VHCURES

Vermont Healthcare Claims Uniform Reporting & Evaluation System

VERMONT

Vermont Department of Banking, Insurance, Securities and Health Care Administration

Executive Summary

Vermont Pharmacy Reporting — Key Findings & Highlights

Commercially Insured & Medicare Part D
VHCURES Data for Calendar Year 2010

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ABOUT THIS REPORT

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) has a statutory mandate to collect eligibility and claims data for Vermont residents from health insurers through the Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES). Health insurers include carriers, third-party administrators (TPAs), pharmacy benefit managers (PBMs), any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to healthcare provided to Vermont residents.

The VHCURES data set represents over 80% of total enrollment in commercial plans. (Insurers with fewer than 200 Vermont members are not required to submit paid claims data to VHCURES.) Medicare Parts C and D pharmacy claims also are included in pharmacy reporting. For those major insurers that submit data, the claims amounts, service counts, and enrollment details represent a complete accounting for their population group. Statewide totals that sum the data from all VHCURES reporters, however, do not represent 100% of the entire commercially insured population of Vermont. Data may be unrepresented in VHCURES for multiple reasons, including:

- Some pharmacy claims from PBMs may be generated from carve-out benefits provided separately from medical benefits.
- There may be a small proportion of carve-out pharmacy claims attributed to individuals whose medical claims are not yet included in the VHCURES data set.
- Some insurers have not completed their data filings or are out of compliance with the state's reporting requirements.

Reporting will improve as more insurers comply with Vermont state requirements and submit data for Vermont members.

This report presents key findings from the pharmacy data collected through VHCURES. Two reporting sources were used for this executive summary:

- The Vermont Report Card for 2008–2010 includes an aggregate summary measure of pharmacy utilization and cost for the Vermont commercial population, ages 0–64 only. The Report Card does not include any information on therapeutic class or specific drug trends and does not include information on Medicare Part C or Part D.
- New pharmacy data generated for this executive summary include detailed therapeutic class information. The report includes commercial, Medicare Part C, and Medicare Part D information. The new report was available for 2010 services only and does not include any trend information. Trend reporting by therapeutic category is planned during 2012. The volume of members with Medicare Part C is low and will not be evaluated in this executive summary.

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SUMMARY

The VHCURES database includes data from Vermonters insured by commercial plans for individuals aged 0–64 and those older adults insured by Medicare Part D. The commercial population includes 342,320 members, with total payments of $260.8 million ($64 per member per month [PMPM]). The Medicare Part D population includes 62,872 members, with total payments of $151.8 million ($201 PMPM).

This report includes trends in overall pharmacy utilization and payments (2008–2010) for the entire VHCURES commercial population. It also includes 2010 data on enrollment and payments for Vermont's commercial and Medicare Part D payers, major pharmacy payers and hospital service areas (HSAs), data on the leading therapeutic categories of drugs, and on the drugs that drive payments for pharmaceuticals in Vermont. Finally, utilization differences between the Medicare Part D and commercial populations are presented. Highlights of the pharmacy reporting include:

- **Trends in Payments**[1] — Total payments for prescription drugs increased from $232.4 million to $260.8 million between 2008 and 2010. On an unadjusted per member per month (PMPM) basis, payments increased 19% — from $62 PMPM to $74 PMPM — due to the combined effect of an 11% increase in utilization and an 8% increase in price. Between 2008 and 2010, the use of generic medications increased by 23%, while use of brand medications decreased by 13%. Out-of-pocket spending increased by 16% during the same time period.
- **Payments by Major Payer** — For the commercial population (not Medicare Part D) in 2010, Blue Cross Blue Shield of Vermont had the highest payments for pharmacy ($61.8 million) and the greatest number of pharmacy members (69,706 members). It was followed by CIGNA ($39.5 million; 56,601 members), Medco Health Solutions ($28.4 million; 33,045 members), and CVS Caremark ($23.8 million; 34,851 members).
- **Payments by Hospital Service Area** — The highest pharmacy PMPM payments for the commercial population were found in the Rutland HSA ($77 PMPM), while the lowest payments were found in St. Albans and St. Johnsbury ($58 PMPM). PMPMs are not adjusted for differences in age, gender, health status, etc. For the Medicare Part D population, the highest PMPM payments were found at Newport ($226) and Rutland ($214), while the lowest payments were found in White River Junction ($178). One factor potentially contributing to Rutland's higher payments is the fact that Rutland had the lowest percentage of prescriptions filled with generic drugs among the HSAs.
- **Leading Therapeutic Cost Categories** — For commercial and Medicare Part D combined, the leading therapeutic categories in terms of total cost were cardiovascular agents ($56.8 million), antidepressants ($31.7 million), gastrointestinals ($29.6 million), antidiabetics ($29.4 million), antiasthmatics ($28.6 million), and antipsychotics ($25.7 million). Together, these six categories accounted for 49% of total drug costs in Vermont.
- **Drivers of Pharmacy Payments** — This report describes some of the key drugs driving pharmacy payments for each of the leading therapeutic categories. For commercial and Medicare Part D combined, the drugs with the highest total payments included the antidiabetic Lantus ($15.9 million), the asthma controller Advair Diskus ($14.1 million), and the cholesterol reducer Lipitor

