IMPROVING BENEFICIARY HEALTH

Over the past 25 years, prescription drugs have become increasingly central to the health of Americans. When the Medicare program was created almost forty years ago, prescription drugs represented but a small portion of administered medical care. Today, at least one medication is prescribed—or continued—in 65 percent of visits to physicians when the patient is 65 or older. Until recently, Congress did not provide coverage for prescription drugs under Medicare, even though the importance of prescription medicines increased. In 2001, CMS estimated that 24 percent of Medicare beneficiaries did not have any type of prescription drug coverage. The Medicare Modernization Act (MMA) takes an important step by establishing a new benefit to cover a large portion of the growing cost of prescription drugs. In addition, the MMA strengthens the role of coordinated care plans and greatly expands the number of beneficiaries who will be able to enroll in these plans. As a result of these two major reforms, and other actions such as Medicare coverage of an initial physical exam for new Medicare enrollees and improved coverage of other preventive services, we expect that the health status of millions of Medicare beneficiaries will be improved because of the MMA than under the previous benefit structure.

Starting in 2006, beneficiaries will have, for the first time, access to modern integrated health benefits through insurance plans, including preferred provider organization (PPO) plans with drug coverage similar to that available to Federal employees and many millions of privately insured Americans under 65. Those who choose to remain in traditional Medicare will be able to enroll in the new Prescription Drug plans.

Medicines. There is no question that prescription drugs have significantly improved the treatment and management of many major conditions, including: stroke (anticoagulant therapy), heart disease (antihypertensive medications), and heart failure (cholesterol-lowering statins). These drugs significantly reduce inpatient admissions and lengths of stay. They reduce future costs and, far more importantly, save lives.[1] The MMA will ensure that all seniors have access to these drugs.

For example, a recent study found that the use of statins in cholesterol-lowering drug therapy reduced the incidence of coronary disease-related deaths by 24 percent in elderly men and women (ages 70 to 82) with a history of, or risk factors for, vascular disease, and also reduced the incidence of non-fatal heart attacks and fatal or non-fatal strokes in these patients.[2] In addition, the Heart Outcomes Prevention Evaluation (HOPE) study

[1] J.D. Kleinke, "The Price of Progress: Prescription Drugs in the Health Care Market," *Health Affairs*, September/October 2001 (accessed from the Web at www.healthaffairs.org).
[2] "Pravastatin in Elderly Individuals at Risk of Vascular Disease (PROSPER): A Randomised Controlled Trial," *Lancet*, 360:9346, 1623-1630, 2002).

has found that antihypertensive drug therapy reduced the combined risk of cardiovascular death, heart attack and stroke by 22 percent in approximately 9,000 high-risk middle-aged and elderly patients (ages 55 and older), with $871,000 in net estimated savings over 4 years, and also significantly reduced the risk of adverse cardiovascular outcomes by 25 to 30 percent in a broad range of high-risk middle-aged and elderly patients with diabetes mellitus.[3]

Increased access to medications will also improve patient compliance with treatment regimens, as treatment regimens fail if individuals cannot afford to buy the drugs their doctors prescribe. The new prescription drug benefit will reduce financial barriers for all Medicare beneficiaries and provide coverage with little or no cost to those who have low incomes. In 2002, a study of beneficiaries in eight states reported that 25 percent had not filled prescriptions and 27 percent reported skimping on doses, both as a result of financial limitations.[4] Another study of disabled adults found that about half of those reporting medication noncompliance as a result of financial barriers experienced health problems as a result, including pain, discomfort, blood pressure changes, and hospital admissions.[5]

One of the most important effects of the new drug benefit is that it will make drugs affordable to millions of low-income seniors who do not have insurance coverage for their drugs.

A study published this month found that about 32 percent of those who restricted their use of medicines because of cost reported a significant decline in their health status after several years, compared to only 21 percent of those who were able to take all prescribed medicines.[6] The former group had far worse insurance—over 50 percent with no insurance or a policy with no coverage of drugs, compared to only 29 percent in the group that did not feel financially constrained. The coverage provided by the new Medicare prescription drug benefit will greatly reduce the insurance gap.

