

Prescription Drug Cost-Sharing and Antihypertensive Drug Access among State Medicaid Fee for Service Plans, 2012

Background

In 2012, almost all states provided Medicaid Fee for Service (FFS) insurance coverage for people qualifying in certain low income categories (e.g., pregnant women; children; parents and caretaker relatives in families with dependent children or dependent adults that may be elderly, blind, or disabled). In addition, at least 36 states required some Medicaid beneficiaries to participate in a managed care or health care organization (MCO).¹ Many states offered coverage beyond the federal minimum guidelines, although eligibility criteria varied, particularly for adults. In 2012, adults aged 19 and older made up one third (33%) of the national non-disabled Medicaid population.² Estimates show that from 2012 through 2021, an additional 18.3 million people, mostly adults (78%), will be newly enrolled in Medicaid.³

Adult Medicaid beneficiaries are at higher risk for hypertension, diabetes, smoking, and obesity compared with privately insured adults; almost one third of adult Medicaid beneficiaries have hypertension.⁴ Treatment for hypertension is complex, involving specific therapeutic drug classes, dose titration, and multiple drugs.^{5,6} Most patients need at least two antihypertensive drugs to achieve their blood pressure goal, and fewer than half of patients with hypertension have the condition under control.⁷

Federal law authorizes states to implement nominal and above nominal (also called “alternative”) Medicaid cost-sharing policies for “covered” drugs—including outpatient prescription drugs approved by the Food and Drug Administration (FDA), biological products, insulin, and state-authorized over-the-counter drugs—although certain categories of beneficiaries are exempt.^{8,9} Medicaid prescription drug benefits vary by state. Some states require fixed or tiered co-payments, restrict the number of drugs covered, limit access to certain therapeutic classes or brand name drugs through preferred drug lists (PDL), and require prior authorization for non-preferred drugs or products.

Studies show that cost-sharing practices affect medication adherence, and Medicaid beneficiaries who experience cost barriers have higher rates of hospitalization.¹⁰ Patients with higher

co-payments are less likely to adhere to a drug regimen than those with lower co-payments.^{11,12} Even nominal co-payments (\$0.50–\$3.00) reduced prescription drug use among Medicaid recipients by approximately 15%.^{13,14} Caps on the number or volume of prescriptions per month result in reduced use of essential and nonessential drugs.¹² When patients are subject to PDLs, prior authorization, and formulary restrictions, studies have found that providers switch patient medications to a preferred drug within the same therapeutic class or to a different therapeutic class. Switching patients’ antihypertensive medication has resulted in reduced or discontinued compliance with a therapeutic regimen as well as increased emergency room visits and hospital stays among Medicaid beneficiaries.^{6,10,15}

To better understand how prescription drug cost-sharing practices could deter adult Medicaid beneficiaries from taking prescribed blood pressure drugs, we assessed how state Medicaid FFS plans document three types of cost-sharing practices: co-payments, restrictions on the number of prescriptions allowed per month, and PDL or formulary limitations on access to recommended therapeutic drug classes for blood pressure control.

Data Collection

We collected information from Medicaid provider and beneficiary manuals, PDLs, and fee schedules from each state Medicaid Web site between January and October 2012. We compared each state PDL to the list of recommended drug classes in the *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)*, which divides drugs into two tiers.⁵ Tier 1 drugs include five therapeutic classes: thiazide and potassium-sparing diuretics to treat most patients with uncomplicated hypertension, either alone or combined with drugs from other classes, such as angiotensin converting enzyme inhibitors, angiotensin receptor blockers, beta-blockers, or calcium channel blockers for certain high-risk conditions. Tier 2 drugs, for high-risk conditions, include five therapeutic classes: alpha-1 blockers, centrally acting drugs, direct vasodilators, aldosterone receptor blockers, and loop diuretics. We considered a therapeutic

class covered if at least one of the drugs listed in the class, either as a generic, brand name, or combination drug, was available with or without prior authorization.

Findings

Co-Payments (Figure 1)

- Of the 48 states that offered a Medicaid FFS plan option in the first or second quarters of 2012, 81% require a co-payment (ranging from \$0.50 to the full cost of the drug) on any generic or brand name prescription drug.
- Most states (71%) require co-payments for generic and brand name drugs.

