Though prescription drug costs are one of the fastest growing components of overall healthcare costs in the US, they still account for a small proportion (~10%) of healthcare spending.

Studies have shown that a $1 increase in drug spending translates into a saving of $2.06 in hospital spending.

With increasing health care costs and decreasing revenues, states throughout the country are curtailing Medicaid benefits.

Since outpatient prescription drugs are optional benefits under Medicaid, several states have implemented policies limiting prescription drug utilization to certain costs.

Policies such as prior-authorization or prescription cap that are generally aimed at reducing prescription drug costs have been shown to have an adverse impact on patient health, thereby driving medical costs upwards and negating any cost-savings.

On July 1, 2005, Mississippi (MS) Medicaid implemented a prescription cap policy restricting the number of prescriptions filled per month by a beneficiary to five (two brand-name and three generic medications).

Objectives

• The purpose of this study was to examine the impact of prescription cap policy on overall medical services utilization and costs among MS Medicaid beneficiaries.

Methods

• For the purpose of this study, a retrospective analysis of the MS Medicaid fee-for-service (FFS) administrative claims data for medical services (hospitalizations, emergency room [ER] visits, and office visits) dated between July 1, 2004 and June 30, 2006 was performed.

• MS Medicaid eligibility and enrollment files were used to obtain beneficiaries demographic and monthly enrollment information, respectively.

• Data was de-identified, and the study was approved under the exempt status by the University of Mississippi Institutional Review Board.

• The study included two data periods: 12-month pre- and post-prescription cap date of July 1, 2005.

• In both study periods (July 1, 2004-June 30, 2005 [pre-cap] and July 1, 2005-June 30, 2006 [post-cap]), beneficiaries who were 21 to 64 years of age during the 12-month period and were continuously enrolled for 10 months or more were included.

• After applying the study inclusion and exclusion criteria, a final set of 89,115 (pre-cap cohort) and 87,518 (post-cap cohort) beneficiaries remained.

• Using segmented regression analysis, trends in medical services utilization and cost per beneficiary per month (RPCM) were examined over the two-year study period (pre- and post-prescription cap).

• Physician office visits displayed a decreasing trend in the 12 month pre-cap period (estimate coefficient = -0.0055, p<0.0015) (Figure 2).

• Though the implementation of prescription cap was associated with a decrease in the number of physician office visits, this effect did not reach statistical significance (parameter estimate coefficient = 0.0258, p=0.0824) (Figure 2).

• There was no significant difference in hospitalization costs in the pre-and post cap period.

Results

Program: Physician/Office Visit/Hospitalization Visits

• In the 12-month period before the implementation of the cap, a decreasing trend in ER visits was observed (parameter estimate coefficient = -0.0024, p=0.0001) (Figure 1).

• The implementation of the cap resulted in an increase in the utilization of ER visits (parameter estimate coefficient = 0.0160, p=0.001; absolute difference = 0.0167 visits/PRBM) (Figure 1).

• Emergency Room Visits Pre-cap (β) = -0.0024, SE = 0.0007, p-value = <.0001

• Pre-cap (β) = 0.0180, SE = 0.0026, p-value = 0.0001

• Trend Change (β) = 0.0605, SE = 0.0308, p-value = 0.8444

• Physician Office Visits

• Pre-cap (β) = -0.0053, SE = 0.00144, p-value = 0.0015

• Trend Change (β) = 0.0258, SE = 0.0141, p-value = 0.0624

• Hospitalization Visits

• Pre-cap (β) = -0.00011, SE = 0.00076, p-value = 0.1512

• Segment Change (β) = 0.00400, SE = 0.000746, p-value = 0.5892

• Trend Change (β) = 0.00049, SE = 0.00107, p-value = 0.6513

Conclusion

• The implementation of prescription cap policy was associated with an immediate increase ER visits among beneficiaries enrolled in MS Medicaid.

• Further, an increase, although not statistically significant, was observed in the number of physician office visits.

• An increasing trend in ER visit costs was also observed in the one-year post-period.

• The results of this study highlight the increase in medical services utilization and costs with the implementation of a restrictive prescription cap policy.

References


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