As a result, we expect that health outcomes will be improved for large numbers of Medicare beneficiaries, potentially several million of the estimated one-fifth of all beneficiaries without drug coverage. While a precise prediction of reduced mortality and morbidity is not possible using existing research findings (for example, the July 2004 study uses only self-reported health status as a measure of effect), these improvements in health outcomes are likely to be substantial.

Coordinated Care. The MMA also substantially increases the number of seniors who will have access to more than one plan offering comprehensive, coordinated benefits. At

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[3] See, for example, Jennifer V. Linseman, PhD, and Michael R. Bristow, MD PhD, "Drug Therapy and Heart Failure Prevention," *Circulation*, 107:1234, American Heart Association, 2003

[4] Dana G. Safran, et al, "Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?" *Health Affairs* Web Exclusive W253, July 2002 (accessed from the Web at www.healthaffairs.org).

[5] Jane Kennedy and Christopher Erb, "Prescription Noncompliance Due to Costs Among Adults with Disabilities in the United States," *American Journal of Public Health*, July 2002.

[6] Michele Heisler et al, "The Health Effects of Restricting Prescription Medication Use Because of Cost," *Medical Care*, Volume 42 No 7, July 2004.

present, one-third of beneficiaries have access to only one coordinated care offering, and another one-third has no access to any alternative plan. Under Medicare Advantage, we expect that all beneficiaries will have access to several PPO plans, and many more to multiple HMO plans. We believe that as many as one-third of all beneficiaries will enroll in these plans by 2010, compared to only about eleven percent today. There will also be specialized plans available to those with chronic diseases.

Coordinated care plans offer the special advantage of being responsible for all health care services—hospital, medical, drugs, devices, and more—needed by enrollees. These plans are paid a capitated amount per enrollee and stand to benefit by simultaneously holding down costs while attracting and retaining enrollees. In other words, they have substantial incentives to invest in cost-effective medicines and other interventions that keep enrollees both healthy and satisfied with care. They also have incentives to monitor enrollee compliance with medication instructions, to encourage healthy behaviors such as improved diets, and otherwise to invest in enrollee health.

We know that Medicare Advantage plans are highly valued by beneficiaries. A recent study published in JAMA, which uses data from the Consumer Assessment of Health Plans survey, supports this conclusion. For example, while fee-for-service beneficiaries rated their care slightly higher than Medicare Advantage enrollees rated their care, the ratings for both groups are quite high (8.91 versus 8.86 on a scale of 1-10). This same study pointed out other areas where private plans excelled compared to fee-for-service in providing quality care and highly-valued services to beneficiaries:

- Medicare Advantage enrollees reported significantly fewer problems with paperwork, information, and customer service;
- Medicare Advantage enrollees were more likely to report having received immunizations for influenza and pneumonia; and,
- Medicare Advantage enrollees who were smokers were more likely to report having received counseling to quit.

Substantial research evidence shows that HMOs substantially reduce the frequency of hospitalization compared to traditional fee-for-service medicine, while achieving equal health outcomes. According to the JAMA study, if all the elderly beneficiaries in fee-for-service were in managed care, about 1.4 million more Medicare beneficiaries would receive the flu vaccine in a year, translating into thousands of fewer deaths and hospitalizations annually.

Other reforms. The MMA initiates a number of other reforms to improve health. The Medicare Replacement Drug Demonstration, announced on June 24th, will provide 50,000 persons with cancer and other serious diseases access to self-administered medicines, taken at home, that Medicare Part B previously covered only when provided in a doctor's office or an institutional setting. We expect significant health gains for enrollees who will no longer have to travel, or undergo an intravenous procedure (with potential risk of infection and other complications), to obtain and use vital drugs. Once the new Medicare

prescription drug benefit begins, all patients with these conditions will be able to obtain Medicare prescription drug coverage for these drugs on an outpatient basis.

New beneficiaries will obtain an initial preventive physical examination upon enrolling in Medicare. In addition, important cardiovascular screening tests and diabetes screening tests will be covered under traditional Medicare, as well as under Medicare Advantage. New chronic care improvement projects will be started, also under traditional Medicare. Under Medicare Advantage, plan quality improvement efforts will be redirected, and refocused, in order to direct health care where it will more directly benefit patients. And new technologies will be emphasized, such as electronic prescribing to use the Internet to improve the speed and accuracy of prescriptions.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecomments