Report on Data Call Related to Prescription Drug Coverage of Generics and Biosimilars

Prepared by the

Maine Bureau of Insurance

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Introduction

The Maine Bureau of Insurance ("BOI") was directed by Public Law 2023, Chapter 177, "Resolve, Directing the Superintendent of Insurance to Collect Data from Health Insurers Related to Prescription Drug Coverage of Generic Drugs and Biosimilars" to collect data from carriers in Maine regarding the placement of prescription drugs and biosimilars on each carrier's prescription drug formulary, and to report its findings to the Health Coverage, Insurance and Financial Services Committee ("HCIFS")[1].

During the summer of 2024, BOI sent a request for information to seven carriers providing prescription drug coverage in Maine and then met with the carriers to discuss the parameters of the data call and respond to questions about the scope of the data call. Carriers included in this report are Anthem Health Plans of Maine, Cigna Health and Life Insurance Company, Aetna Life Insurance Company/Aetna Health Insurance, Harvard Pilgrim Healthcare, Community Health Options, UnitedHealthcare Insurance Company, and Taro Health.

Key Findings

Carriers have similar procedures for evaluating generics and biosimilar drugs. The decision to include a medication on a drug formulary involves a balance of clinical and financial considerations.

Generic prescription drugs are filled in much greater numbers than brand name drugs and cost considerably less than brand-name drugs.

The average net cost of a 30-day generic drug prescription in 2023 was $27, while the cost of branded drug was $327 and the cost of a specialty drug was $4,431. The average cost of a biosimilar was $893. There are far fewer biosimilar drug prescriptions filled than specialty drug prescriptions. One carrier did not have any biosimilar prescriptions filled.

- In plan year 2023 across all seven carriers, there were 829 biosimilar drugs dispensed compared to 52,047 specialty drugs.

As one carrier explained, while generics and biosimilars are often preferred for their lower acquisition costs, branded products may sometimes cost less due to rebates, which can reduce the net cost to levels comparable to or even below the net cost of generics or biosimilars.

- The average rebate for brand-name drugs in 2023 was $187 and for specialty medicines the average rebate was $1,743.

[1] The Food and Drug Administration (FDA) defines a generic drug as one that is created to be the same as a marketed brand-name drug in dosage, safety, route of administration, quality, performance characteristics, and intended use. Generics use the same active ingredients as the brand-name drug but may have minor differences with inactive ingredients. It defines a biosimilar drug as one that is very similar to an original FDA approved biologic medication. They are used for treating many chronic and severe medical conditions such as diabetes, arthritis, osteoporosis, and multiple sclerosis. Biosimilars are made from natural and living sources like animal and plant cells and microorganisms such as bacteria or yeast. They must be made from the same types of sources as the original biologic, provide the same benefits, be given at the same strength and dosage, and not be expected to cause new or worsening side effects.

Section I: Brand and Generic Drugs

Question 1: The total number of generic equivalent drugs considered.

The BOI asked carriers to report the total number of generic drugs considered for placement on their respective formularies in 2022 and 2023. Below, Table A provides data submitted by each carrier.

Table A[2]
The total number of generic equivalent drugs considered

Carrier	2022	2023
1	38	43
2	176	156
3	66	79
5	37	44
6	N/A	66
7	25	30

The number of generic drugs considered across the carriers covered by this report ranged from 25 to 176 in 2022 and 2023.

Question 2: The total number of generic drugs added to the formulary.

The BOI asked carriers to report the total number of generic drugs added to their respective formularies in 2022 and 2023.

Table B[3]
The total number of generic drugs added to the formulary

Carrier	2022	2023
1	33	36
2	158	138
3	62	74
5	30	24
6	N/A	66
7	22	27

[2] Carrier 4 has been excluded from Table A because it reported that its Pharmacy and Therapeutics (P&T) Committee did not review any generics in 2022 and 2023. Instead, the P&T Committee reviewed and approved the carrier's Value Analysis Committee (VAC) guidelines.

