POLICY & PRACTICE

Low-Income Seniors Helped

The Centers for Medicare and Medicaid Services has proposed new rules that would allow more low-income Medicare beneficiaries to remain in their current prescription drug plan without having to pay a premium. Each year, CMS recalculates the amount of premium that will be paid by Medicare for low-income beneficiaries in each region, meaning that individual Part D plans might be fully covered by the subsidy in one year but not the next year. Until now, CMS has randomly reassigned some beneficiaries to another Part D plan if their current plan's premium would be higher than the subsidy amount. The new rules, proposed last month and slated to be finalized in time for the 2009 plan year, would allow some prescription plan sponsors to offer a reduced premium to some individuals eligible for the low-income subsidy. The proposal would apply in regions where there otherwise would be fewer than five prescription drug plan sponsors with a "zero-premium" plan option for low-income beneficiaries.

Coverage Improves Health

Uninsured adults 55-64 years old, particularly those with cardiovascular disease or diabetes, saw their health improve significantly once they became eligible for Medicare, a study from Harvard Medical School, Boston, reported. The study looked at more than 5,000 adults who were continuously insured and more than 2,200 who were uninsured persistently or intermittently in the decade before they became eligible for Medicare. The researchers found that, compared with previously insured adults, previously uninsured adults reported significantly improved health trends after age 65, both overall and for measures related to mobility, agility, and adverse cardiovascular outcomes. Depressive symptoms did not improve significantly in uninsured individuals with these other conditions once they became eligible for Medicare, but depressive symptoms did improve in previously uninsured adults without these other conditions once they became eligible for Medicare. By age 70, the differences in health status between the previously uninsured and those who had been insured continuously were reduced by about half. The study appeared in the Dec. 26 issue of JAMA.

Grant Funds Medical Home Study

The American College of Physicians has received a $225,000 grant from the Commonwealth Fund to study the cost of providing a patient-centered medical home. The grant, part of the Commonwealth Fund's Patient-Centered Primary Care Initiative, will help underwrite a 10-month study which began in November. ACP committed matching funds late in 2007, the organization said. "Understanding the economics of the patient-centered medical home is essential to the development of payment strategies that support the adoption and spread of the model," ACP Vice President Dr. Michael Barr, who is directing the study, said in a statement.

Retiree Benefits Can Be Cut

A new federal regulation will allow employers to provide more limited health care benefits for retirees who are eligible for Medicare. The rule, which the Equal Employment Opportunity Commission released in late December, responds to a court of appeals case in which the court held that health insurance benefits provided to Medicare-eligible retirees must cost the same as those provided to early retirees. Both labor unions and employers complained to the EEOC that compliance with the decision would force companies to reduce or eliminate current retiree health benefits. The EEOC said that the new rule makes it clear that employers are allowed to coordinate retiree benefits with the Medicare program. "By this action, the EEOC seeks to preserve and protect employer-provided retiree health benefits, which are increasingly less available and less generous," said EEOC chair Naomi Earp in a statement. AARP sharply panned the new policy. "It is a wrong-headed move to legalize discrimination, allowing employers to back off their health care commitments based on nothing more than age," said AARP legislative policy director David Certner in a statement.

Expanded INR Monitor Coverage

CMS is considering expanding coverage for home prothrombin time (international normalized ratio) monitoring. Currently, monitoring is limited to patients with mechanical heart valves. The agency proposes to expand coverage to those patients with chronic atrial fibrillation or deep vein thrombosis who require chronic oral anticoagulation with warfarin, have been anticoagulated for at least 3 months, have undergone an educational program on anticoagulation management and demonstrated the correct use of the device, continue to correctly use the device, and use the device to self-test no more than once a week. CMS said it will gather feedback on its proposal, but did not provide a timetable for a final decision.

Judge Overturns Rx Info Law

A federal judge has overturned a Maine law that would have restricted medical data companies' access to physician prescribing information. In a decision that relied heavily on a previous ruling in New Hampshire, U.S. District Judge John Woodcock said that the law would prohibit "the transfer of truthful commercial information" and would violate the free speech guarantee of the First Amendment. The Maine law was challenged on constitutional grounds by IMS Health, Wolters Kluwer Health, and Verispan, all medical data companies that collect, analyze, and sell such data to pharmaceutical manufacturers. The companies also argued that the law bucks a national trend toward greater transparency in health care information.

