Uncertain Access to Needed Drugs: Florida's Medicaid reform creates challenges for patients

Florida's Experience with
MEDICAID REFORM

This policy brief examines the benefits for prescription drugs available for Medicaid beneficiaries in Broward and Duval counties, the two pilot counties for Florida's Medicaid reform. Prescription drugs are critical for many Medicaid beneficiaries, especially for people with chronic and disabling conditions, and represent 13 percent of overall Medicaid spending in the United States. Growth in drug spending makes this a reasonable area for cost containment efforts. Yet numerous studies have shown that barriers to access for drugs can result in worsened health outcomes and even increased costs through higher emergency room use or more hospitalizations. To assess whether beneficiaries have adequate access to the drugs they need, researchers analyzed drug benefits and preferred drug lists used by health plans participating in Medicaid reform, as well as results from focus groups conducted with parents and people with disabilities receiving Medicaid.

Overview of Findings

Beneficiaries are reporting problems getting access to needed drugs. Beneficiaries with disabilities who participated in the focus groups reported that access to drugs was perhaps the most serious problem they were having with their Medicaid reform pilot program plans. Some found their prescribed drugs were not covered, and others had to switch to alternative medications. Either scenario can have a negative impact on health outcomes.

Half of the HMOs participating in the reform pilot are using the new benefit flexibility offered under reform to limit their drug benefit. Seven out of 14 reform HMOs limit the number or dollar value of prescriptions that can be filled. Although these limits are high, those beneficiaries at risk of exceeding them normally have multiple health conditions that could worsen if they are denied the ability to get all their drugs.

Virtually all reform HMOs include fewer commonly prescribed drugs on their preferred drug lists than the existing Medicaid program does in the rest of the state. Preferred drug lists are used to encourage appropriate drug use and to reduce drug costs. The barriers created for obtaining drugs not on the list may be reasonable for those who can be safely switched to alternate medications, but for others – especially those with mental illness – the barriers can prevent access to the drugs that allow them to stay healthy.

Making informed choices about plans based on drug needs is proving to be challenging, at best, for beneficiaries. In focus groups, beneficiaries reported that access to drugs is an important basis for choosing a plan, but choice counselors are unable to help beneficiaries determine which plans cover their drugs or whether covered drugs will be dispensed without restrictions. Nor is it easy to get information on plans' preferred drug lists by phone or on the web. Even if the information is available, it can be hard to find a plan that includes all of a patient's drugs on its preferred drug list.

Do Plans Differ in the Drug Coverage They Offer?

One of the highly touted features of Florida's Medicaid reform pilots is the consumer's opportunity to choose among health plans, allowing the consumer to compare differences in benefits among plans and select the one that best meets his or her needs. The federal waiver that authorized Florida's Medicaid reform plan gives health plans discretion to modify their drug benefits as long as the plans offer coverage that meets the needs of 98.5 percent of beneficiaries.

Specifically, plans must cover at least nine prescriptions per month, or $5,312 in annual drug costs, for non-disabled adults, and 16 prescriptions per month, or $24,473 in annual drug costs, for adults with disabilities. Provider-sponsored networks, as long as they are paid on a fee-for-service basis, are not permitted to adopt these benefit limits, and no plans may apply these limits to children and pregnant women. Among the Medicaid reform health plans, two of the three HMOs operating in Duval County and four of nine HMOs in Broward County have adopted either a monthly prescription limit or an annual dollar limit.[1]

Although nearly all drugs are eligible for coverage under Medicaid, a preferred drug list is a tool that encourages use of drugs on the list and makes it more difficult to use other drugs. Florida has used a Medicaid preferred drug list statewide since 2001 as the basis for negotiating with manufacturers for supplemental rebates. HMOs operating under reform (like all HMOs operating under Medicaid) also have the flexibility to adopt a preferred drug list.[2] All HMOs operating in the pilot program have done so. The restrictions created by the preferred drug lists, unlike the overall benefit limits, apply to children as well as adults. (Provider-sponsored networks must use the state's preferred drug list.) Beneficiaries can obtain a drug that is not on the preferred drug list through a prior authorization request that requires the prescribing physician to obtain approval.[3]

The Jessie Ball duPont Fund has commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program in Broward and Duval counties. This policy brief is the third in a series and provides insight into the impact of changes on beneficiaries' access to prescription drug medications in the two counties.

JESSIE BALL DUPONT FUND

What Drugs Are Included On Pilot Plan Preferred Drug Lists?