[3] Carrier 4 has been excluded from Table B because it reported that its P&T Committee did not review any generics in 2022 and 2023. Instead, the P&T Committee reviewed and approved the carrier's VAC guidelines.

The number of generic drugs added to formularies across the carriers covered by this report ranged from 22 to 158 in 2022 and 2023.

Additional information from carriers:

Carrier 1 stated that if generic equivalents become available for covered brand drugs losing patent protection, the generic equivalents are automatically added to the formulary, or the brand drug is covered at a generic copay. It further explained that they identify all first-time generic approvals as listed directly from the FDA's website and remove the duplicate listing (based on drug name, so the drug is only listed once even if it has multiple strengths). Generics that are provider-administered are also deleted from this calculation because the medication would be covered under the plan's medical benefits rather than covering the medication through the prescription drug benefit. 33 generics were added to the formulary in 2022 and 36 in 2023.

Carrier 2 stated that with the exception of closed classes[4], non-specialty generics are automatically added to the formulary and default to a Tier 1 (lowest member cost sharing) status; specialty drugs typically default to a Tier 4 status. Carrier 2 further stated that hundreds of new National Drug Codes (NDCs) are added every year and would be extremely difficult to identify. For the purposes of this response, a new generic is considered to be a drug that was a single source drug at the beginning of the year and a multi-source drug by the end of the year.

Question 3: The criteria used in deciding whether to add a generic to the formulary.

Several carriers noted that determining formulary inclusion for new generics involved focusing on clinical appropriateness and effectiveness, according to national guidelines. Others started there, then added evaluations of cost savings or other cost criteria. Each carrier's detailed response is below:

Carrier 1 explained that it designs its formularies to meet the expectations of members, health care professionals and customers for quality, cost-effective pharmacy benefits. Its formularies include FDA-approved brand and generic drugs, including specialty drugs.

Every quarter, the company reviews each formulary in depth. It also reviews therapeutic classes when a new product is added to a class of drugs, and when there is new clinical information about the therapeutic class.

It bases formulary decisions on an extensive review of FDA-approved drugs. It maintains a P&T Committee to provide clinical input on all decisions and invites others outside or within the company who have specialized or unique knowledge, skills, and judgment to participate in the review process.

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[4] The carrier explained that its National Formulary is an open formulary with closed classes. Most drugs are included on the National Formulary; however, there are select classes that are considered closed, meaning some drugs in the class are Non-Formulary. These Non-Formulary drugs have clinically appropriate alternatives in the class that are available on formulary. For example, in the Diabetes class "Biguanides", Metformin (generic Glucophage XR) is on formulary, and Metformin (Glumetza and Fortamet) are Non-Formulary. Therefore, "Biguanides" is considered a "closed class".

Carrier 2 reported that in general, non-specialty generics are automatically added to the formulary and default to a Tier 1 status, and specialty drugs typically default to Tier 4. The Value Analysis Committee (VAC) has the ability to override the line extension guidelines by placing a generic in a different tier status. The VAC may consider financial information (i.e., average wholesale price, rebates, ingredient cost, cost of care, copayments, coinsurance), market factors and customer impact to determine tiers/levels.

Carrier 3 stated that its formulary development process is based on three principles:

- Clinical appropriateness of the drug, not cost, is its foremost consideration.
- The prescribing physician always makes the final decision regarding an individual patient's drug therapy.
- It develops clinically sound formularies based on evaluations of independent physicians.

Guided by these three principles, Carrier 3's formularies are developed through a four-step process, involving the work of three distinct committees.

The Therapeutic Assessment Committee (TAC) is an internal clinical review body, consisting of clinical pharmacists and physicians employed by the carrier's Pharmacy Benefit Manager (PBM). The TAC is tasked with reviewing specific medications following approval by the FDA, and with making a formulary placement recommendation to the National P&T Committee.[5]

The VAC is composed of employees from the carrier's PBM. The VAC reviews drugs designated as "access" or "optional" by the P&T Committee and develops a formulary placement recommendation. VAC is required to add medications with an "include" designation to the formulary, while drugs with an "exclude" designation may not be preferred on the formulary.