[1] Note that the trends discussed in this bullet pertain only to the commercial population, ages 0–64. Medicare data available for payment trending analysis is not available in the VHCURES data set.

($11.5 million). Also driving payments higher were the widespread use of antidepressants and the high per-day expense of drugs used to treat schizophrenia and multiple sclerosis.

METHODS

Onpoint used membership and claims data from VHCURES, Vermont's all-payer claims database, to examine pharmacy use and cost for Vermonters with insurance coverage under commercial, Medicare Part C, and/or Medicare Part D plans.

Two reporting sources were used for this executive summary:

- **The Vermont Report Card for 2008–2010** — This report includes an aggregate summary measure of pharmacy utilization and cost for the Vermont commercial population (ages 0–64 only). It does not include any information on therapeutic classes or specific drug trends and does not include information on Medicare Part C or Part D.
- **New Vermont pharmacy data** — New pharmacy data were generated for this executive summary, including detailed therapeutic class information and data by plan (for commercial, Medicare Part C, and Medicare Part D). The new report was available for 2010 services only and does not include any trend information. Trend reporting by therapeutic category is planned for 2012.

The eligibility and claims data used for this report included only Vermont residents. The claims data included services provided to residents by providers regardless of provider location. For geographic reporting, members were assigned to their hospital service area (HSA) of residence, not the location where medical services were provided or medications obtained.

Pharmacy claims data were used to determine the number of prescriptions filled and the number of days' supply. Claims have National Drug Codes (NDC) attached to them, which identify the firm that manufactures, repackages, or distributes a drug; the drug form and size; and the drug strength, dose, and formulation. In a given year, there may be 250,000 different NDC codes in use. Lipitor (atorvastatin), for example, may be represented by 125 different NDC codes.

For the purpose of the reports developed for BISHCA, Onpoint purchased and applied the *Red Book®: Pharmacy's Fundamental Reference* to classify NDC codes into manageable detailed (e.g., Lipitor) and major therapeutic (e.g., antihyperlipid) reporting categories. *Red Book* also was used to determine whether the drug was generic or brand.

Expenditures were derived from the payment information on administrative medical claims. Data included plan payments and member cost share (i.e., coinsurance, deductible, and copayments) reported on claims.