- Five states (10%) require co-payments for brand name drugs only.
- Nine states (19%) do not require co-payments for any drug.

Cap on Number of Prescriptions per Month (Figure 2)

- Almost one third (31%) of states restrict the number of prescription drugs a Medicaid recipient can obtain per month; however, 10 of these states allow a provider to override or exempt essential drugs or certain health conditions (e.g., hypertension) from the limit.
- Twelve states (25%) cap both generic and brand name drugs.
- Three states (6%) cap brand name drugs only.

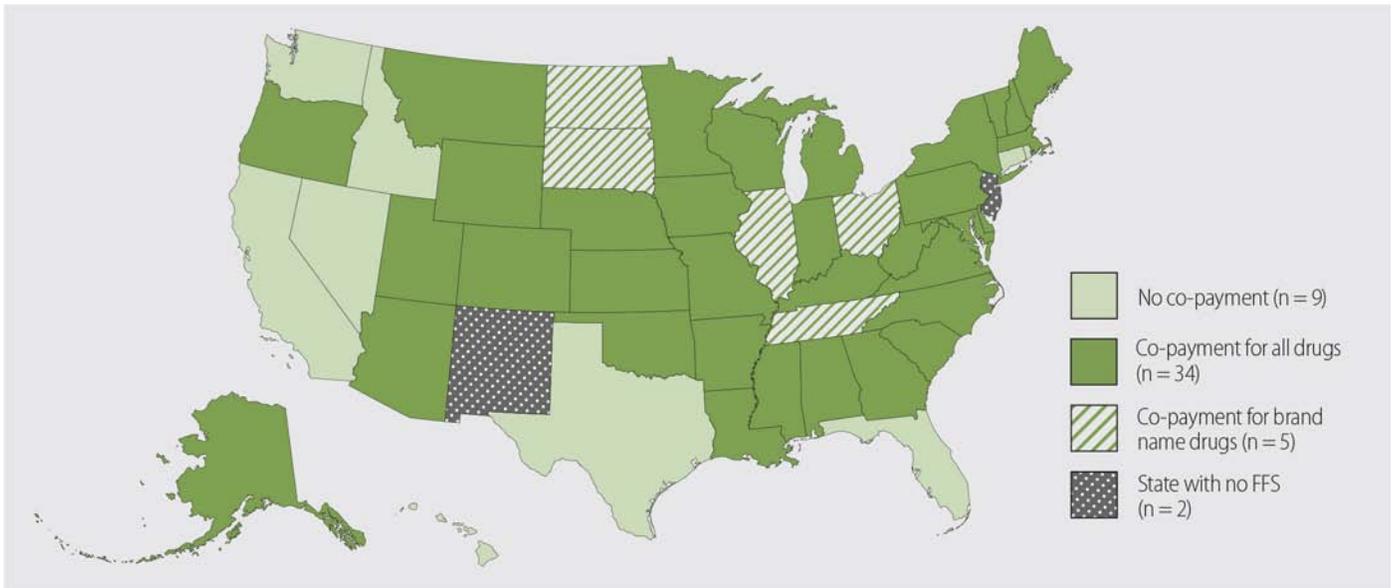


Figure 1. States with Medicaid FFS Prescription Drug Co-Payments, 2012

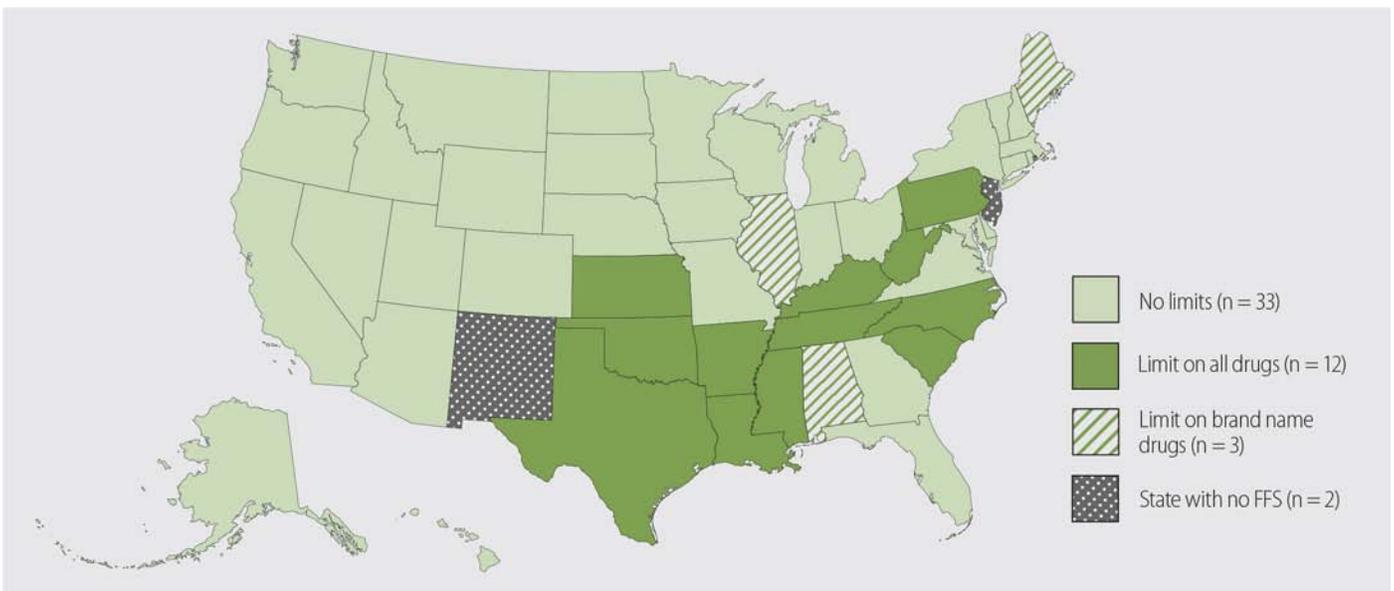


Figure 2. States with Medicaid FFS Limits on Prescriptions per Month, 2012

PDL Coverage (Figure 3)

- Almost one third of states (29%) cover all 10 classes of antihypertensive drugs through a PDL.
- The majority of states (76%) cover most or all Tier 1 and some Tier 2 drug classes.
- Eleven states (23%) cover five or fewer drug classes.
- Overall, coverage of Tier 2 drugs is limited; 70% of states cover two or fewer Tier 2 drugs, and 10 of those states provide no coverage.
- The most common Tier 2 drug classes covered were alpha-1 blockers and centrally acting drugs.

Multiple Cost-Sharing Practices (Table 1 and Figure 4)

To assess the cumulative effects of multiple cost-sharing practices, we categorized each cost-sharing practice into one of three levels based on the potential impact to a patient with hypertension

and co-morbidities. We assigned a value from 1 to 3 for each level of cost-sharing practice and added the scores across cost-sharing practices for each state. State plans range from no cost-sharing (score = 3) to a maximal level of cost-sharing (score = 9) with co-payments on all drugs, limits on the number of drugs per month, and limited coverage of all antihypertensive drug classes.

- On average, state Medicaid FFS plans document at least two cost-sharing practices. For example, a Medicaid plan may require a co-payment as well as limit the number of drugs available in a given month, or a plan may require a co-payment but the PDL does not cover Tier 2 anti-hypertensive drugs.
- Most states (69%) have Medicaid FFS plans with multiple cost-sharing practices at an intermediate or higher level, which could deter access to antihypertensive drugs.