The National P&T Committee is a group of independent, actively practicing physicians and pharmacists who are not employed by the PBM. It is tasked with reviewing medications from a purely clinical perspective.[6] The P&T Committee reviews the final formulary placement recommendations of the TAC and VAC on an annual basis. It meets six times per year to evaluate new and existing medications.

Carrier 4 stated that it completes a clinical, evidence-based determination on the relative safety and efficacy of a drug under consideration. The P&T committee's clinical findings on the drug govern decisions about the medication for formulary placement. The carrier then performs a pharmacoeconomic review utilizing a cost benefit and cost effectiveness analysis. It considers the economic implications to customers, clients, and the insurer. Its economic and business considerations for formulary placement may include:

- Availability of contracting opportunities (including the prescription drug acquisition cost, available rebates, cost effectiveness, and the medical cost offset) that directly or indirectly reduce the client's pharmacy, medical or other expenses (including opportunities that reduce

[5] Carrier 3's P&T Committee can establish one of the following four formulary placement designations: *include*, *access*, *optional*, or *exclude* from a formulary.

[6] The National P&T Committee members do receive a stipend for preparation and participation in the meetings, based on "a reasonable estimate of revenue lost by not seeing patients while out of the office for meeting attendance and preparation."

the carrier's financial obligations if the carrier, rather than the client or plan, has financial responsibility for claims expenditures). Contracting opportunities, if accepted, may impact the tier placement.

- The amount paid by the carrier or an affiliate to the pharmacy for a drug.
- Renumeration directly or indirectly earned by the carrier from the pharmaceutical manufacturer or third parties that is attributable to a product's coverage status and/or utilization under plans administered or insured by the carrier or its health plan affiliates.

Economic and business considerations for formulary placement may not include:

- Availability of contracting opportunities to the extent such opportunities do not directly or indirectly reduce clients' pharmacy, medical, or other expenses.
- Consideration of revenue that is directly for the benefit of the carrier or its affiliates without a client or customer expense or premium reduction.
- Any remuneration earned by a pharmacy affiliate of the carrier that is not remitted to the carrier, the client, or the member either directly or through contracted cost reductions.

Carrier 5 explained that when a new generic becomes available, it is added to the formularies with coverage mirroring that of the corresponding brand. If a brand is covered on the preferred tier, then the generic will also be added to the formulary on the preferred tier. Likewise, if the corresponding brand is non-formulary, the new generic will also be non-formulary at the time of generic launch.

Carrier 5 further explained that if a new generic drug is part of a class of drugs managed with a "preferred product strategy" in place, then the generic may not be added to the formulary until further cost/strategy evaluations are done. On an annual basis, the clinical pharmacy team reviews and evaluates the cost and utilization of all generics and may add, remove, or change the tier of generics on the formulary.

Carrier 5 stated that the corresponding multi-source brand remains on the formulary when the generic is added. On a regular basis, it evaluates the coverage of these multi-source brands and may place the branded drug on a higher cost tier or remove them altogether from the formulary. It makes changes to the formulary effective either immediately or on a specified date, consistent with its notification policies.

Carrier 6 provided a list of factors that its P&T Committee considers when deciding whether to add a medication to its formulary. These factors include:

- **Clinical Efficacy and Safety:** Evaluating the effectiveness of the medication in treating the intended condition and its safety profile compared to existing alternatives.
- **Therapeutic Need:** Assessing the necessity of the medication based on the current treatment landscape and whether it addresses an unmet medical need.
- **Cost-Effectiveness:** Analyzing the cost of the medication in relation to its clinical benefits.