To test the breadth of the plans' preferred drug lists, researchers examined copies of the lists for all HMOs operating in the reform pilot program.[4] Researchers examined the availability of 50 drugs commonly used by Florida Medicaid beneficiaries, including the 30 drugs with the highest number of prescriptions dispensed, the 30 top drugs in the state by total cost, or both.[5]

The state's Medicaid preferred drug list includes 48 of the 50 drugs (96 percent) on the top drugs list.[6] By contrast, among the pilot plans, only the preferred drug list established by United Healthcare, matches this level of coverage.[7] The other HMOs list between 74 percent and 90 percent of the top drugs.

For 13 of the top 50 drugs, at least two of the reform plans omit them from their preferred drug list. These drugs include treatments for a variety of health conditions, including five mental health drugs, two treatments for high cholesterol, and two for gastrointestinal reflux and ulcers.[8]

Scope of Preferred Drug Lists Medicaid Reform Plans

Plan	Broward	Duval	# of Top 50 Drugs Included	% of Top 50 Drugs Included
Florida Medicaid PDL			*48*	*96%*
United HealthCare	✓	✓	48	96%
Vista (Buena Vista and Vista Health Plan)	✓		45	90%
Humana	✓		44	88%
Wellcare (Health Ease and Staywell)	✓	✓	41	82%
Total Health Choice	✓		39	78%
Amerigroup	✓		39	78%
Preferred Medical Plan	✓		37	74%

Less inclusive drug lists do not necessarily preclude beneficiaries from obtaining a particular drug their physician prescribes, because exception requests and appeals theoretically can be used to fill any legitimate prescription. In some cases, the plan excludes a drug based on the assertion that other therapeutic alternatives are equally effective treatments; by giving preferred status to one, it gains leverage in negotiating with manufacturers for lower prices. Among the statins taken to treat high cholesterol, for example, most plans restrict access to Lipitor. In these cases, plans typically say it is reasonable to do so because less expensive generic statins are available and equally effective. But even this substitution may raise concerns for some. While generic statins may be effective alternatives for many patients, evidence reviews suggest Lipitor is the best drug choice for patients who, in addition to highly elevated LDL cholesterol, have had a heart attack or have acute coronary syndrome.[9]

Drugs Most Often Omitted From Reform Plans' Preferred Drug Lists

Drug	Class	Top 30 by Scrips	Top 30 by Dollars	Number of Plans Not Including Drug
Nexium	Gastrointestinal		✓	7
Lipitor	High cholesterol	✓	✓	6
Synagis	Respiratory syncytial virus		✓	6
Prevacid	Gastrointestinal	✓	✓	4
Abilify	Antipsychotic		✓	3
Actos	Diabetes		✓	3
Geodon	Antipsychotic		✓	3
Zocor	High cholesterol	✓	✓	3
Zyprexa	Antipsychotic		✓	3
Lexapro	Antidepressant	✓	✓	2
Potassium Chloride	Mineral (often taken with diuretics)	✓		2
Topamax	Epilepsy, migraines		✓	2
Zoloft	Antidepressant	✓	✓	2

For mental health drugs, there are greater concerns since not all patients respond well to a single therapeutic alternative in a drug class. For example, there is evidence that disruption in existing mental health treatment regimens is associated with "symptom relapse or exacerbation, hospitalization, or other unintended adverse consequences among psychiatric patients."[10] As a result, many states (including Florida) excluded these drugs from restrictions in their Medicaid preferred drug lists. Similarly, the Medicare Part D program requires its plans to cover nearly all antidepressants and antipsychotic drugs.

Yet, in Florida, four reform HMOs restrict access to some antidepressants or antipsychotic drugs. Wellcare (which accounts for more than one-third of total enrollment in each reform county), for example, fails to include three of the five frequently used antipsychotic drugs (Abilify, Geodon, and Zyprexa). While each plan gives unrestricted preferred status to at least two of these five drugs, patients taking the others will need to go through some process for requesting prior authorization or an exception to the preferred drug list. This requires at least an inquiry to the patient's doctor and may require a visit to determine whether a substitution is appropriate. If a substitution is made, the mental health patient will certainly require increased monitoring to see if his or her condition worsens. In some cases, the patient may simply stop taking a drug.

Similarly, two HMOs (Preferred and Total) fail to list the two most commonly prescribed antidepressants. Generic alternatives such as paroxetine (Paxil) and fluoxetine (Prozac) are available from these plans and may be acceptable alternatives for new patients. But patients who have received stable control through Lexapro or Zoloft should generally stay with those drugs and may find the process for getting exceptions to be onerous.

Does Drug Coverage Influence Beneficiaries' Selection of a Health Plan?