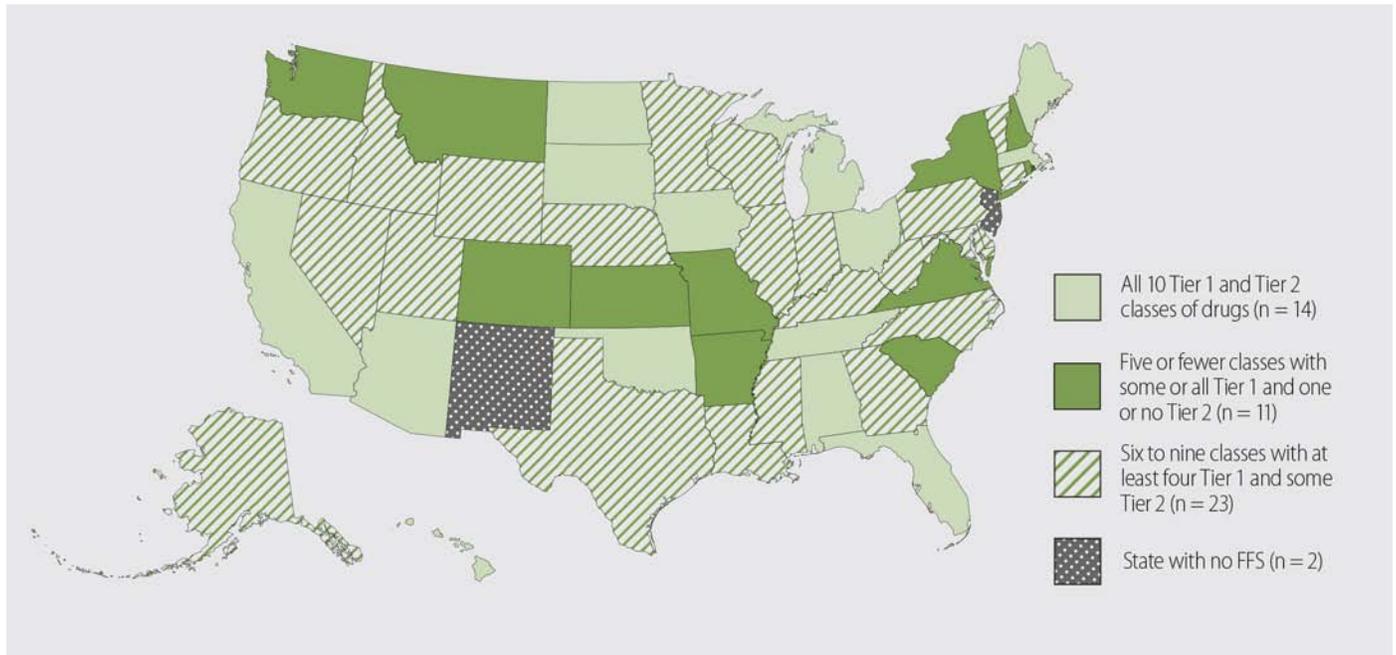


Figure 3. State Medicaid FFS PDL Coverage of JNC 7 Antihypertensive Drugs, 2012

Value	Cost-Sharing Practices		
	Co-Payment	Prescription/Month Limit	PDL Antihypertensive Drug Coverage
1	None	None	All 10 Tier 1 and Tier 2 classes of drugs
2	Brand name only	Brand name only	Six to nine classes with at least four Tier 1 and some Tier 2
3	All drugs	All drugs	Five or fewer classes with some or all Tier 1 and one or no Tier 2