- **Utilization Data:** Reviewing real-world evidence and clinical trial data to understand how the medication performs in diverse patient populations.
- **Guideline Recommendations:** Considering national and international clinical guidelines that support the use of the medication.
- **Pharmacoeconomics:** Evaluating the overall economic impact, including budget impact analyses and long-term cost savings.

Carrier 6 explained that the net cost of a medication is the actual expense incurred by the healthcare provider after accounting for discounts. It is a crucial factor in formulary decisions as it reflects the true economic impact of adding a medication. While generics and biosimilars are often preferred for their lower acquisition costs, branded products may sometimes cost less in the end due to rebates, which can reduce the net cost to levels comparable to or even below those of generics or biosimilars.

Carrier 7 stated that newly launched generic prescription drugs are reviewed to determine initial tier placement on the Prescription Drug List (PDL) and/or benefit coverage. Generics will generally be considered for initial tier placement and/or benefit coverage equal to that of the current cost tier than the brand, or covered if the brand is not covered, if certain criteria are met. Generics may be excluded from coverage at launch if the reference brand product is covered and certain criteria are met (e.g., high-cost National Drug Code (NDC) generic product). New-to-market generic products that do not have a reference brand product available in the market and which have not been treated as a line extension will be reviewed for a tiering and coverage decision.

Generic product cost will be monitored on a quarterly basis to determine if re-review of generic product PDL coverage status or tiering is warranted. Re-review of generic products will be based on clinical, economic/financial, and pharmacoeconomic evaluation.

Question 4: For each brand drug on the formulary that lost patent protection during the year, list the tier of the brand drug, list any generic equivalent considered, indicate whether the generic was a "first generic," note whether the generic was added to the formulary, and if the generic was added, indicate the formulary tier placement of the generic.

The FDA approved 107 "First Generic" drugs in 2022, and 90 in 2023.[7] "First Generics," as the name implies, are the very first generic versions of marketed brand-name drug products to be approved by the FDA and are formulated to work in the same way as the brand-name product and provide the same clinical benefit.[8]

[7] For 2022 data, see: https://www.fda.gov/drugs/drug-and-biologic-approval-and-ind-activity-reports/2022-first-generic-drug-approvals. For 2023 data, see: https://www.fda.gov/drugs/drug-and-biologic-approval-and-ind-activity-reports/2023-first-generic-drug-approvals.
[8] New Generic Drug Approvals for 2024: https://www.drugs.com/generic-approvals.html

Table C Loss of patent protection for brands		
Carrier	**2022**	**2023**
1	49	45
2	62	69
3	21	24
4	42	43
5	26	21
6	N/A	66
7	24	29

Between 2022 and 2023, the number of brand drugs that lost patent protection ranged from 21 to 69.

Please visit https://www.maine.gov/pfr/insurance/node/1017 to view each carrier's individual data submission for Question 4. Each submission contains a list of each brand drug, generic equivalent, whether a generic was a first generic, whether a generic was added to the formulary, and the tier placement of the generic if it was added to the formulary.

Question 5: The number of requests received from members and/or their provider for formulary exceptions for generic drugs.

The range of requests varied greatly due to the underlying number of members covered by each carrier (i.e., insurers with the highest membership have a higher number of formulary exception requests.

Table D The number of requests received from members and/or their provider for formulary exceptions for generic drugs		
Carrier	**2022**	**2023**
1	0	0
2	2,601	3,434
3	1	137
4	89	100
5	1,160	2,497
6	N/A	0
7	0	0

Between 2022 and 2023, the number of requests received from members and/or their provider for formulary exceptions for generic drugs ranged from 1 to 3,434.

Section II: Specialty and Biosimilar Drugs

Question 6: The total number of biosimilar drugs considered.

Table E The total number of biosimilar drugs considered		
Carrier	**2022**	**2023**
1	5	30
2	24	48
3	10	5
4	8	5
5	5	3
6	N/A	20
7	4	2

From 2022 to 2023, the number of biosimilar drugs considered ranged from 24 to 48 across all carriers.

