TennCare drug cap stirs anxiety

Patients worried about how they'll fill their prescriptions

By Mary Powers

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She was naming the medications that had given her back some of the life eroded by multiple sclerosis when the phone rang. She listened for a minute and asked: "You don't have samples of Provigil? Do you know of any other way to get it?" After a few more questions, Arlene Branham hung up the phone and wiped away tears. Branham, 42, of Raleigh, is among the roughly 379,000 Tennessee adults now bumping up against TennCare's new prescription drug limit.

Last month, Tennessee became one of a handful of states to limit how many prescription drugs it will buy for some TennCare patients. TennCare serves as Tennessee's Medicaid. Funded with state and federal dollars, it is designed primarily to provide health care to the state's poorest residents. Most adults covered by TennCare are now limited to three generic and two brand-name drugs every month. They'll pay $3 for each brand-name drug. Although some TennCare patients have always paid co-pays, previously there was no medication limit.

Now Tennessee is one of only a few states that don't provide for individual exemptions to the cap.

That's left TennCare patients like Branham scrambling to figure out how she'll fill the eight prescriptions she receives monthly to manage her arthritis and MS. It also has state officials, advocates and health policy analysts debating the wider impact.

Critics argue it will drive up state spending for hospitalization, outpatient and other medical services and lead to unnecessary pain and suffering. The Tennessee Justice Center, a nonprofit legal advocacy group, charged that Gov. Phil Bredesen reneged on a promise to soften the prescription cap. The administration denies the charge. Bredesen argues the drug cap and other planned benefit cuts are painful but necessary. The limits are part of an overhaul that included cutting about 190,000 adults from the program. It is all designed to safeguard the state budget and other state programs.

Tough choices

For Branham, finding medication has become almost a full-time job. When the prescription limit began, she met with her three doctors and asked if any of her prescriptions could be dropped. "They all feel like what I'm taking is necessary." But the TennCare cap did prompt her doctors to switch from brand name to generic drugs to treat her pain and sleep problems. She decided to use part of her TennCare drug coverage to buy a name brand MS drug that costs about $1,685 per month and an antidepressant that runs about $380 per month.

A doctor found free samples of medicine to treat her fatigue, a common MS symptom. For her arthritis, she's using a friend's leftover Celebrex. She said there is an informal network of individuals offering leftover medicine at no cost to patients who need it. That left Branham with two unfilled prescriptions for medicine to combat other MS side effects, including incontinence. Doctors have said generics aren't an option and free samples aren't available.

Branham currently relies on a $1,000 monthly disability check to pay her drug bill and expenses. "I just don't have the money to buy them myself," Branham said. She said the drugs would cost about $370 per month. She tried skipping doses, until her sister persuaded her to stop. She's applied to pharmaceutical company programs that provide low cost or free drugs to qualified patients. She's been turned down by one and knows she's unlikely to qualify for others because TennCare provides some coverage. Branham is simply doing without those drugs.
Some exemptions

Michael Drescher, a TennCare spokesman, acknowledged that states with Medicaid prescription drug limits typically allow individual exemptions. He said a 1999 legal agreement known as the Grier decision prevented that option for TennCare patients. In August, a federal judge agreed to some of the state's requests to modify the Grier decision. But the changes weren't enough to allow the state to implement a system that would allow physicians to seek individual exemptions, Michael Kirk wrote in a letter to The Tennessee Justice Center. Attorney Kirk was part of the state's legal team. Marilyn Elm, a TennCare spokesman, said it would be several months before the state considered easing the limits.

TennCare is already paying for more than five prescriptions for some patients. They include those battling AIDS, cancer, tuberculosis, hemophilia, Parkinson's disease and hepatitis C. Although the patients aren't exempt from the monthly prescription cap, certain medications are. The state has drawn up a list of about 200 medicines, vaccines, prenatal vitamins, diabetes and other treatment supplies that don't count toward the patient's monthly limit.

TennCare also isn't limiting the number of prescription drugs it will buy for the roughly 682,400 covered children and teenagers and nursing home residents or the estimated 97,000 adults whom Bredesen recently announced would remain on the program. Those are patients who originally qualified for TennCare because of relatively high medical bills and low income.

But that won't help patients like Branham.

Will it backfire?

Health policy analysts warn that prescription caps could backfire and ultimately drive up TennCare costs. They point to New Hampshire's experience. In the early 1980s, the state limited to three the number of prescription drugs it would buy for Medicaid patients.

Harvard researchers tracked how the cap affected various groups, including frail older residents and those battling chronic mental illness. After the cap was introduced, patients got about 30 percent fewer prescriptions filled, including those for insulin and high blood pressure. Older New Hampshire residents were also more likely than comparable New Jersey residents to land in a nursing home. The investigators also reported that the state's cost for treating the mentally ill rose $1,530 per patient.

Dr. David Mirvis of the University of Tennessee Center for Health Services Research was among those who cited New Hampshire's results when predicting Tennessee's new drug cap will likely increase TennCare costs.

That's because experience suggests patients will delay buying their medicine, reduce their dose or skip taking it entirely. "You would hope people would cut out the non-essential medicines. But they don't. It is the first (prescriptions) of the month that get filled," Mirvis said. "What happens then to patients who don't get their medicine? They end up in the hospital."

Tennessee has among the nation's highest rates of prescription drug use. "It is an obvious target (for cost containment). It stands out like a sore thumb. The issue is how do you approach it," he said.

Dr. Alan Sager, who directs the health program at the Boston University School of Public Health, said doctors, not patients, are key to reducing medical waste and unnecessary prescriptions. "It is the doctors who know where the waste is," he said.

TennCare's Drescher dismissed such criticisms and said New Hampshire is too different from Tennessee to provide meaningful predictions.
Other savings

TennCare isn't relying on caps alone to tame drug costs. The program has negotiated additional rebates from pharmaceutical companies, joined a multi-state drug purchasing pool, expanded patient co-pays, developed a list of medications it will pay for without prior approval, and stepped up efforts to influence physician prescribing.

Richard Cauchi of the National Conference of State Legislatures said those are among the most popular strategies employed by states struggling to control costs. Fewer states have adopted or maintained drug caps, said Cauchi, the group's health program director. New Hampshire eventually replaced its cap with a $1 per prescription co-pay. Cauchi said Colorado backed off a planned cap in the face of physician opposition.

"In many states, caps are used in connection with prior authorization," he said, meaning a doctor must request and receive prior approval before those Medicaid programs will pay for extra prescriptions. Caps are "not an area that the states have bragged about substantial savings, but that isn't to say that it isn't having the effect states want."

Sager argues states must get tougher when negotiating with pharmaceutical companies.

"When you go after price you are doing your job as a politician and not pretending to be a doctor," he said.

West Virginia is one state slated to try such an approach. The state's new pharmaceutical advocate is charged with developing an approved state drug list and then negotiating with drug companies on behalf of all state agencies, from Medicaid to the prisons, that purchase drugs.

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