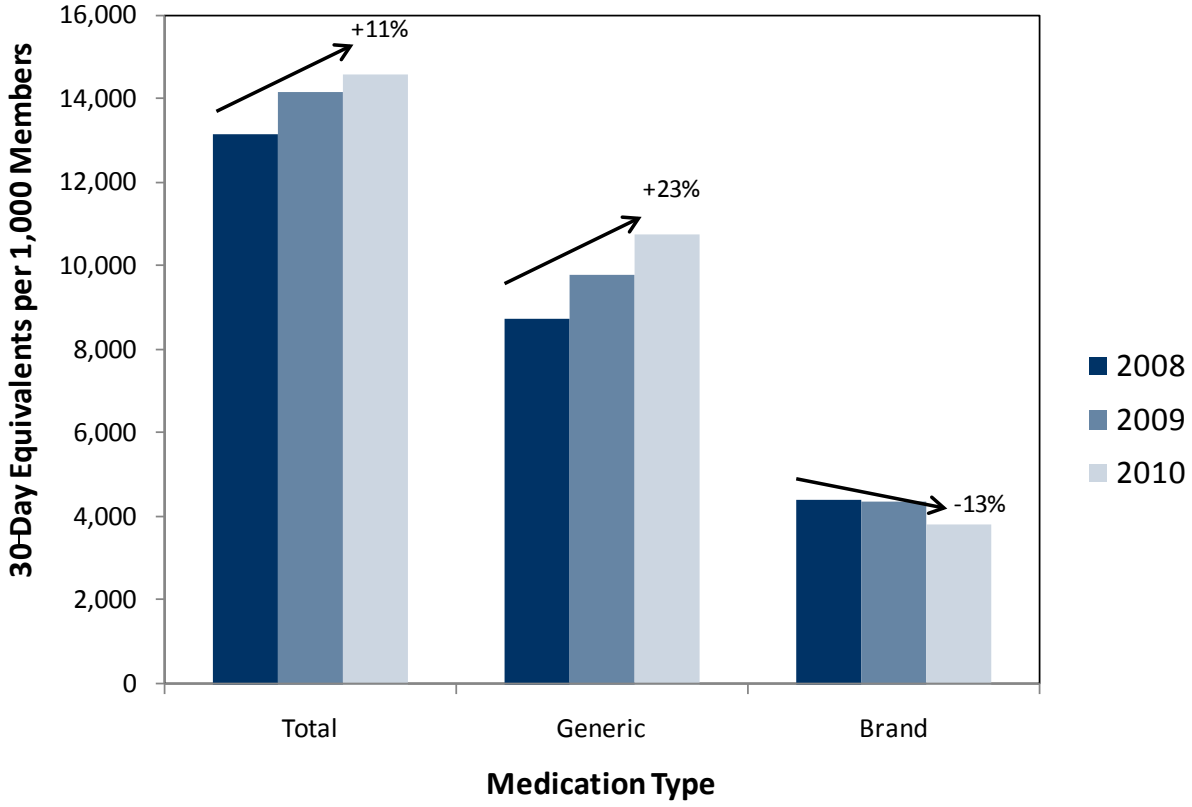
RESULTS

Total Pharmacy Trend, 2008–2010 (Commercial Major Medical, Ages 0–64)[2]

The source of trend information in this section is the Vermont Report Card for 2008–2010. Total payments for prescription drugs increased from $232.4 million to $260.8 million. On a per member per month (PMPM) basis, payments increased from $62 PMPM to $74 PMPM during this time (+19%) — an increase due to the combined effect of an 11% rise in utilization and an 8% rise in price.

The rate of pharmacy use was measured as 30-day equivalents per 1,000 members (see Figure 1). Between 2008 and 2010, total pharmacy use increased by 11% in Vermont. This was due to a 23% increase in use of generic medications and a 13% decrease in the use of brand medications.

Figure 1. Generic, Brand, and Total Pharmacy Use (2008–2010)



In 2008, 34% of prescriptions filled were brand drugs, while 66% were generic. In 2010, 26% of filled prescriptions were brand drugs, while 74% were generic.

[2] Note that the trends discussed in this section, "Total Pharmacy Trend, 2008–2010," pertain only to the commercial population. Medicare data available for payment trending analysis is not available in the VHCURES data set.

Despite the shift to generic drugs between 2008 and 2010, the average price for prescription drugs (per 30-day equivalent) increased from $57 to $61 (+8%).

The member share of payments for pharmacy increased from $13 PMPM in 2008 to $16 PMPM in 2010, a 16% increase in out-of-pocket spending over the two years. However, during this time period, the proportion of total pharmacy payments paid by members decreased slightly — from 21.6% in 2008 to 21.0% in 2010. Nationally, members pay an average of 19.3% of pharmacy payments.[3]

[3] Express Scripts' 2010 Drug Trend Report (April 2011)

Pharmacy Reporting by Major Payer

Table 1 shows the average number of prescription drug members covered by each of the major pharmacy payers as well as the total payments by payer.