Question 7: The total number of biosimilar drugs added to the formulary.

Table F The total number of biosimilar drugs added to formularies		
Carrier	**2022**	**2023**
1	2	7
2	21	19
3	2	0
4	6	3
5	2	1
6	N/A	20
7	0	4

The number of biosimilar drugs added to formularies ranged from 0 to 21 in 2022 and 2023.

Question 8: The criteria used in deciding whether to add a biosimilar drug to the formulary.

Similar to the criteria used for evaluating generic drugs, several carriers noted that determining formulary inclusion for new biosimilars focused on clinical appropriateness and effectiveness, according to national guidelines. Other carriers also included evaluations of cost savings or other cost criteria. Each carrier's response is listed below.

Carrier 1 explained that it designs formularies to meet the expectations of members, health care professionals and customers for quality, cost-effective pharmacy benefits. Its formularies include FDA-approved brand and generic drugs, including specialty drugs.

Every quarter, it reviews each formulary in depth. It also reviews therapeutic classes when a new product is added to a class of drugs and when there is new clinical information about the therapeutic class.

It bases formulary decisions on an extensive review of FDA-approved drugs. It maintains a Pharmacy and Therapeutics (P&T) Committee to provide clinical input on all decisions and invites others outside or within the company who have specialized or unique knowledge, skills, and judgment to participate in the review process.

Carrier 2 reported that with the exception of closed classes, specialty biosimilars default to a Tier 4 status for the National 4-Tier formulary. In closed classes, specialty biosimilars will default to a Non-Formulary status. The P&T Committee does have the ability to override the line extension guidelines by placing a biosimilar in a different tier status. It may consider financial information (i.e. average wholesale price, rebates, ingredient cost, cost of care, copayments, coinsurance), market factors and customer impact to determine tiers/levels.

Carrier 3 stated that its formulary development process is based on three principles:

- Clinical appropriateness of the drug, not cost, is the foremost consideration.
- The prescribing physician always makes the final decision regarding an individual patient's drug therapy.
- It develops clinically sound formularies based on evaluations of independent physicians.

Guided by these three principles, Carrier 3's formularies are developed through a four-step process, involving the work of three distinct committees (see Carrier 3's response to question 3 above).

Carrier 4 stated that it completes a clinical, evidence-based determination on the relative safety and efficacy of a drug, including biosimilars. The P&T committee's clinical findings on the drug govern decisions about the medication for formulary placement. The carrier then performs a pharmacoeconomic review utilizing a cost benefit and cost effectiveness analysis. It considers the economic implications to customers, clients, and the insurer. (See Carrier 4's response to question 3 above.)

Carrier 5 reported that similar to all new drugs, biosimilar drugs are reviewed and evaluated for safety and efficacy, encourage the lowest net cost product(s), which may continue to be the reference product despite a biosimilar being available.

Carrier 6 referred to the formulary development document from its PBM, supplied in response to Section I, Question 3, above.

Carrier 7 explained that if a newly launched biosimilar drug meets certain criteria to be considered a line extension[9], it may be placed in the same coverage status and tier as a currently available reference product previously reviewed by the Prescription Drug List Management Committee (PDL MC). If the biosimilar drug is not treated as a line extension, it will generally be excluded from coverage at launch and will be reviewed by the PDL MC for a final coverage status and tier placement decision. Alternatively, biosimilar drugs not treated as a line extension may be covered in the highest-cost tier at launch, if coverage at launch is determined to be warranted, typically due to clinical justification, and will standardly be reviewed by the PDL MC for final coverage status and tier placement decision.

Biosimilar drugs will undergo clinical, economic/financial, and pharmacoeconomic evaluations. Biosimilar drugs that are determined to be of higher value (incorporating clinical, economic/financial, and pharmacoeconomic factors) will generally be covered and placed in lower-cost tiers. Products determined to be of lesser value will generally either be covered in a higher-cost tier or excluded.

