FDA Approved Drugs. Available online at: [www.centerwatch.com/drug-information/fda-approved-drugs/](http://www.centerwatch.com/drug-information/fda-approved-drugs/). Last accessed 01/02/2019.