For the commercial population, Blue Cross Blue Shield of Vermont had the highest payments for pharmacy ($61.8 million) and the greatest number of pharmacy members (69,706 members), followed by CIGNA ($39.5 million; 56,601 members), Medco Health Solutions ($28.4 million; 33,045 members), and CVS Caremark ($23.8 million; 34,851 members).

Most of the Medicare Part D population (56,173 of 62,872 members) fell into the "Others" category. Further research determined that the leading payers for Medicare Part D were SilverScript, United Healthcare, Health Net Life, First Health Life, CVS, Accendo, and Humana.

Table 1. Average Prescription Drug Membership and Pharmacy Payments by Major Payer

	COMMERCIAL (2010 ONLY)		MEDICARE PART D	
PAYER	AVERAGE RX MEMBERS	PAYMENTS (MILLIONS)	AVERAGE RX MEMBERS	PAYMENTS (MILLIONS)
Blue Cross Blue Shield of Vermont	69,706	$61.8	--	--
CIGNA (CT General)	56,601	$39.5	2,093	$7.1
Medco Health Solutions	33,045	$28.4	--	--
CVS Caremark	34,851	$23.8	3,512	$9.8
The Vermont Health Plan	12,592	$21.8	--	--
Express Scripts, Inc.	39,530	$19.1	181	$0.3
WellPoint NextRx	9,897	$7.7	913	$3.1
MVP Health Plan, Inc.	6,019	$5.2	--	--
MVP Select Care, Inc.	2,904	$1.9	--	--
SilverScript Insurance Co.			8,339	$33.3
United Healthcare Insurance			16,499	$23.5
Health Net Life Insurance			3,803	$14.5
First Health Life & Health Insurance			7.670	$13.2
Accendo Insurance			1,632	$9.2
Humana Insurance			4,325	$8.6
Others*	77,174	$51.7	21,567	$29.0
TOTAL	**342,320**	**$260.8**	**62,872**	**$151.8**

* Others (commercial) = WellPoint, Aetna, CBA, BCBS MA, Others (Medicare Part D) = Pennsylvania Life Insurance Company, Medco Containment, Wellcare Prescription, HealthSpring Life & Health, Aetna Life-Medicare, etc.

Pharmacy Payments by Hospital Service Area

Pharmacy payments were evaluated by the Hospital Service Area (HSA) of residence and presented on a per member per month (PMPM) basis (see Table 2). These rates were not adjusted for age, gender, or health risk differences between HSAs. The highest pharmacy PMPM payments for the commercial population were found in the Rutland HSA ($77 PMPM), while the lowest payments were found in St. Albans and St. Johnsbury ($58 PMPM). For the Medicare Part D population, the highest PMPM payments also were found in Newport ($226) and Rutland ($214), while the lowest payments were found in White River Junction ($178).

One factor potentially contributing to the higher payments in Rutland is the fact that Rutland had the lowest percentage of prescriptions filled with generic drugs among the HSAs. In Rutland, 71% of prescriptions were filled with generics in 2010 compared to the state average of 74%. The highest percentage of generics was found in St. Johnsbury (77%).

Table 2. Pharmacy Payments (PMPM) by Hospital Service Area and Insurance Type (Commercial and Medicare Part D)

	AVERAGE MEMBERS		PAYMENTS (PMPM)		%TOTAL SCRIPTS FILLED WITH GENERICS
HSA	COMMERCIAL	MEDICARE PART D	COMMERCIAL	MEDICARE PART D	
Barre	36,176	6,599	$61	$201	76%
Bennington	19,820	5,348	$65	$203	74%
Brattleboro	16,509	3,597	$67	$203	75%
Burlington	108,354	11,856	$59	$204	73%
Middlebury	15,985	2,869	$65	$201	73%
Morrisville	11,417	2,638	$61	$181	74%
Newport	12,615	4,096	$62	$226	74%
Randolph	7,405	1,547	$65	$203	76%
Rutland	30,434	7,885	$77	$214	71%
Springfield	14,395	4,086	$71	$182	74%
St. Albans	23,794	4,338	$58	$206	73%
St. Johnsbury	13,222	3,290	$58	$193	77%
White River Junction	32,195	4,722	$69	$178	74%
TOTAL	**342,320**	**62,872**	**$64**	**$201**	**74%**

Leading Therapeutic Categories

Table 3 presents data on utilization (days' supply), total payments, and payments per day's supply by major therapeutic categories of drugs for the total VHCURES pharmacy population (including commercial and Medicare Part D).

