Oregon Health Plan Drug Copay Analysis: Executive Summary

Cost-sharing is a common method health care payers use to help manage rising drug costs. Over 98% of employer sponsored health plans use some form of cost-sharing as a component of drug benefit management. A 2003 survey of state Medicaid agencies found that more than 80% had cost-sharing, in the form of copayments (copays), for prescription drugs as a component in their benefit management program.

Despite the limited research about the health consequences of prescription drug copays in vulnerable populations, state Medicaid programs are poised to implement more aggressive levels of cost-sharing under provisions of the 2005 Deficit Reduction Act (DRA). Under this law, states are given the flexibility to increase copayment levels up to 10%-20% of the cost of the service or product depending on the enrollee’s income and alter the enforceability allowed by providers. Neither option is currently being pursued by Oregon. The DRA also allows state Medicaid programs to waive copays entirely for preferred products.

On January 1, 2003, the state of Oregon implemented a copay requirement for prescription drugs and a variety of outpatient services for clients enrolled in the fee-for-service (FFS) Medicaid program, the Oregon Health Plan (OHP). Copays for prescription drugs were set at $2 for generic and $3 for branded products. In addition, $3 copays were charged for outpatient services, including office visits, home visits, outpatient hospital services, outpatient surgery, outpatient treatment of chemical dependency, outpatient treatment for mental health, occupational and physical therapy, speech therapy, restorative dental work, and vision exams.

Given the widespread implications of this policy and the lack of data on the impact in this population, research evaluating both intended and unintended consequences of Medicaid copays for prescription drugs is needed. The goal of this study was to evaluate the impact the implementation of a prescription drug copay policy on prescription drug and medical service utilization in a FFS Medicaid population.

Methods
This study was a pre/post trend analysis using aggregated claims data from the Oregon FFS Medicaid program for patients receiving an OHP Plus benefit package. Monthly pharmacy and medical encounter claims data for 12 months before and 24 months after copay implementation were used to estimate utilization changes. The first objective of this study was to quantify overall and drug class specific prescription drug utilization changes after the copay policy was introduced. Second, changes in the utilization of medical services such as office visits, emergency room (ED) visits, and hospitalizations were evaluated after policy implementation. Finally, we examined the impact of this policy in cohorts of patients identified as having one of several common chronic diseases.
We also attempted to evaluate the impact of this policy change on patients with specific chronic diseases. We identified cohorts of with chronic respiratory disease (asthma and chronic obstructive pulmonary disease), diabetes mellitus, schizophrenia, depression, and cardiovascular disease and quantified changes in utilization of drugs by whether or not the agent is at all used for that particular disease.

**Key Findings**

**Study Population**
- Over the 3 year study period, we identified 116,822 OHP Plus patients potentially affected by the copay policy
- 66% of subjects were eligible through the TANF program, followed by 26% from the ABAD program, and 7% from Old Age Assistance

**Overall Trend Analysis**
- Implementation of copay policy was associated with an immediate and significant 17% reduction in overall prescription drug use (measured on a per member per month basis)
- No change was observed overall trend from before to after policy

**Figure 1: Overall pharmacy utilization PMPM**

- Drug classes for schizophrenia and depression among all subjects were observed to decline immediately by nearly 20%, while drugs for diabetes decreased significantly by 13%
• We did not observe significant increases in the rates of office visits, emergency department visits, or hospitalizations associated with the copay policy implementation.

• Use of generic medications increased from an average market share of 52% to 59% (7% increase) as shown in figure 2.

Figure 2: Generic Marketshare

Chronic Disease Cohorts
• Cohorts ranged in size from 451 in the respiratory disease group to 1222 in the diabetes cohort
• With the exception of those with cardiovascular disease, all studied cohorts appeared to exhibit a differential response depending on if the drug was used for their specific condition:

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Cohort use of drugs for disease</th>
<th>Cohort use of drugs not for disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>No change</td>
<td>12% drop</td>
</tr>
<tr>
<td>Respiratory</td>
<td>No change</td>
<td>8% drop</td>
</tr>
<tr>
<td>Depression</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>No change</td>
<td>15%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>No change</td>
<td>No change</td>
</tr>
</tbody>
</table>

• Significant changes in health services utilization were not observed in any of the studied cohorts
Discussion and Recommendations

- This study, along with other published literature, suggests that low income and vulnerable populations are sensitive to even low levels of cost-sharing, even if those copays are voluntary.

- Sensitivity to copays varied by drug class, however, reduction in utilization was observed in all studied drug classes.

- The differential copay structure appears to have elicited a moderate shift from brand to generic drug use.

- While immediate increases in the use of other health services was not observed, significant reductions in a number of drug classes is cause of concern.

- In an analysis of subjects identified with five chronic conditions, patients’ response to the copay policy differed by the specific indication of the drug. That is, patients with diabetes preferentially reduce their use of non-diabetes drugs compared to drugs specifically use to treat diabetes.

- Given the price sensitivity of this population, we recommend reducing or eliminating copays for drugs or classes of drugs that are both inexpensive to the state (e.g. most generic agents) and have strong evidence of effectiveness.