Implications of Research on Drug Cost Containment for the Medicare Drug Benefit

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U.S. Prescription Drug Expenditures

U.S. Rx Drug $ as Proportion of Health Expenditures

Source: Data from the Centers for Medicare & Medicaid Services, Office of the Actuary
Social Security, Medicare, and Medicaid Spending as a Percent of GDP

Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration, Office of the Actuary, Centers for Medicare and Medicaid Services, and the Congressional Budget Office.

Examples From Pharmaceutical Policy Research

- Limits (caps) on reimbursement
  - Similar to “donut hole”

- Drug cost sharing

- Preferred Drug Lists/ Prior authorization
Effects of Cap on Antidepressant Use

Effect of Cap on Emergency Mental Health Services

Effects of Reimbursement Cap on Nursing Home Admissions

Observed & Predicted Use of Essential Drugs With Change in Cost Sharing

Effect of Increased Cost-Sharing on Oral Hypoglycemic Use in 5 Managed Care Organizations

How Much Is Too Much?

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Figure 1. Trends in OH Use Stratified by Level of Increased Cost-sharing ($1-$6, $7-$10, and >$10).
Effect of a $0.50 per Rx Copayment on Medication Use by Medicaid Recipients in South Carolina

Nelson, Reeder & Dickson. Med Care Aug. 1984 p.724
Well-Controlled Studies of Cost-Sharing on Essential Medication Use and Health Outcomes among Poor or Chronically Ill* (N=12 Studies)

Types of Policy Change

- Cap: 5 studies
- Copay: 4 studies
- Deduct: 3 studies

Declines in Essential Drug Use

- Yes: 9 studies
- No: 0 studies
- N/A: 3 studies

Adverse Health Events

- Yes: 3 studies
- No: 1 study

Lexchin and Grootendorst, Int J Health Serv, 2004
Policies Promoting “Preferred” Drugs Within a Therapeutic Class

Preferred Drug Lists (PDLs): Common tools to reduce use of expensive “non-preferred” drugs
  ● Prior authorization (PA) usually required
  ● Often “fail first” requirement (that an alternative be tried before a non-preferred drug)

Differential copayments/incentives
  ▪ Patients pay higher copays for non-preferred drugs
    ● “Three-tier” copays
    ● Reference-based pricing
Key Issues In Tiered Copays and Reference Pricing

- Differences in clinical response to (or side effects of) “similar” drugs
- Appropriateness of patient response to incentives
- Availability of exemptions
- Effects of medication switching
PILLS FOR THE MIND
How new drugs that treat MENTAL ILLNESS are helping people like Kevin Buchberger come out from the darkness
MaineCare Preferred Drug List for Atypical Antipsychotics (7/2003)

Preferred Step Order*:

“Preferred” Atypicals: Fail first
1. Risperidone (Risperdal)
   ↓ (If Fail)
2. Ziprasidone (Geodon) or Quetiapine (Seroquel)
   ↓ (If Fail)

“Non-preferred” Atypicals: PA
- Olanzapine (Zyprexa) or Aripiprazole (Abilify)

* or PA can be requested to bypass step order
Clinical Anecdote on Maine PDL

“One 26 year old male was stabilized on Seroquel, but the pharmacy rejected his re-fill… because it hadn’t been prior authorized. The patient… left without his meds, and didn’t tell anyone. After 10 days… he was rehospitalized. He is now homeless and a member of the AMHI class.”

“Zyprexa and Seroquel…denied for 50 year old bipolar…. Stable and no hospital or crisis use for over 5 years. Past use of risperidol unsuccessful. MD requested zyprexa and was denied. Requested Seroquel and was denied, too. Client went to crisis unit for the first time in five years.”

Source: spontaneous physician reports to NAMI
Effects of Medicaid Prior Authorization Policy on Use of Nongeneric and Generic NSAIDs

Decrease = 65% (95% CI, 60 to 71%)
Effects of Prior Authorization for NSAIDs on Expenditures for Outpatient Services

Increase = 3% (95% CI, -13 to 18%)
Principles for Preferred Drug Lists

- First, measure level of inappropriate use

- Avoid access restrictions for:
  - drugs with heterogeneity in patient response
  - vulnerable populations
    - e.g., schizophrenia, bipolar illness, AIDS, seizure

- Avoid enforced drug switching in well-controlled chronic illness
Principles for Preferred Drug Lists

- Provide multiple preferred agents/choices
- Use simple/rapid prior approval procedures
- Support quality/education as well
- Evaluate quality impact
MEDICARE DRUG BENEFIT

Benefits and Consequences for the Poor and the Disabled

## Dually Eligible: Poorer, Sicker and Underserved

<table>
<thead>
<tr>
<th></th>
<th>Duals</th>
<th>Non-dual Medicare</th>
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<tbody>
<tr>
<td>Fair/Poor Health</td>
<td>83%</td>
<td>57%</td>
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<tr>
<td>Mental Illness</td>
<td>33%</td>
<td>12%</td>
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<tr>
<td>In Nursing Homes</td>
<td>19%</td>
<td>3%</td>
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<tr>
<td>Minority Group</td>
<td>43%</td>
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Average Monthly Expenditures for Income Level of $5,000-$9,999

<table>
<thead>
<tr>
<th>Category</th>
<th>Average Monthly Expenditures, $</th>
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<td>Discretion Income</td>
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Increased Cost-Sharing

- **Part D**
  - $1 to $2 for generics
  - $3 to $5 for brands

- **Medicaid**
  - Zero cost-sharing in 10 states
  - Range of $1-$3 in other states
    - Majority $\leq$ $2

Source: Kaiser Commission on Medicaid and the Uninsured
Formulary Restrictions in Part D

- Plans permitted to restrict coverage to 2 drugs/class
  - “Classes” too broad
    - All newer/older hypoglycemics
    - Assume, often incorrectly, equivalence

- Eliminated coverage of several essential medications
  - Benzodiazepines/barbiturates/meds for substance abuse

- Many plans rely on utilization management w/unknown effects
  - PA/Fail First medication → switches w/ unknown safety
Steps to Maximize Benefits, Reduce Risks

■ Educate Rxers re: intra-class variation
  ● Effectiveness and side effects
  ● Reduce risks of medication switches

■ Make Part D data available to researchers/policymakers

■ Commission studies of health/econ effects
  ● Changes in cost-sharing
  ● Formulary restrictions

■ Modify policies leading to underuse/adverse events