Carrier 7 stated that it conducts ongoing review of the PDL. If there is new clinical, economic/financial, or pharmacoeconomic evidence that warrants re-review of a biosimilar drug, the drug will be reviewed again.

Question 9: For each specialty drug on the formulary for which a biosimilar is available, list the tier of the specialty drug, list any biosimilar considered, whether the biosimilar was added to the formulary, and if a biosimilar was added, the formulary tier placement of the biosimilar.

Please visit https://www.maine.gov/pfr/insurance/node/1017 to view each carrier's individual data submission for Question 9. Each submission contains a list of each specialty drug, its tier, equivalent, any biosimilar drug considered, whether a biosimilar was added to the formulary, and which tier placement a biosimilar received if it was added to the formulary.

[9] In general, a line extension is a new product to market which has the same active ingredient and route of administration as an existing product. Some examples would be a new extended-release formulation of a product currently available only in an immediate-release formulation, or new oral solution formulation of a product currently available only in an oral tablet formulation.

Question 10: The number of requests received for formulary exceptions for biosimilar drugs.

Table G The number of requests received for formulary exceptions for biosimilar drugs		
Carrier	**2022**	**2023**
1	5	6
2	4	5
3	0	0
4	0	0
5	5	17
6	N/A	0
7	0	1

As noted in the table, several carriers reported that they did not receive any requests for a formulary exception for a biosimilar drug. Of those that reported receiving an exception request, the range of requests varied from a low of 4 requests for Carrier 2 in 2022 to a high of 17 requests for Carrier 5 in 2023.

Section III: All Drugs

Below are the tables completed by the seven carriers for plan years 2022 and 2023. The tables include the number of 30-day prescriptions issued in each drug category, the gross costs, rebates received, and net costs. The Bureau calculated the average rebate and average net cost based on the information provided by the carriers.

All Carriers

All Carriers Plan Year 2022						
Drug Type	**Number of Prescriptions**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	2,321,125	$59,592,541	$235,367	$57,041,932	$0.10	$24.58
Brand	377,243	$138,633,632	$52,504,396	$89,297,381	$139.18	$236.71
Specialty	46,010	$260,198,377	$62,392,079	$198,253,853	$1,356.05	$4,308.93
Biosimilar	621	$723,772	$357,609	$626,735	$575.86	$1,009.24
Total	2,677,710	$458,198,209	$115,489,452	$344,269,789	$43.13	$128.57

All Carriers Plan Year 2023						
Drug Type	**Number of Prescriptions**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	2,311,423	$64,536,098	$1,354	$62,136,622	$0.00	$26.88
Brand	326,448	$162,323,187	$60,971,292	$106,820,552	$186.77	$327.22
Specialty	52,047	$315,990,751	$90,721,534	$230,668,926	$1,743.07	$4,431.94
Biosimilar	829	$881,294	$425,249	$740,099	$512.97	$892.76
Total	2,612,972	$542,472,549	$152,119,428	$399,107,419	$58.22	$152.74

From 2022 to 2023, the average net cost of a brand-name drug increased 38% from $237 in 2022 to $327 in 2023; and the average rebate received for branded drugs rose 34%. Rebates for brand-name drugs represented 38% of the gross cost in plan year 2023. The average net cost of a specialty drug was $4,432 and the average rebate was $1,743 per prescription filled in 2023.

