CONNECTICUT
OHS Office of Health Strategy

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TOP TEN LIST OF OUTPATIENT PRESCRIPTION DRUGS PURSUANT TO PUBLIC ACT 23-171 SEC. 8

PRELIMINARY REPORT FOR PUBLIC COMMENT BY MARCH 1, 2024

Statutory Reference: Public Act 23-171 Sec. 8
The Office of Health Strategy (OHS) is charged by statute to develop a list of not more than ten outpatient prescription drugs that OHS determines are provided at substantial cost to the state or critical to public health. The list must be based on the specifications outlined in Public Act 23-171 Sec. 8(d)(1):

- The list must include no less than one generic drug;
- The list must include drugs from different therapeutic classes;
- The wholesale acquisition cost (WAC) of such outpatient prescription drug (A) increased by not less than sixteen per cent cumulatively during the immediately preceding two calendar years, and (B) was not less than forty dollars for a course of treatment.

**The statute requires that criteria be based upon the wholesale acquisition cost (WAC) of the drug, less all rebates paid to the state for the drug. The rebate data is unavailable at this time.*

Public Comment**:** Under Public Act 23-171 Sec. 8 (d)(2) OHS is making a preliminary list available for public comment for the next 30 days until March 1, 2024. During the public comment period, any manufacturer of an outpatient prescription drug included on the preliminary list may produce documentation to OHS to establish that the drug by NDC, less all rebates, does not meet the criteria established above. If OHS is satisfied with the documentation, the agency will remove the drug from the preliminary list 15 days after the closing of the public comment period before publishing the annual list.

The list of Top 10 highest cost drugs that both increased by more than **16%** in WAC from CY 2020-2022 and were higher than **$40** for a course of treatment are located here: - https://portal.ct.gov/OHS/Pages/Prescription-Drug-Reporting-System

Please submit all comments via email to Krista Moore, krista.moore@ct.gov.

Source of Data: OHS prepared the 2023 drug list using the All-Payer Claims Database (APCD), CT Insurance Department Managed Care Enrollment, and WAC data from Micromedex Redbook. APCD data is submitted by the insurance carriers, Medicaid, and the state employee plan. The Micromedex data is incorporated into the APCD and updated on a quarterly basis. The data utilized in this analysis is for calendar years 2020-2022, with six months of claims run out for expenses incurred in 2022.

Note: The APCD data includes commercial claims for all fully insured Connecticut health plans and some self-insured plans, namely, state employees and retirees, and the CT Partnership 2.0

municipalities plan. Per the 2016 Supreme Court Gobeille Decision[1], self-insured employers are not required to submit claims data to state APCDs. However, research OHS has reviewed shows no evidence that self-insured plans differ systematically from fully insured plans in terms of benefit design or price.[2] The APCD does not contain information on pharmacy rebates.

Methodology: OHS utilized the statutory criteria of $40 for a course of treatment to identify 250 outpatient prescription drugs by National Drug Code (NDC) with the highest total commercial costs. The total commercial cost for each drug is either 1) the allowed amount for a pharmacy claim or, 2) the sum of the insurer paid amount and member out of pocket cost (i.e. deductible, co-insurance and co-pay). After identifying the drugs that cost at least $40 for a course of treatment and were among the 250 drugs with the highest total spending in the APCD, OHS then used the associated Micromedex 2020 – 2022 WAC data for each NDC on the list to determine if its cumulative price increases for the three-year period exceeded 16%. The list represents the Top 10 highest cost drugs that met the statutory criteria.

OHS may release separate information or data that provides useful information to enhance transparency. The additional lists will also be based on the state plan dataset.

This listing and any additional list or data releases which OHS posts or makes available, will not trigger the information and data filings required by Conn. Gen. Stat. § 19a-754b (c)(2) from drug manufacturers, until the next list is released in March 2025.