Drugs are an important component of health care for many Medicaid beneficiaries, and many consider this an important criterion when choosing a plan. Nearly all participants in the focus groups, held in January and February of 2007, suggested that access to drugs was a critical factor in choosing a plan, along with their ability to stay with their doctors.[11] Information on drugs was particularly important to people with disabilities and others who take several drugs.

What beneficiaries most want to know is whether their particular drugs are covered. Yet the choice counselors answering the hotline do not have access to plans' preferred drug lists. If asked, they suggest that beneficiaries contact the plans directly to determine if their drugs are available without restriction.

But getting this information from the plans may not be easy. To test the ease of accessing this information, researchers contacted all reform HMOs by telephone. In most cases, the researcher was unsuccessful in getting a satisfactory response to the calls.[12] Eventually, researchers succeeded in locating the preferred drug lists on plan websites, although doing so required persistence and computer search skills. Finding this information is, at best, challenging for Medicaid beneficiaries who may lack the computer access, search skills, literacy, or time to get the information they need.

Basic information on the scope of the benefit is available to beneficiaries in the state's plan comparison brochures and from the choice counselors. But even that information has proven challenging for beneficiaries to obtain and understand. Focus group participants were asked to use the brochures to answer several questions about which plans had the best drug benefits for a person who "needed a lot of prescription drugs." The majority failed to select the plans with unlimited coverage.

Are Beneficiaries Having Problems with Access to Needed Drugs?

The challenges described above are not necessarily a problem if, in the end, patients get the drugs they need. Unfortunately, early reports suggest that this may not be the case.

Access to prescription drugs was probably the most common concern raised in the focus groups of beneficiaries with disabilities in both Broward and Duval counties (and one of the key concerns for parents). More than half of those with disabilities reported problems getting their medications after joining a reform plan or during the transition to reform. Some reported having to switch medications to one available on their new plan's preferred drug list. Others reported going without medications because plans would not cover them or because they were unable to get an appointment with their doctors quickly enough to get a new prescription.

One patient in Duval County reported difficulties in getting an appropriate anti-seizure medication covered. The doctor had to request an exception every month and finally wrote a letter to request an ongoing exception. Another patient learned that a nebulizer medication used to treat asthma was no longer available.

In some cases, doctors were willing and able to request exceptions that would allow the patient to get the originally prescribed drugs. But in many cases, patients became too discouraged to pursue their concerns, doctors were not willing to take the time to make the request, or plans were unwilling to grant an exception. A few focus group participants reported that doctors had provided them samples when the plan would not provide the needed drug. One participant reported switching from one plan to another because his doctor could not get a needed medication approved. Virtually no one in the focus groups was aware of his or her right to an interim three-day supply. These findings suggest that safeguards in the system to ensure that preferred drug lists do not ultimately restrict access to needed drugs are not working in these cases.

The Challenge Beneficiaries Face in Selecting a Plan That Includes Their Drugs

Eduardo is a Medicaid beneficiary in Broward County who takes six different drugs to treat a mental health condition, as well as muscle spasms and acid reflux. He is able to use generic or over-the-counter versions of his drugs where available. Only one plan,Total Health Choice includes all six drugs on its preferred drug list, without restrictions. A second plan, Humana, would cover all six drugs if Eduardo met the conditions for prior authorization for one drug. But Eduardo may not learn whether he meets those conditions until he is enrolled and his doctor submits the appropriate paperwork.

If Eduardo lived in Duval County, however, he would find that United HealthCare and Wellcare (the only plans operating in Duval County) include only four and three, respectively, of his six needed drugs in their preferred drug lists.

Availability of One Beneficiary's Drugs Under Reform

Drug	United HealthCare	Vista (Buena Vista and Vista Health Plan)	Humana	Wellcare (Health Ease and Staywell)	Total Health Choice	Amerigroup	Preferred Medical Plan
Fluoxetine	✓	✓	✓	✓	✓	✓	QL
Benztropine	✓	✓	✓		✓	✓	✓
Abilify		PA	✓		✓		
Clonazepam	✓	✓	✓	✓	✓	✓	✓
Torsemide			PA		✓	✓	✓
Omeprazole	✓	QL	✓	✓	✓	✓	QL
Number available unrestricted	4	3	5	3	6	5	3
Number available, including restrictions	4	5	6	3	6	5	5

✓ – The drug is on the preferred drug list
PA – Prior authorization is required to receive this drug under this plan
QL – Quantity limits are applied to this drug by this plan

Physicians echoed the concern about access to drugs. As reported in Briefing #2 (May 2007), a majority of responding physicians had cases of Medicaid patients where plan benefit limits or formularies impeded their ability to provide needed treatments. Some cited specific concerns as well. One physician complained that two plans "seem to have very different criteria for prior authorization of injectible medications which are medically necessary. They consistently deny based on medically necessary indications and dosages. [These plans] should NOT determine dosages!" Another physician reported that many patients had lost their primary care doctors in the transition and that the case manager was having "a rough time getting drugs, therapies, referrals, etc., for these patients."