Carrier 1

Carrier 1 Plan Year 2022						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	55,455	$1,327,048.91	$0.00	$1,327,048.91	$0.00	$23.93
Brand	7,824	$4,008,581.53	$1,525,077.95	$2,483,503.58	$194.92	$317.42
Specialty	697	$4,176,410.75	$1,128,211.93	$3,048,198.82	$1,618.67	$4,373.31
Biosimilar	0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	63,976	$9,512,041	$2,653,290	$6,858,751	$41.47	$107.21

Carrier 1 Plan Year 2023						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	62,230	$1,438,874.39	$0.00	$1,438,874.39	$0.00	$23.12
Brand	7,879	$5,075,962.02	$1,906,429.67	$3,169,532.35	$241.96	$402.28
Specialty	894	$5,142,339.95	$1,713,213.84	$3,429,126.11	$1,916.35	$3,835.71
Biosimilar	1	$528.36	$0.00	$528.36	$0.00	$528.36
Total	71,004	$11,657,705	$3,619,644	$8,038,061	$50.98	$113.21

From Plan Year 2022 to Plan Year 2023, Carrier 1's number of prescriptions increased by 11%, while its net cost increased by 17%.

Carrier 2

Carrier 2 Plan Year 2022						
Drug Type	**Number of Prescription (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	919,848	$29,586,448.62	$235,367.29	$29,351,081.33	$0.26	$31.91
Brand	165,518	$66,154,709.76	$26,039,989.89	$40,114,719.87	$157.32	$242.36
Specialty	16,818	$111,519,860.35	$24,727,935.65	$86,791,924.70	$1,470.33	$5,160.66
Biosimilar	50	$113,944.51	$34,647.06	$79,297.45	$692.94	$1,585.95
Total	1,102,234	$207,374,963	$51,037,940	$156,337,023	$46.30	$141.84

Carrier 2 Plan Year 2023						
Drug Type	**Number of Prescription (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	895,576	$34,109,554.39	$979.97	$34,108,574.42	$0.00	$38.09
Brand	141,078	$74,999,632.76	$28,631,552.84	$46,368,079.92	$202.95	$328.67
Specialty	17,452	$126,555,945.88	$33,157,922.53	$93,398,023.35	$1,899.95	$5,351.71
Biosimilar	45	$118,741.68	$25,899.24	$92,842.44	$575.54	$2,063.17
Total	1,054,151	$235,783,875	$61,816,355	$173,967,520	$58.64	$165.03

From Plan Year 2022 to Plan Year 2023, Carrier 2's number of prescriptions decreased by 4%, while its net cost increased by 11%.

Carrier 3

Carrier 3 Plan Year 2022						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	204,135	$7,766,115.02	$0.00	$5,450,873.64	$0.00	$26.70
Brand	41,989	$17,497,864.69	$5,428,799.87	$15,237,209.84	$129.29	$362.89
Specialty	3,425	$28,208,675.97	$3,438,074.30	$25,218,156.76	$1,003.82	$7,362.97
Biosimilar	531	$500,112.44	$295,856.30	$464,828.79	$557.17	$875.38
Total	250,080	$53,972,768	$9,162,730	$46,371,069	$36.64	$185.42

Carrier 3 Plan Year 2023						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	250,531	$8,598,300.90	$40.90	$6,200,137.74	$0.00	$24.75
Brand	39,544	$22,736,691.69	$7,957,791.48	$20,247,555.92	$201.24	$512.03
Specialty	4,011	$39,337,595.14	$7,714,419.07	$37,022,885.12	$1,923.32	$9,230.34
Biosimilar	692	$542,462.98	$322,451.41	$504,065.81	$465.97	$728.42
Total	294,778	$71,215,051	$15,994,703	$63,974,645	$54.26	$217.03

From Plan Year 2022 to Plan Year 2023, Carrier 3's number of prescriptions increased by 18%, while its net cost increased by 38%.

