

PRESCRIPTION DRUG CAPS – AN INEFFECTIVE POLICY THAT HARMS PATIENTS

Facing double-digit annual increases in prescription drug costs in their Medicaid budgets, states are looking at every alternative to cut costs.¹ One policy that is both widely adopted and widely criticized is to place monthly or annual caps on the number of prescriptions that an enrollee of a state Medicaid or other state prescription drug plan may fill. Despite the fact that these policies have been repeatedly discredited in peer-reviewed studies as not only harmful to patients but also as ineffective in reducing total medical costs, states continue to adopt these policies, which promise initial cost savings and are simple to understand and implement. Many alternative policies are available, however, which promise substantial savings without harming patient health.

Research and experience has discredited prescription drug caps

Several studies including one dating back nearly 20 years have discredited drug caps as an effective strategy for cutting costs, and have documented worsened health for patients subject to caps. People with limited prescription drug coverage skip their medicines, make more trips to the hospital and die sooner than patients with unlimited benefits, according to a 2006 New England Journal of Medicine study.² Comparing the medical records of 157,275 people in a plan that covered only the first \$1,000 worth of drugs with those of 41,904 people who had unlimited drug coverage, the study found that those subject to caps on drug coverage spent 31 percent less on drugs, but their total medical costs were not significantly lower, as they had a 9 percent greater chance of going to the emergency room and a 13 percent greater chance of landing in the hospital. The study found that any savings in drug costs from the cap were offset by increases in the costs of hospitalization and emergency department care, and the annual death rate of people whose drug benefits were capped was 22 percent higher than those with unlimited benefits.³

The 2006 study reaffirms findings of a 1987 clinical study of the impacts of a New Hampshire policy capping prescriptions for Medicaid enrollees at 3 per month. The research, directed by Dr. Stephen B. Soumerai and published in the New England Journal of Medicine in 1987 and 1991, compared costs and health outcomes in New Hampshire, which capped prescriptions, and New Jersey, which did not. As Dr. Jerry Avorn describes in his book *Powerful Medicines: The Benefits, Risks and Costs of Prescription Drugs*,⁴ “The findings were astonishing.” Although the health status of patients in the two states was nearly identical in the months before the cap was implemented, “... once the limits were applied the New Hampshire Medicaid patients ended up in nursing homes, hospitals, or cemeteries significantly more often than the similar New Jersey Medicaid patients, who retained full drug coverage.”⁵ Although initially the caps appeared to save money, since prescription costs went down at first, once state costs of additional hospitalizations and nursing home institutionalization were

factored in, “it turned out the program had hardly saved the New Hampshire Medicaid Program any money after all.”⁶

States nonetheless continue to adopt this failed policy.

According to October 2005 data, at least 12 states had drug caps (37 were surveyed).⁷ Despite the availability of better alternatives and the impact on patient health, states continue to adopt policies that arbitrarily limit the number of prescriptions that can be filled. In 2006, both Tennessee and West Virginia adopted policies incorporating drug caps to save money in state health programs. TennCare now limits adults to five prescriptions per month, and only two of them can be brand-name medications. These restrictions are among the tightest limits anywhere in the country. While they have saved money up front in TennCare, anecdotal evidence is that the policy is already negatively affecting the health of enrollees.⁸ In West Virginia, Medicaid enrollees who fail to sign or meet then goals of a "personal responsibility contract" will have their benefits reduced, and could face caps on the number of prescriptions that would be covered or other benefits.⁹ In Mississippi, effective July 1, 2005, Medicaid enrollees are allowed five prescriptions per month - two brand-name drugs and three generic medications. The previous policy allowed them to receive up to seven prescriptions per month -- five of any type and two additional drugs that require prior authorization. Facing a lawsuit challenging this policy as applied to HIV-positive people, who must take a prescription drug “cocktail” of several medications, the state lifted this policy with respect to HIV-positive persons.¹⁰ Many others with chronic conditions, however, are also required to take multiple prescriptions and they remain subject to the arbitrary cap.

There are better alternative policies available

There are many alternatives to capping prescriptions that promise significant savings without the negative consequences that have been documented with caps. Some of these policies include multi-state and multi-program purchasing pools, negotiating better prescription drug prices and rebates by adopting an enforceable preferred drug list with prior authorization for non-preferred drugs, enacting state false claims acts to address Medicaid fraud, eliminating the middleman vendor or adopting transparency standards for vendors that negotiate rebates, promoting generics, and communicating clinical research and efficacy information to medical providers and consumers. Another policy option for increasing savings without limiting access to prescription drugs is to maximize participation in 340B pricing under the federal Public Health Act.

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¹ Spending in the United States for prescription drugs rose from \$40.3 billion in 1990 to \$188.5 billion in 2004. A survey last year of 33 state Medicaid programs anticipated Medicaid prescription drug spending increases of 14.3% for 2005-06 FY, consistent with the prior year's growth of 12.9% (Crowley & Ashner, “State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update,” (October 2005). The cost of cancer and specialty drugs is especially high and spending on these drugs is rising rapidly. Overall spending on high cost specialty drugs in the U.S. soared 17.5 percent last year and is expected to more than double by 2009 to \$90 billion, according to a recent report (see Medical News Today reporting on January 2005 study in the American Journal of Managed Care, accessed at <http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>. Spending on

injectable drugs for inflammatory diseases such as rheumatoid arthritis and crohn's disease soared 35 percent, and spending on cancer drugs known as anti-neoplastics, which were administered outside a doctor's office, rose 19.2 percent. (see, "Spending on Specialty Drugs Soar," by Theresa Agovino, Associated Press, San Jose Mercury News, June 6, 2006).

² John Hsu, Mary Price, Richard Brand et al, "Unintended Consequences of Caps on Medicare Drug Benefits," The New England Journal of Medicine, June 1, 2006. See also "Benefit Limits Mean More Hospital Visits, Study Says," Reuters, June 6, 2006, Washington Post.

³ Ibid.

⁴ Jerry Avorn, MD, "Powerful Medicines: The Benefits, Risks and Costs of Prescription Drugs," Alfred A. Knoff, 2004, see Chapter 12 "Live Cheap or Die," at 189-197.

⁵ Avorn at 193, 195.

⁶ Avorn at 197. See details of NJM articles on these studies by Soumerai and Avorn at 428.

⁷ "State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update," by Jeffrey S. Crowley and Deb Ashner, Health Policy Institute, Georgetown University, and Linda Elam, Kaiser Commission on Medicaid and the Uninsured (October 2005).

⁸ See National Public Radio story, "NPR Examines Effect of TennCare's Monthly Prescription Limits on Residents of Cocke County, Tenn.," by Julie Rovner, broadcast Jun 21, 2006, posted online at www.npr.org.

⁹ "Medicaid Reform Plan Likely Illegal, Center on Budget and Policy Priorities Says," posted Jun 05, 2006, www.kff.org.

¹⁰ "Medicaid Drug Policy Limiting Prescription Drugs Soon Will Be Lifted for HIV-Positive People, Assistant AG Says," posted Jan 31, 2006, www.kff.org.