—Jane Anderson

Study Charts Success of Physicians in Recovery

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — Of 104 physicians in New York state who were admitted to substance abuse treatment programs between 2003 and 2004 and were monitored for a mean of 41 months by the state's Committee for Physicians' Health, only 9 (9%) were discharged because of noncompliance with program expectations.

That might spell success at first glance, but at the annual meeting of the American Academy of Addiction Psychiatry, Dr. Marc Galanter emphasized the need for more research to optimize treatment outcomes for physicians in recovery.

"There are still a number of issues to be considered," said Dr. Galanter, professor of psychiatry and director of the division of alcoholism and drug abuse in the department of psychiatry at New York University, New York. "One is the need for prospective study—following the treatment contemporaneously—which we have yet to see," he said. "Another is to better understand the role of medication."

Buprenorphine inevitably will be used more widely; however, the question of whether physicians should be allowed to practice while taking opioid maintenance therapy is likely to become a political issue at the state level, he said.

He also recommended that a more active role for cognitive-behavioral therapy "be studied because this is a modality that is currently regarded as essential to effective treatment."

Dr. Galanter based his remarks on results from a study he led that sought to provide an independent evaluation of the oversight and rehabilitation of 104 substance-abusing physicians who had completed their monitoring period by the New York State Committee for Physicians' Health (CPH). About 30% of physicians who enroll in the CPH program receive at least 28 days of inpatient treatment. Components of ambulatory management include workplace monitoring, 12-step program attendance, and random urine toxicologies.

The researchers, who were not affiliated with CPH, selected the 104 records at random (Am. J. Addict. 2007;16:117-23). The mean age of the study participants was 42 years, most (96) were male, about half (51) were married, and 66 were employed as physicians at the time of admission.

More than half (59) had a history of substance abuse treatment, and 38 had attended 12-step meetings before program admission. In addition, 33 were in psychotherapy of some sort prior to admission, and 27 were taking psychiatric medications, primarily antidepressants.

The most common primary substance of abuse was alcohol (38), followed by prescription opiates (35), said Dr. Galanter, who is also the editor of the journal Substance Abuse.

The top five medical specialties represented were anesthesia (22 physicians), internal medicine (11), family medicine (10), obstetrics and gynecology (9), and pediatrics (8). "Anesthesia is overrepresented among impaired physicians because of access to addictive agents, and because in some cases people go into anesthesia attracted to the idea of handling and having access to opioids," Dr. Galanter said.

The overall period of treatment and monitoring averaged 41 months; 30 participants required inpatient hospitalization.

Fifteen physicians did not want to attend 12-step meetings but were pressed by counselors to do so. Of those, nine later went. "The outcome of those pressed to go was not significantly different from that of the other patients," he said. "So apparently the coercive nature of the treatment in that regard was not compromising to the outcome."

Of the 104 patients, 38 relapsed as confirmed by urine toxicology or by confirmation from an informed source. Even under good circumstances, some relapse is inevitable before the patient is stabilized, Dr. Galanter said. However, one complication is that physician impairment programs are responsible for serving large numbers of physicians.

Even under good circumstances, some relapse is inevitable before the patient is stabilized.

DR. GALANTER

"The pressure of the needs of public health that they experience puts them in a difficult position," Dr. Galanter said. "My impression is that it's remarkable how effective they are in balancing the physician needs against the demands of the general public."

Predictors of relapse included past use of cocaine, unemployment at the time of program admission, a greater mean number of urines tested, and a longer length of program involvement.

Nine patients were discharged for noncompliance with program expectations. "They essentially lost the option of practicing medicine," he said. "Relatively speaking, this gives you an idea of a very good outcome, considering that full compliance is essential to success in this program."

Dr. Galanter said he considers the 12-step component of the CPH program essential to overall success. Given the need for full abstinence before returning to practice, he pointed out, these spiritually oriented 12-step programs are uniquely valuable in ensuring an optimal outcome.

"It's really remarkable what transformation many of these physicians experienced over the course of rehabilitation," he said. "What we don't know is how we can compare recovery of this kind to recovery based on opioid replacement or on the variety of medications that we're going to be using. It's an issue of tremendous importance in terms of our investigation of future psychosocial modalities." ■