Medicare Rx Benefit Causes 'Confusion and Paralysis'

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WASHINGTON — Delegates to the 2005 White House Conference on Aging made it clear that they weren't happy with Medicare's new prescription drug benefit.

Challenging administration claims that the benefit's tools were accessible and easy to use, delegates recommended that Part D be simplified to create one prescription drug program for beneficiaries.

The Medicare drug benefit was one of 50 resolutions chosen as the "top" issues on aging by the 1,200 delegates at the meeting. Delegates were then charged with drafting implementation strategies suggesting how these resolutions might be put into action. Nearly half of the resolutions addressed health care issues, including Medicare and Medicaid, long-term care, and training health care personnel.

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The new drug benefit is "clearly in line" with the principles of the White House Conference on Aging to promote the dignity, health, and economic security for current and future generations, Mike Leavitt, secretary of the Department of Health and Human Services, said in his address to the delegates. "The benefit will be of immediate help to older Americans now," plus the next group of rapidly expanding aging Americans, the baby boomers, said Mr. Leavitt, who said he helped his own parents enroll in the drug benefit.

His remarks were a hard sell for the delegates, which included governors, members of Congress, and representatives from the National Congress of American Indians, national organizations, academia, business, and industry.

The main source of frustration has been the complexity of the plan, said Ellen Camerieri, a delegate from the Bronx, N.Y., and executive director of Riverdale Senior Services Inc. "Secretary Leavitt talked about how easy it is to sign up … and to get your family together to do it. But what if [you're an aging patient] and you don't have a family?"

In her own community, she said, there's a sense of "confusion and paralysis" over the drug benefit.

Opting into a new drug program under the benefit can be daunting, especially if a beneficiary has a Medigap policy that's not a union or government pension, "but a policy to help them bridge the gap between what Medicare covers and what the actual costs are. You have a vast number of seniors who have had a relationship with a policy, and now must decide whether to continue in the new version of that policy under Part D, or go to the [numerous] other odd policies [offered] within their state."

Dr. Mark McClellan, CMS administrator, assured delegates that the agency is taking steps to ensure that there is not any lapse in drug coverage. "For example, we have worked closely with states over the past year to obtain very high match rates between their enrollment information and Part D enrollment—match rates well over 99%."

The agency also has developed a process for a "point of sale" solution, if the beneficiary somehow has not been automatically enrolled in Part D. In addition, multiple efforts are taking place to provide counseling and assistance to beneficiaries, he said.

Seniors "can ask" before they sign up for the plan whether all of the drugs they are taking now are covered, and the agency has tools so that patients can find the lowest cost for a particular drug, Dr. McClellan said.

Yet, his praise of the new 800-MEDICARE customer service line evoked jeers from some delegates. "He claims that every call was answered right away," said Steve Kofahl, a delegate from Seattle. But when one of Mr. Kofahl's employees tried to call the number to get information, that person "could not get through."

The problem is a patient has to be able to predict the future to know which plan he or she should sign up for, Ms. Camerieri said. Certain plans under the new benefit cover certain drugs and not others "and you might not be on a medication you'll be needing in 6 months" when you sign up, she said. There's a limited ability to change your plan without some penalty, she said.

Many in the health care field would like to think that Part D is for the people, Ms. Camerieri said. "But the underlying suspicion is that it was drafted to benefit the pharmaceutical and insurance companies who are the people putting together these plans," she said.

"We want Medicare—not the private insurance companies—to negotiate drug prices," agreed Marilyn Askin, a delegate from West Orange, N.J.