Table 1. Categories of Cost-Sharing Practices

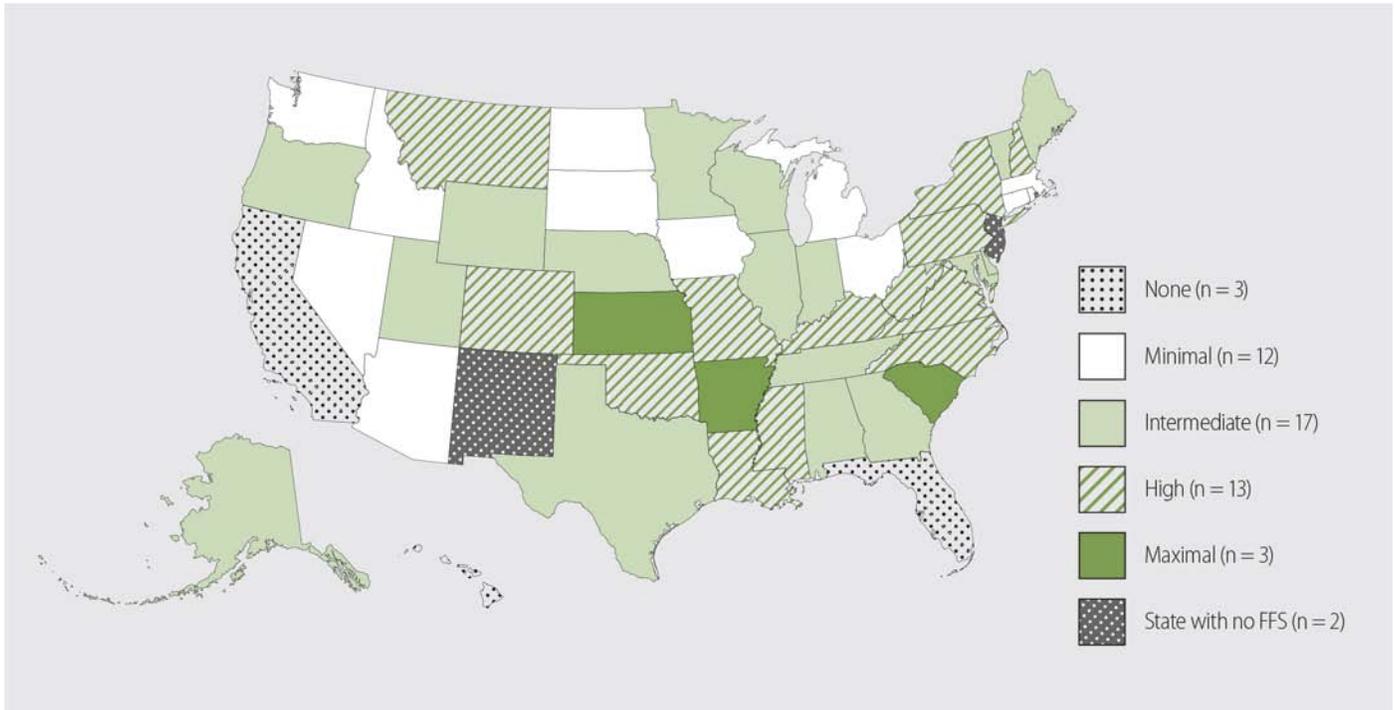


Figure 4. State Medicaid FFS Cost-Sharing Practices Relevant to Hypertension Prescription Drug Access, 2012

Implications

Most Medicaid FFS beneficiaries taking antihypertensive drugs are likely to encounter one or more cost-sharing practices that may affect their ability to continue treatment as prescribed. Co-payments—even just a few dollars each in many states—are the most common cost-sharing practice. Although less common, one third of states cap the number of prescriptions covered per month, which is likely to have the greatest effect on adults with multiple chronic conditions. Patients with hypertension and other chronic diseases, such as diabetes, often need two to three antihypertensive drugs.

The prevalence of multiple chronic diseases in the United States is increasing along with out-of-pocket spending. By 2005, nearly 10% of Medicaid beneficiaries younger than 65 years had three or more chronic conditions, spending an average of \$870 per year in out-of-pocket costs, mostly on drugs.¹⁶ In any given month, an adult Medicaid beneficiary may need to cover multiple co-payments and possibly some drugs entirely out of pocket to adhere to treatment plans for each health condition. In 2013, the federal maximum “nominal cost-sharing” rate for people with income at or below 150% of the Federal Poverty Level (FPL) increased to \$4 for preferred drugs and \$8 for non-preferred drugs; higher rates for non-preferred drugs may apply to people with income above 150% of the FPL.¹⁷

States may authorize cost-sharing for non-preferred drugs within a therapeutic class or waive or reduce costs for preferred drugs

that are determined by the state to be the most cost-effective prescription drug within a therapeutic class.^{8,9} Even though all states cover most or all Tier 1 antihypertensive drug classes, Medicaid beneficiaries are likely to encounter some difficulty (e.g., prior authorization, higher co-payments) in accessing brand name or non-preferred drugs. However, if the prescribing physician determines a preferred drug is less effective or may have adverse effects, the non-preferred drug must be made available at the same cost-sharing rate as the preferred drug.^{8,9}

Access to the full array of Tier 2 antihypertensive drug classes is restricted in many state PDLs, although Medicaid beneficiaries may gain access to these drug classes through prior authorization. Federal law allows states to exclude drugs from a PDL or formulary under certain conditions, including if there is no “significant, clinically meaningful therapeutic advantage... over other drugs included in the formulary,” and a written basis for the exclusion is available to the public.¹⁸ A report by the Kaiser Commission on Medicaid and the Uninsured found that state Medicaid directors used net price as the deciding factor when considering which drugs to add to the PDL because of a lack of studies comparing the clinical effectiveness of multiple drugs used to treat the same condition.¹⁹ This finding suggests state pharmacy and therapeutics committees may have made such determinations for the Tier 2 classes of drugs because of clinical research gaps or a lack of translational information on comparative effectiveness.

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