Carrier 4

Carrier 4 Plan Year 2022						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	93,234	$4,908,269.96	$0.00	$4,908,269.96	$0.00	$52.64
Brand	5,891	$3,807,867.58	$1,494,799.07	$2,313,068.51	$253.74	$392.64
Specialty	5,270	$27,371,529.92	$5,726,357.78	$21,645,172.14	$1,086.60	$4,107.24
Biosimilar	24	$53,470.91	$27,106.11	$26,364.80	$1,129.42	$1,098.53
Total	104,419	$36,141,138	$7,248,263	$28,892,875	$69.42	$276.70

Carrier 4 Plan Year 2023						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	115,489	$6,230,916.66	$0.00	$6,230,916.66	$0.00	$53.95
Brand	5,592	$3,280,348.64	$1,471,426.99	$1,808,921.65	$263.13	$323.48
Specialty	8,424	$39,552,525.48	$11,183,130.70	$28,369,394.78	$1,327.53	$3,367.69
Biosimilar	78	$188,105.72	$66,240.97	$121,864.75	$849.24	$1,562.37
Total	129,583	$49,251,897	$12,720,799	$36,531,098	$98.17	$281.91

From Plan Year 2022 to Plan Year 2023, Carrier 4's number of prescriptions increased by 24%, while its net cost increased by 26%.

Carrier 5

Carrier 5 Plan Year 2022						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	981,164	$15,054,546	$0.00	$15,054,546	$0.00	$15.34
Brand	145,129	$45,007,392	$16,938,575	$28,068,817	$116.71	$193.41
Specialty	15,790	$81,551,461	$25,200,443	$56,351,018	$1,595.97	$3,568.78
Biosimilar	16	$56,244	$0.00	$56,244	$0.00	$3,515.25
Total	1,142,099	$141,669,643	$42,139,018	$99,530,625	$36.90	$87.15

Carrier 5 Plan Year 2023						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	907,362	$12,795,610	$0.00	$12,795,610	$0.00	$14.10
Brand	119,747	$53,064,184	$19,371,210	$33,692,975	$161.77	$281.37
Specialty	17,233	$95,529,202	$33,216,879	$62,312,323	$1,927.52	$3,615.87
Biosimilar	13	$31,455	$10,657	$20,798	$819.77	$1,599.85
Total	1,044,355	$161,420,451	$52,598,746	$108,821,706	$50.36	$104.20

From Plan Year 2022 to Plan Year 2023, Carrier 5's number of prescriptions decreased by 9%, while its net cost increased by 9%.

Carrier 6

Carrier 6 Plan Year 2023						
Drug Type	**Number of Prescriptions (30 day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	2,460	$104,061	$333	$103,728	$0.14	$42.17
Brand	599	231,092	83,196	147,896	$138.89	$246.90
Specialty	8	26,119	6,997	19,122	$874.63	$2,390.25
Biosimilar	0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	3,067	$361,272	$90,526	$270,746	$29.52	$88.28

Carrier 6 did not have data to report for Plan Year 2022.

Carrier 7

Carrier 7 Plan Year 2022						
Drug Type	**Number of Prescriptions (30-day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	67,289	$950,112	$0.00	$950,112	$0.00	$14.12
Brand	10,892	$2,157,216	$1,077,154	$1,080,062	$98.89	$99.16
Specialty	4,010	$7,370,439	$2,171,057	$5,199,382.50	$541.41	$1,296.60
Biosimilar	0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	14,902	$9,527,655	$3,248,211	$6,279,444	$217.97	$421.38

Carrier 7 Plan Year 2023						
Drug Type	**Number of Prescriptions (30-day scripts)**	**Gross Cost**	**Rebates Received**	**Net Cost**	**Average Rebate**	**Average Net Cost**
Generic	77,775	$1,258,781	$0.00	$1,258,781	$0.00	$16.18
Brand	12,009	$2,935,276	$1,549,685	$1,385,591	$129.04	$115.38
Specialty	4,025	$9,847,023	$3,728,971	$6,118,051.87	$926.45	$1,520.01
Biosimilar	0	$0.00	$0.00	$ 0.00	$0.00	$0.00
Total	16,034	$12,782,299	$5,278,656	$7,503,643	$329.22	$467.98

From Plan Year 2022 to Plan Year 2023, Carrier 7's number of prescriptions increased by 14%, while its net cost increased by 21%.