The leading therapeutic categories in terms of total cost were cardiovascular agents ($56.8 million), antidepressants ($31.7 million), gastrointestinals ($29.6 million), antidiabetics ($29.4 million), antiasthmatics ($28.6 million), and antipsychotics ($25.7 million). Together, these six categories accounted for 49% of total drug costs in Vermont.

The leading therapeutic categories in terms of utilization (total days' supply) were cardiovascular agents (63.1 million days' supply), antidepressants (20.1 million), estrogens and hormonal drugs (12.2 million), gastrointestinals (11.4 million), and antidiabetics (10.1 million).

Therapeutic categories varied greatly in terms of payments per day's supply. Immunosuppressants ($25.87 per day) and antineoplastics ($11.86 per day) were on the high end, while the widely used cardiovascular agents ($0.90 per day) and anti-anxiety drugs ($0.96 per day) were on the low end.

Table 3. Drug Utilization, Payments, and Payments per Day by Therapeutic Category (Commercial and Medicare Part D)

THERAPEUTIC CATEGORY	DAYS' SUPPLY (MILLIONS)	TOTAL PAID (MILLIONS)	PAID PER DAY
Cardiovascular Agents	63.1	$56.8	$0.90
Antidepressants	20.1	$31.7	$1.58
Gastrointestinals	11.4	$29.6	$2.59
Antidiabetics	10.1	$29.4	$2.91
Antiasthmatics	6.9	$28.6	$4.13
Antipsychotics	2.7	$25.7	$9.48
Special Drugs	4.0	$22.9	$5.79
Anti-Infectives	5.0	$20.1	$4.05
Antineoplastics	1.2	$14.1	$11.86
Blood Agents	3.6	$12.9	$3.61
Estrogens & Hormonal Drugs	12.2	$12.8	$1.04
Narcotics	4.2	$12.0	$2.85
Other CNS agents	3.2	$10.7	$3.34
All Other	7.1	$10.6	$1.50
Other Autonomic	3.2	$10.6	$3.32
Immunosuppressants	0.4	$10.6	$25.87
Stimulants	2.1	$10.4	$5.07
Anticonvulsants	5.8	$10.3	$1.77
Ear, Nose & Throat Prep	4.5	$9.6	$2.14
Dermatologicals	3.1	$8.6	$2.80
Oral Contraceptives	6.0	$7.8	$1.30
Anti-Anxiety	4.6	$4.4	$0.96
Non-Steroid Anti-Inflammatory	3.1	$4.4	$1.40

THERAPEUTIC CATEGORY	DAYS' SUPPLY (MILLIONS)	TOTAL PAID (MILLIONS)	PAID PER DAY
Migraines	0.5	$4.3	$8.68
Smooth Muscle Relaxants	1.1	$3.2	$2.88
Antihistamines	1.7	$2.1	$1.19

What Drives Pharmacy Payments?

Therapeutic categories were broken into subcategories to get a better idea of what drives pharmacy payments in Vermont. These figures are for the total Vermont VHCURES population (including commercial and Medicare Part D).