COMMONLY USED ABBREVIATIONS AND DEFINITIONS

Abbreviations

APCD – All Payer Claims Database
DSS – Connecticut Department of Social Services
NDC - National Drug Code
WAC – Wholesale Acquisition Cost

Definitions

Brand Drug – a prescription drug, having a unique NDC, marketed under a proprietary name or registered trademark name, including a biological product, and approved under a New Drug Application or Biologics License Application.

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[1] Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016) . Accessed January 9, 2024 at Accessed https://supreme.justia.com/cases/federal/us/577/312/

[2] Christine Eibner et al. (2011) Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA). Accessed January 9, 2024 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4945181/#:~:text=Overall%2C%20we%20find%20little%20evidence,exemptions%20for%20self%2Dinsured%20plans

Estimated Total Commercial Cost (HMO and Indemnity) – the estimated total cost of a drug reimbursed by the commercial insurers (Aetna, Anthem, Cigna, Connecticare, United HealthCare), which is the allowed amount for a pharmacy claim, or the sum of the paid amount and member out of pocket cost (i.e. deductible, co-insurance and co-pay). These costs include estimated self-insured costs determined based on CT Insurance department managed care enrollment for HMO and indemnity health plans ratio of fully insured to self-insured, and assuming the use rate and cost per prescription for each drug (NDC) were similar for the two groups (i.e., . fully insured enrollees and self-insured enrollees).

Estimated Total Commercial Cost (from OHS' APCD)– the estimated total cost of a drug reimbursed by the commercial insurers (Aetna, Anthem, Cigna, Connecticare, United HealthCare), which is the allowed amount for a pharmacy claim, or the sum of the paid amount and member out of pocket cost (i.e. deductible, co-insurance and co-pay). These costs are from OHS' APCD and include fully-insured and state employees.

Estimated Total Medicaid Cost – the estimated total cost of a drug reimbursed by the DSS' Medicaid program, which is the allowed amount for a pharmacy claim, or the sum of the paid amount and member out of pocket cost (i.e., deductible, co-insurance and co-pay).

Estimated Total State Employee Cost – the estimated total cost of a drug reimbursed by the commercial insurers (Aetna, Anthem, Cigna, Connecticare, United HealthCare) for state employees and retirees. This cost is the allowed amount for a pharmacy claim, or the sum of the paid amount and member out of pocket cost (i.e. deductible, co-insurance and co-pay). This number is included in Estimated Total Commercial Cost but is broken out for this analysis.

Estimated Total Prescriptions (HMO and Indemnity)– the estimated total number of prescriptions reimbursed by commercial insurers for that NDC. This includes estimated self-insured prescriptions.

Estimated Total Prescriptions (from OHS' APCD)– the estimated total number of prescriptions reimbursed by commercial insurers for that NDC. This includes fully-insured and state employees.

Estimated Medicaid Prescriptions – the estimated total number of prescriptions reimbursed by DSS' Medicaid program.

Estimated State Employee Prescriptions – the estimated total number of prescriptions for state employees and retirees reimbursed by commercial insurers for that NDC. This number is included in Estimated Total Commercial Prescriptions but is broken out for this analysis.

Generic Drug – a prescription drug, having a unique NDC, whether identified by its chemical, proprietary or nonproprietary name, that is not a brand drug, is therapeutically equivalent to a brand drug in dosage, strength, method of consumption, performance and intended use, and approved under an Abbreviated New Drug Application. Generic Drug includes a biosimilar product.

National Drug Code – a code maintained by the federal Food and Drug Administration that is

uniquely assigned by manufacturer, product, and packaging.

Per Unit - defined by the federal definition 42 USC 1395w-3a the term “unit” means, with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids.

Rebate – a discount, chargeback, or other price concession that affects the price of a prescription drug product.

Therapeutic Class – a group of drugs used for the treatment, remediation, or cure of a specific disorder or disease.

Therapeutic Description – a description of the therapeutic class and treatment of illness or condition.

Wholesale Acquisition Cost- defined by the federal definition 42 USC 1395w-3a as the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.