Advise Patients Carefully Regarding Part D Benefit

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

PHILADELPHIA — Physicians can help Medicare beneficiaries who are trying to select a Medicare drug coverage plan, but they have to make sure they follow all the rules, Charlene L. McGinty said at the annual meeting of the American Health Lawyers Association.

The drug benefit, also known as Part D, was passed by Congress in 2003 and became effective in January 2006. Patients pay an annual deductible of $250 as well as a premium of about $35 per month, depending on the plan they choose. The plan then pays 75% of drug costs until the patient has spent $2,250. After that, in most plans, the patient has to pay the next $3,850 out of pocket; this period is known as the "doughnut hole" or "coverage gap." Once the beneficiaries' bills hit $5,100, the plan pays 95% of any remaining drug costs for the rest of the year. Low-income beneficiaries receive a more generous benefit.

Drug plans are administered by private insurers, but of all the plans participating, 20 plans represent 90% of the market, said Ms. McGinty, a partner in an Atlanta law firm. "The biggest group is [affiliated] with UnitedHealth Group," she added. There are 10 "national plans" approved by the Centers for Medicare and Medicaid Services; those plans are recommended for snowbirds who live in one place during the spring, summer, and fall but go south or west for the winter.

To help beneficiaries navigate the maze of plans, there are some things physicians are allowed to do, Ms. McGinty said. She recommended asking patients the following questions about the plans they're considering signing up with:

► How much is the deductible—the standard $250, or less?

► What about copays? Does the plan require a set copay or does it charge "coinsurance," which means the patient must pay a certain percentage of the drug cost, whatever it is?

► Which pharmacies are included in the plan's pharmacy network? "Many seniors have established relationships with pharmacies and pharmacists," said Ms. McGinty. "They may not want to change them."

► What is in the formulary? Are the patients' drugs covered, or will they have to go through prior authorization or step therapy before they can get their particular medications?

One audience member pointed out that although plans are supposed to review their formularies once every 180 days, their pickup of drugs approved in 2005 was "unbelievably poor." If the plans base their formulary decisions on the model formulary published by the United States Pharmacopeia, that formulary is updated only once a year, he noted.

Ms. McGinty agreed that "there is a potential lag" to the new drugs coming on the model formulary, but added that each plan's pharmacy and therapeutics committee also is supposed to be keeping track of new drug approvals and deciding whether to add a new drug.

Off-Label Drug Use

Plans are supposed to approve off-label use as long as the use is listed in one of three drug compendia, said Greg Jones, with the program integrity group at the Centers for Medicare and Medicaid Services. But trying to help a patient get a drug for an off-label use not listed in a compendium will be a "trouble spot" for doctors, he conceded.

Although providers can give patients some help in choosing a drug plan (and even help low-income beneficiaries fill out the paperwork to get better benefits) "tension exists because there are limitations on what providers can say" about various drug plans, Ms. McGinty explained. For example, providers cannot make specific plan recommendations, they can't steer an undecided enrollee to one plan over another, and they can't accept plan applications. ■

Medicare D 'Doughnut Hole' Halts Many Drug Regimens

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — Patients taking antidepressants and cholesterol-lowering drugs who are in pharmacy-capped plans, like the new Medicare Part D drug benefit, often stop taking their drugs when they reach the cap, Geoffrey Joyce, Ph.D., said at the annual research meeting of Academy Health.

According to his research, anywhere from 6% to 11% of patients in the Medicare Part D program are likely to hit what is known as the "doughnut hole" of coverage in any given year, said Dr. Joyce, a senior economist with the RAND Corp., Santa Monica, Calif.

A major concern about patients who stopped taking their drugs was that only about 40% of them restarted those drugs at the beginning of the new year.

The so-called doughnut hole is the gap in coverage that goes into effect during a coverage year when a patient's drug expenditures reach $2,250, and continues until the expenditures reach $5,100. Prior to reaching the doughnut-hole gap, beneficiaries have a $250 annual deductible and pay 25% of their drug costs. After expenditures have reached $5,100, catastrophic coverage kicks in and patients pay only 5% of costs. Within the doughnut hole, patients pay 100% of their drug costs.

Many health economists and others have worried that the Medicare Part D patients most likely to spend their way into the doughnut hole are the sickest patients, and that those patients might become noncompliant with their medication regimens when they surpass their $2,250 limit. Dr. Joyce and colleagues looked at two employer health plans with drug benefits that had a cap on coverage of $2,500, to get an idea of what is likely to happen with the Medicare plan.

In the years considered (2003 and 2004), 7% of beneficiaries in one plan and 11% in the other plan hit the cap.

The median time of year when patients hit the cap was September. However, one-quarter of the patients who hit the cap did so in June, meaning they had no drug coverage for a full 6 months, Dr. Joyce said.

Patients did not appear to switch from brand-name drugs to generic drugs in any appreciable degree when they reached the cap. However, some patients did stop taking certain drugs. The most common medications the patients stopped taking were antidepressants and cholesterol-lowering drugs.

What was most concerning about those who stopped was that only about 40% of those who stopped then restarted those drugs at the beginning of the new year, he said. Previous studies of drug benefit caps have shown that they do reduce plan costs significantly. In one study of a Kaiser Permanente plan, a cap resulted in 31% lower drug costs.

That study found, however, that there may be a price to pay for curtailing drug benefits too drastically, Dr. Joyce noted.

Overall, the Kaiser study found that the capped plan did not result in higher medical care costs. But there were more hospitalizations and more emergency department visits in the capped plan, compared to a noncapped plan. There was also a 22% higher mortality among patients in the capped plan.

Given the higher hospitalization and ED visit rates, the finding that medical care costs were no higher is probably a statistical anomaly, and is not accurate, he said.

In this study, the investigators have begun looking at ancillary costs that might be associated with patients' not filling prescriptions they otherwise would have filled. But that work is not completed yet. ■

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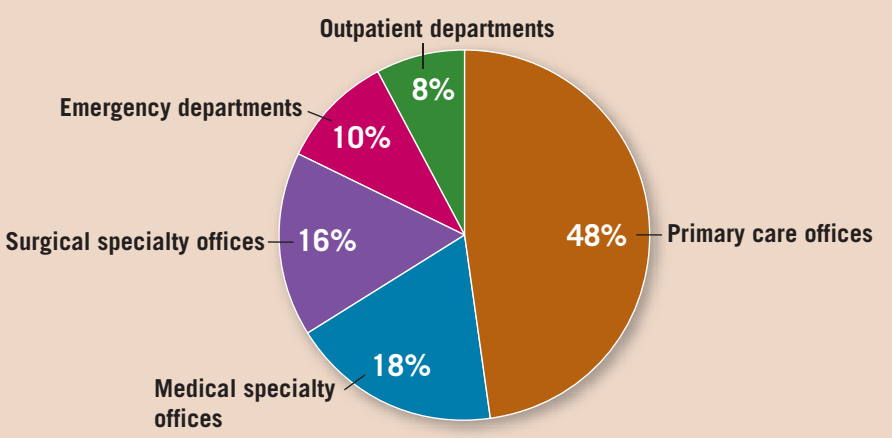
DATA WATCH

Almost Half of the 1.1 Billion Ambulatory Care Visits in 2004 Were to Primary Care Doctors



Source: Estimated data, Centers for Disease Control and Prevention