Delegates drew up language insisting that the White House recognize the work that comes out of the conference. In the meantime, they agreed to follow through on their grassroots efforts and to meet to disseminate the recommendations. ■

POLICY & PRACTICE

Medicare Patients Welcome

Most physicians have kept their doors open to Medicare patients despite previous reductions in their pay, according to a study from the Center for Studying Health System Change (HSC). The proportion of U.S. physicians willing to treat Medicare patients stabilized during the last half of 2004 and the first half of 2005, with nearly 75% reporting their practices were open to all new Medicare patients. In 2004-2005, 73% of physicians reported accepting all new Medicare patients, an increase from 71% in 2000-2001, but not statistically different. Physicians' willingness to treat Medicare patients remained high, despite a 5.4% payment cut in 2002 that was not fully offset by smaller increases in subsequent years. Only 3.4% of physicians reported closing their practices to new Medicare patients in 2004-2005, also statistically unchanged from 2000-2001. Moreover, the proportion of primary care physicians accepting all new Medicare patients increased significantly from 62% in 2000-2001 to 65% in 2004-2005. "While concerns about Medicare beneficiary access have focused on physician payment, policy makers should recognize that Medicare fees are only one factor in physician decisions to accept new patients," said HSC president Paul B. Ginsburg, Ph.D.

Ban on False Information

The Health and Human Services Department may not deliberately disseminate false or misleading scientific information under a recent federal law. The provision, part of the fiscal 2006 HHS appropriations law, also prohibits the questioning of scientific advisory panel nominees about their political affiliation, voting history, and positions on topics unrelated to the capacity in which they are to serve. "If your doctor gives you misleading scientific information, it's called malpractice," said Dr. Francesca Grifo, senior scientist and director of the scientific integrity program at the Union of Concerned Scientists. "It should already have been illegal for political appointees in government posts to knowingly provide false information, so this ban at HHS represents a modest but important first step in ensuring scientific integrity in federal policy-making and better health care for us all."

Cardiac Rehab Coverage Expanded

Medicare is proposing to expand national coverage for cardiac rehabilitation services to three additional groups of beneficiaries: those who have had heart valve repair or replacement, percutaneous transluminal coronary angioplasty (PTCA), and heart or combined heart-lung transplant. "With this proposed coverage decision, [the Centers for Medicare and Medicaid Services] seeks to expand coverage to a greater number of beneficiaries with cardiac illness," said Administrator Dr. Mark B. McClellan. "But just as importantly, we hope that our proposed decision will raise the public's awareness regarding cardiac rehabilitation services in general." The agency further proposed that cardiac rehabilitation services be comprehensive and include medical evaluation, education, and nutrition services. Medicare has covered cardiac rehabilitation services for beneficiaries following heart attack, coronary artery bypass surgery, and angina since the 1980s and this coverage will continue. A comment period on the proposed decision ended on Jan. 23. CMS plans to issue a final decision within 60 days following the close of the comment period.

Patterns of Trial Registration

The act of clinical trial registration alone is not a good indicator of adherence to registration policies, according to a study that analyzed the quality of information provided during the registration process, and patterns of trial registration (N. Engl. J. Med. 2005;353:2779-87). The researchers reviewed clinicaltrials.gov records to determine patterns of completion of the "Intervention Name" and "Primary Outcome Measure" data fields for trials registered on May 20 and Oct. 11, 2005, and for trials registered during the interval between these two dates. "When trial sponsors have the option of providing information of marginal clinical value in a particular data field, our findings show that some companies provide useful information and others do not," the researchers found. This may indicate varying degrees of comfort with different levels of disclosure. For example, of the 2,670 studies registered by industry between the two dates, 76% provided information in the Primary Outcome measure field, although these entries varied markedly in their degree of specificity. "It is unacceptable for a trial sponsor not to register its trial in a complete, meaningful, and timely fashion," Dr. Jeffrey Drazen and Dr. Alastair J.J. Wood wrote in a related editorial. "If a company continues to register trials using meaningless data, with no respect for the registration process and the patients who participate in those trials, investigators and patients should refuse to participate."

Top Stories of 2005

The growing number of uninsured patients, the public health impact of Hurricane Katrina, and registration for the new Medicare drug benefit were among the top health policy stories of 2005, according to an informal Commonwealth Fund/Health Affairs survey. The survey listed 15 policy stories, compiled by fund staff and journal editors, and asked Web site visitors to select the five they considered the most important. Other top vote-getters among the 1,100 respondents were stories indicating that the U.S. health care system doesn't perform as well as those of several other industrialized nations on various clinical indicators and in reported patient experiences, and that health care costs continue to increase.

—Jennifer Lubell