- **Cardiovascular Agents ($56.8 million)** — Among the cardiovascular agents, antihyperlipidemic drugs (cholesterol-reducing agents) were the leading subcategory in terms of cost, accounting for $28.2 million. Lipitor ($11.5 million) was a key contributor, accounting for 41% of the spending on antihyperlipidemics but only 18% of the use. Payments for antihyperlipidemics were moderated by the widespread use of the generic simvastatin, which cost an average of $0.61 per day's supply compared with $3.67 per day's supply of Lipitor for the commercial population. Other cardiovascular drugs accounting for high payments included two widely utilized generic drugs, the ACE inhibitor lisinopril ($9.3 million) and the beta blocker metoprolol succinate ($9.2 million).
- **Antidepressants ($31.7 million)** — The high payments for antidepressants were due primarily to their widespread utilization in the population — second only in utilization to cardiovascular agents. The brand drugs Effexor XR, Cymbalta, and Lexapro were the leading drugs for cost in this category, accounting for 63% of the total antidepressant payments.
- **Gastrointestinals ($29.6 million)** — Nexium accounted for $8.8 million (30%) of the total payments for this category. Pantoprazole, the generic version of Protonix, had $5.0 million in total payments. Generic omeprazole, a proton pump inhibitor, had a very high utilization rate and, as a result, $4.1 million in total payments.
- **Antidiabetics ($29.4 million)** — More than half of antidiabetics payments were attributable to Lantus, a brand insulin ($15.9 million). Another $4.3 million went to payments for Actos, a medication used to improve blood sugar (glucose) control in adults with Type 2 diabetes.
- **Antiasthmatics ($28.6 million)** — Antiasthmatics include controller medications and sympathomimetic agents (rescue medications). Controller medications accounted for nearly two-thirds of the days' supply of antiasthmatics used and 81% of payments for antiasthmatics. Eighty-six percent of payments for controllers went to brand name asthma controllers Advair Diskus ($14.1 million) and Singulair ($5.2 million). Among sympathomimetic agents, ProAir HFA accounted for the largest payments ($4.7 million).
- **Antipsychotics ($25.7 million)** — Antipsychotics payments were driven by their high price per day's supply. Approximately 78% of these payments went to Seroquel, Abilify, and Zyprexa, which are used to treat schizophrenia.
- **Special Drugs ($22.9 million)** — Special drugs with high payments included Copaxone for multiple sclerosis ($7.9 million) and Enbrel for rheumatoid arthritis ($6.4 million). Other notable drugs in this category were drugs such as Flomax, which is used to treat prostate problems, and Viagra for erectile dysfunction.

Commercial & Medicare Part D — Leading Categories & Drugs

The VHCURES database includes data from Vermonters insured by commercial plans and those insured by Medicare Part D. The commercial population includes 342,320 members, with total payments of $260.8 million ($64 PMPM). The Medicare Part D population includes 62,872 members, with total payments of $151.8 million ($201 PMPM). Table 4 shows the top 10 therapeutic categories in terms of cost for both commercial and Medicare Part D populations.

While the two populations had some overlaps (e.g., antidepressants, gastrointestinal drugs, antihyperlipidemics, asthma controllers, and diabetes [insulin]), they generally had very different utilization patterns. Among the noticeable differences:

- Central nervous system tranquilizers/antipsychotics were by far the highest cost therapeutic category for the Medicare Part D population but appeared in the ninth spot for the commercial population.
- For the commercial population, several therapeutic categories were in the top 10 for cost but did not appear on the Medicare Part D list. These included antineoplastic drugs (chemotherapy), immunosuppressants (typically used after organ transplant), central nervous system stimulants, and hormones and synthetic contraceptive oral combination drugs.
- Conversely, several therapeutic categories that were in the top 10 for cost for Medicare Part D failed to appear on the commercial list. These included autonomic nervous system drugs, blood coagulation drugs, central nervous system opiate agonists, and other cardiovascular drugs.

Table 4. Leading Therapeutic Categories in Terms of Total Payments (Commercial and Medicare Part D)

	COMMERCIAL		MEDICARE PART D	
RANK	TOP THERAPEUTIC CATEGORIES	TOTAL PAID (MILLIONS)	TOP THERAPEUTIC CATEGORIES	TOTAL PAID (MILLIONS)
1	Antidepressants	$22.5	CNS - Tranquilizers/antipsychotics	$17.7
2	Gastrointestinal	$19.4	Antihyperlipidemic	$10.4
3	Antihyperlipidemic	$17.8	Gastrointestinal	$10.3
4	Asthma – Controller	$14.0	Antidepressants	$9.2
5	Antineoplastic	$10.2	Asthma-- Controller	$8.2
6	Diabetes – Insulin	$9.2	Autonomic	$7.0
7	Immunosuppressants	$9.1	Blood Coagulation	$6.7
8	CNS– Stimulants	$9.0	Diabetes – Insulin	$6.7
9	CNS – Tranquilizers/Antipsychotics	$8.0	CNS – Opiate Agonists	$6.5
10	Hormones & Synthetic Contraceptive Oral Combination	$7.7	Other Cardiovascular	$5.9

Table 5 shows the top 10 drugs in terms of cost for the commercial and Medicare Part D populations. As with the top therapeutic categories, there was some overlap in the top drugs between the two groups. For both groups, payments were highest for Lantus, followed by Advair Diskus. Lipitor and Nexium also appeared on both lists.

