Medicaid Prescription Drug Policy and Serious Mental Illness

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There is uncertainty about the best way to control costs in Medicaid

- The CBO estimates that the number of non-elderly enrollees in Medicaid and CHIP will increase by 17 million in 2016

- Initially this increase is paid for by federal subsidies, but eventually the cost will fall to the states

- States have increasingly looked to cut costs – especially drug costs – to prevent expansions from breaking their budgets
Serious mental illness poses a policy dilemma

- Medicaid provides an important safety net for patients with serious mental illness -- schizophrenia, bipolar disorder and major depressive disorder (MDD)

- There is tension between cost-containment and access to care

- Policymakers need to understand the implications of cost-containment efforts for the most vulnerable patients
A road map

- The prevalence and cost of serious mental illness in Medicaid
- Policy trends
- A review of existing evidence
- Implications and suggestions for policy
Mental illness is highly prevalent among Medicaid beneficiaries

• Estimates suggest 30-40% of Medicaid beneficiaries have some form of serious mental illness\textsuperscript{1,2}
  
  – For example, 2-3% have schizophrenia and 18% suffer from major depression

• Average spending is twice as high for beneficiaries with serious mental illness\textsuperscript{2}

• Over 30% of individuals with schizophrenia are Medicaid beneficiaries\textsuperscript{3}
Medicaid spending on mental health services has grown sharply

10-year projected baseline estimates of Medicaid enrollment and Federal Medicaid spending

- The CBO projects an average annual growth rate of 8% and 2% over the next 10 years for Federal Medicaid payments and plan enrollment, respectively; Growth in Federal Medicaid spending is set to outpace growth in per capita GDP.

Note: On average from fiscal year 2012 to fiscal year 2013, federal Medicaid payments represent approximately 57 percent of total Medicaid payments. The Affordable Care Act, which expands Medicaid coverage starting in 2014, provides enhanced federal matching rates for certain populations, leading to an average federal share for Medicaid ranging between 58 percent and 60 percent, depending on the year.

Note: These figures are the total number of individuals enrolled in Medicaid at any point during the fiscal year and include enrollment in the territories. Some beneficiaries are enrolled for only part of the year; enrollment on an average monthly basis, as shown by the black trend line, would be about 80 percent of these figures.

Federal spending on the poor and sick non-elderly will nearly double as a fraction of national income.

Medicaid now pays more than one out of every four dollars spent on mental health treatment

Medicaid’s prescription drug spending in mental health has increased sharply

The policy response

- Facing rising costs, state Medicaid programs often turn to formulary restrictions
  - Policies aimed at lowering costs by directing patients away from brand drugs and towards generics

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<th>Formulary Restrictions in Medicaid</th>
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<td><strong>Step-therapy</strong></td>
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<td><strong>Prior authorization</strong></td>
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<td><strong>Quantity limit</strong></td>
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The use of Medicaid restrictions for antipsychotics increased dramatically from 1999-2008

Source: Author’s calculations
Restrictions on antidepressants have also increased

Source: Author’s calculations
Meanwhile, medical spending is rising much faster than prescription drug spending in Medicaid.

Source: Author’s calculations
What are the implications of these policies for Medicaid beneficiaries with mental illness?

• States adopted restrictions to cut costs

• How did this affect treatment patterns and outcomes?\(^4\)
  – Did patients continue to receive appropriate care?
  – Were there fewer or more acute complications?
  – How did non-health outcomes – criminal activity, employment, etc. – evolve and how did these affect state spending?

• We need to understand the full impact of these policies to assess whether drug cost savings translated into lower overall spending for state governments
Formulary restrictions increase the likelihood that patients return to failed treatments or stop treatment.

**Replication of failure increases under formulary restrictions**

- In states where FR limit access to all atypicals, the likelihood of a patient resuming the same atypical after having ceased treatment for at least 30 days increases by 20.1% relative to patients in states without restrictions.

**Formulary restrictions facilitate higher discontinuation rates among patients with schizophrenia**

- Additionally, patients in states that impose FR on all atypicals are 11.6% more likely to discontinue all treatments.

Prior authorization is associated with higher prevalence of mental illness within a state’s criminal justice system

**Increased likelihood of showing symptoms of psychosis in states with prior authorization requirements on atypicals**

- All Inmates: 2.7%
- Violent Crime: 3.0%
- Drug Offense, Non-violent: 4.5%
- Non-drug, Non-violent: 2.5%

**Increased likelihood of being diagnosed with schizophrenia in states with prior authorization requirements on atypicals**

- All Inmates: 1.2%
- Violent Crime: 2.0%
- Drug Offense, Non-violent: 1.1%
- Non-drug, Non-violent: 2.2%

Formulary restrictions generally lead to higher rates of discontinuation

- A review of the literature shows that cost sharing policies and formulary restrictions generally lead to higher rates of discontinuation, in addition to poor adherence, and lower rates of drug utilization (Goldman et al. 2007).

Effect of prior authorization and cost-sharing on odds of medication continuity

Brown et al. (2013): For schizophrenic and/or bipolar patients, medication continuity was less likely for those in states that required prior authorization for antipsychotics, and/or a $1 copayment for branded medication.

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Carve-out implemented in a TN Medicaid program

- Higher discontinuation rates
- Lower drug utilization
- Therapy discontinuation rates increased (OR 1.18, P=0.001)
- Mean days on antipsychotics decreased by 14.4

Source: Ray et al. (2003)
Prior work also suggest that policies targeting brand medications reduce patient utilization of all therapy.

Impact of Formulary Restrictions on Use of Therapy by Patients with Schizophrenia

-40% -30% -20% -10% 0%

All antipsychotics

Targeted drug

- Applies to all atypicals
- Applies to one atypical

In addition to lower drug utilization, formulary restrictions have been associated with poor adherence.

Hartung et al. (2008): A copayment policy in a Oregon Medicaid program caused utilization of prescribed drugs to decrease by 12.4% for schizophrenia patients.

Pharmacy utilization before and after the 2003 copayment policy was implemented.

Formulary restrictions:
- Increased prescription copayment from $1 to $3
- Implemented a 34-day supply limitation

Patient effects:
- Patients became 4.87% less compliant with antipsychotic treatments
- Patients experienced 20.5% more 90 day treatment gaps than patients in control states
- 3.7% reduction in outpatient mental health visits
- 4.2% reduction in mental health care payments

Source: Farley (2010)
Restrictive policies tend to increase medical services such as ER visits and hospitalizations

**Soumerai et al. (1994)**: Formulary restrictions led to 15-49% reductions in drug utilization for schizophrenia patients, but also increased the number of ER visits and hospitalizations. The $1,530 average increase in costs per patient was 17 times higher than the savings in drug costs to Medicaid.

**Goldman et al. (2007)**: This literature review showed that drug cost sharing led to an increase in medical services (inpatient and emergency medical services) for schizophrenia patients, suggesting worsened clinical outcomes.
Prescription drugs represent attractive targets for cost-containment, but caution is warranted.

Policies that limit drug spending could have unintended effects on other segments of state budgets:

- Medicaid spending on hospitalizations and emergency rooms
- Criminal justice spending
- Potentially also spending on welfare and public assistance programs
These issues are even more important in the changing health care landscape

- Mental illness is more prevalent in the uninsured population, which is now entering Medicaid
  - Could lead to a significant increase in the demand for mental health services within Medicaid

- States are increasingly looking to cover patients with mental illness through Medicaid managed care
  - Some evidence of cost savings
  - Next few years will be pivotal in determining how managed care firms will choose to manage the utilization of drugs
References


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