Comparing Potential Strategies to Eliminate Medicare Part D's Coverage Gap

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OBJECTIVES: Eliminating the Medicare's coverage gap is on health reform's agenda. This study compares the implications of current House and Senate bills on closing the donut hole as well as use of generic drugs on three outcomes: 1) proportion of beneficiaries entering the gap; 2) duration in the gap; and 3) total and out-of-pocket annual pharmacy spending. METHODS: 2007 pharmacy data of a random sample of beneficiaries enrolled in a Medicare-Advantage Part D plan were used to evaluate these outcomes under three proposals: 1) reducing the size of the donut hole by 50%; 2) reducing the size of the donut hole by 50%, adding a 30% discount for brand-names used in the donut hole (House bill); and 3) switching to generic drugs after several brand-names go off-patent by end-2011. RESULTS: Under 2007 Part D, 20% beneficiaries entered the gap and 3.3% entered the catastrophic period. People stayed in the gap for 132 days, their total pharmacy spending was $4561, with $2337 out-of-pocket and $2224 by Medicare. Under the Senate bill, 14% would enter and 3.5% would go through the gap. Those entering the gap would stay there for 120 days and their total pharmacy spending would be $5214, $2788 out-of-pocket and $2426 by Medicare. The House bill would save additional $791 among beneficiaries entering the gap. Several blockbusters including Lipitor, Zyprexa, Prevacid, Novacip, Actcept will go off-patents by end-2011. If patients switched to their generic counterparts, 17% would enter the gap and 1.8% would enter the catastrophic period. Those entering the gap would spend $4476 total, $2115 out-of-pocket and $2361 by Medicare. CONCLUSIONS: Reducing the gap size can delay entering the gap, but may not reduce beneficiaries' out-of-pocket spending. A strategy combining it with generic use could be more effective.

Beneficiary Choice in Medicare Part D

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OBJECTIVES: To empirically assess the preferences of Medicare beneficiaries in their selection of an approved Part D prescription drug plan. METHODS: A descriptive analysis illustrated the tendencies of those Part D beneficiaries who independently chose their 2007 Part D plan to keep their previous drug coverage and those who considered other available Part D plans. The final study sample included the 2007 internet survey respondents who (by October 2007) were at least 65 years old and insured through Medicare Part D and excluded the Part D beneficiaries automatically enrolled in a Part D plan. The survey period was 12 months, from April 1, 2007 to March 31, 2008. RESULTS: 2,123 people chose their Part D plan. The preferred plan was Blue Cross Blue Shield, which covered 180 out of 185 drugs. People chose their plan by 51% on the basis of brand-name drugs, 19% on the basis of generic drugs, and 28% on the basis of price. CONCLUSIONS: Consumers prefer plans with a larger choice of drugs.

Cost Consequence Analysis of Prescription Drug Label Changes

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OBJECTIVES: To examine the influence of pharmaceutical companies on the quality of prescription drug labels. METHODS: Each label was categorized as one of two levels of prescription drug label quality, as defined by a pharmacy technician. RESULTS: The cost of label changes was $775 per 1000 labels. CONCLUSIONS: Label changes are costly and the savings from label changes would not justify the expense.

The Relationship of Research and Development Activity with U.S. Medical Drug Shortages

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OBJECTIVES: In recent years, efforts to balance access to promising, new technologies with the need to ensure effective and efficient use of limited health care resources have focussed on the adoption of various forms of conditional coverage arrangements, collectively referred to as Access with Evidence Development (AED) schemes. While such arrangements continue to attract interest, concerns over ‘value for money’ have also emerged, raised since they often represent considerable, committed resources for implementation. This project aimed to develop a framework for guiding the design of future AED schemes and apply this framework to the evaluation of existing AED schemes. METHODS: An international workshop involving researchers and decision-makers with experience designing and implementing AED schemes was held. Presentations comprising case studies from Australia, Canada, the UK, and the US were used to highlight issues/challenges and lessons learnt. They were followed by discussions around the strengths/weaknesses and resource requirements of such schemes. Based on this data, results suggest that firms classified as being research-intensive did not have significantly more drugs in short supply for which they were responsible. In addition, we examined the possible association for firms with significant research and development (R&D) operations and other firms in regard to the number of shortages for which they are listed; and 4) that there is no difference between firms with significant R&D operations and other firms in regard to the average duration of their shortages. RESULTS: We failed to reject the null hypotheses for overall, active, and resolved shortages, except in one case. We also found that there was no significant in most of the associations except in the relationship between a firm’s R&D status and the length of its resolved shortages. CONCLUSIONS: Based on this data, these results suggest that firms focused on research and development have reduced resolved shortages. We intend to continue investigating other manufacturer characteristics and their possible association with shortages.

Medicare Part D and its Impact on Prescription Drug Use

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OBJECTIVES: Significant fraction (approximately 30%) of elderly were without prescription drug coverage prior to Medicare Part D. Medicare Part D provided a subsidized prescription drug benefit to all elderly beneficiaries. The objective of this study is to estimate the impact of Part D on the prescription drug utilization among elderly Medicare beneficiaries. METHODS: The analysis uses 2000-2006 Medicare Current Beneficiary Survey (MCBS). The survey contains detailed information on prescription drug coverage, prescription drug utilization, other sociodemographic, economic variables. The sample was limited to those age 65–85 years with complete year of data, either uninsured or who had private coverage. Prescription drug coverage was calculated for each month, if respondent had coverage for at least 6-months they were assumed to be privately insured. We estimate the likelihood of independently chosen use for Medicare Part D data from 2000–2003. We then compared changes in prescription utilization pre- to post Medicare Part D for those more and less likely to be uninsured prior to Part D. RESULTS: In year 2005, approximately 30% of our sample did not have any prescription drug coverage. After Part D was introduced, only 10% of the sample report not having any prescription drug coverage. On an average, total number of prescription used increased by 5 from 2003–2006. Part D also included discount cards which were introduced in June 2004. The results indicated that discount cards increased the number of prescriptions by 3. Therefore, total impact of Part D was approximately 8 more prescriptions. These results were supported in multivariate models (p < 0.01) controlling for various demographic and economic factors. CONCLUSIONS: Medicare part D increased prescription drug use significantly among elderly non-Medicaid population. Future analysis should assess the impact of part D on health care utilization and health.