Other high-cost drugs for the commercial population included Copaxone and Rebif (for multiple sclerosis), Effexor XR (for depression and anxiety), Humira (used to treat conditions such as rheumatoid arthritis and

Crohn's disease), Enbrel (used to treat long-term inflammatory diseases), and bupropion hydrocholide (a generic form of Wellbutrin, antidepressant and smoking cessation drug).

Other high-cost drugs for the Medicare Part D population included: Seroquel, Zyprexa, and Abilify (anti-psychotic drugs), Plavix (used to prevent blood clots that may cause heart attacks and strokes), Oxycodone/APAP (a generic pain medication), and Aricept (for Alzheimer's disease).

High rates of utilization drove up payments for some of these drugs (e.g., bupropion hydrocholide, Lipitor, Oxycodone/APAP, Plavix, and Effexor XR). For others, a high cost per day's supply resulted in high payments (e.g., Copaxone, Humira, Enbrel, and Rebif).

Table 5. Top 10 Drugs in Terms of Total Payments for Commercial and Medicaid Populations, 2010

TOP DRUGS: COMMERCIAL	TOTAL PAID (MILLIONS)	PAID PER DAY SUPPLY	TOP DRUGS: MEDICARE PART D	TOTAL PAID (MILLIONS)	PAID PER DAY SUPPLY
1. Lantus	$9.2	$7.39	1. Lantus	$6.7	$5.73
2. Advair Diskus 250/50	$8.1	$5.67	2. Advair Diskus 250/50	$6.0	$5.81
3. Lipitor	$7.8	$3.67	3. Seroquel	$5.5	$9.10
4. Copaxone	$6.3	$100.93	4. Zyprexa	$4.4	$16.94
5. Effexor – XR	$6.0	$4.90	5. Plavix	$4.0	$4.64
6. Humira	$6.0	$65.06	6. Abilify	$3.7	$16.26
7. Nexium	$5.6	$6.12	7. Lipitor	$3.7	$2.99
8. Enbrel	$5.4	$62.24	8. Oxycodone/APAP	$3.5	$4.45
9. Bupropion hydrocholide	$4.5	$2.16	9. Nexium	$3.2	$5.25
10. Rebif	$4.0	$94.77	10. Aricept	$3.0	$6.34

NEXT STEPS

This is the first report on pharmacy utilization and payments in Vermont based on VHCURES data. Future Vermont pharmacy reports planned for 2012 will trend drug use and cost for the five-year period of 2007–2011 by individual drug and therapeutic category.

The Express Scripts 2010 Drug Trend Report provides some insight into a number of the drugs that may be replaced by generics and into other new drugs that are being developed and may come onto the market.[4] Areas of change that may provide opportunities for utilization shifts and reductions in cost in the next few years include:

- **Cholesterol Treatment —** Generics for Lipitor are expected to come on the market in November 2011, resulting in lower costs for cholesterol treatment drugs.
- **Antidepressants —** The release of additional generics for Effexor XR in June 2011 and the expiration of the patent on Lexapro in March 2012 should result in some shifting to generics for patients using these products.
- **Diabetes —** Actos goes off patent in 2012, leaving opportunities for generic insulin to be developed.
- **Asthma —** The patent for Singulair expires in August 2012, and generics are expected after that. There are also some products under development that soon may compete with Advair.
- **Antipsychotics —** Generic antipsychotics are expected to come on the market soon. Zyprexa's patent expired in October 2011, Seroquel expires in 2012, and Abilify expires in 2015.
- **Gastrointestinal drugs —** Over-the-counter versions of Nexium are likely to be marketed close to the expiration of Nexium's patent in 2014.

Future Vermont pharmacy reports will track the impact on cost of new brand-name drugs coming onto the market. They also will explore the impact of the arrival of generics on the market. As drugs go off patent, shifting away from some of the more expensive brand name drugs to their less-expensive generic versions is expected.

[4] Express Scripts' 2010 Drug Trend Report (April 2011)