These examples suggest that exceptions and appeals may be essential for many to get the medications they need. Unfortunately, data on how often exceptions or prior authorizations are requested or granted – or on how many prescriptions are denied or are dispensed with substitutes at the pharmacy counter – have not been made public by either the plans or the state.

Conclusion

Prescription drugs are among the benefits that Medicaid beneficiaries value most. For many, the drugs they take are a lifeline, and adherence to their drug regimens may be central to keeping them healthy and avoiding unnecessary hospitalizations or emergency room visits. Reports from patients and doctors, however, suggest that problems have been common since reform was implemented. Beneficiaries find it difficult to select a plan that meets their drug needs. Even when they succeed, they may find obstacles in filling their prescriptions. Problems are most common for those with disabilities, who often take multiple medications. Because prescription drugs represent an area in which plans are likely to want to control costs, they appear to be taking advantage of the benefit flexibility provided to them under reform to manage spending. This tendency may increase over time as cost pressures continue, potentially making these access problems worse.

ENDNOTES

[1] An additional HMO, offered by Universal Health Care and approved in December 2006, also limits its drug benefit. Enrollment is restricted in this plan, and it has been excluded it in the analysis presented here.
[2] The model contract used by reform plans states that plans shall "make available those drugs and dosage forms listed in the PDL" and "shall not deny or reduce the amount, duration, and scope of prescriptions solely based on the enrollee's diagnosis, type of illness or condition."
[3] Settlement of a class action case in 2003 (Hernandez et al. v. Medows), requires that beneficiaries receive a written notice whenever their drugs are not covered. The notice must explain why the drug was not covered, what is needed to get coverage, and the circumstances under which an immediate three-day supply must be made available.
[4] The preferred drug lists were provided by Florida Legal Services, Inc., which obtained them in March 2007 via a public records request.
[5] This analysis used state drug utilization data from the website of the Centers for Medicare and Medicaid Services.
www.cms.hhs.gov/MedicaidDrugRebateProgram/SDUD/list.asp Ten drugs appeared on both lists. The data source used did not permit distinguishing those drugs used specifically by reform-eligible beneficiaries.
[6] The state lists all 30 of the highest-volume drugs as measured by the number of prescriptions and all but 2 of the top 30 by dollar volume (Synagis, an expensive drug given to some infants at high risk for respiratory syncytial virus, and Topamax, one of several medications for migraines).
[7] Results are presented here for the seven organizations that sponsor reform HMOs. Two organizations each sponsor two separate plans, and some organizations sponsor plans in both counties.
[8] Several of the drugs on the list are used to treat HIV, which plans are required to cover.
[9] See, for example, www.bestbuydrugs.org where Consumers Union uses the results of evidence-based reviews to make recommendations.
[10] Joyce C. West et al., "Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients During the First 4 Months of the Medicare Drug Benefit," *American Journal of Psychiatry* 164(5), 789-796, May 2007.
See also Haiden A. Huskamp, "Managing Psychotropic Drug Costs: Will Formularies Work?" *Health Affairs* 22(3), 84-96, September/October 2003.
[11] For more detail on the focus groups, see the previous brief, "Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes," May 2007. Available at www.dupontfund.org or hpi.georgetown.edu/floridamedicaid
[12] Two plans indicated that the information could be obtained through the State of Florida's Agency for Health Care Administration. One plan indicated that it could only provide the requested information to beneficiaries or those calling from a phone number in Duval or Broward county. Phone messages were left with managers or public relations officers at five plans but only two of them responded. These two plans indicated that they would try and find the requested information, but it was never provided. In addition to the lack of success, the calls were time consuming and often involved three or more transfers.

This report is made possible through the generous support of the Jessie Ball duPont Fund, The Community Foundation in Jacksonville and United Way of Northeast Florida.

It may be found online at www.dupontfund.org and at hpi.georgetown.edu/floridamedicaid

For more information:

Sherry P. Magill
President
Jessie Ball duPont Fund
One Independent Drive,
Suite 1400
Jacksonville, Florida 32202
904-353-0890

AUTHORS

Jack Hoadley
Joan Alker
Health Policy Institute
Georgetown University
3300 Whitehaven St. NW
Suite 5000, Box 571444
Washington, D.C. 20057
202-687-0880

The authors would like to thank Dave Barish and Jen Thompson for their research assistance and Jeff Crowley for his review of early drafts of this report.