

Effects of the Medicare Modernization Act on Clinicians Involved in Diabetes Care

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Within the next few months, the federal government will implement the first major reorganization of the Medicare system for many years: the Medicare Prescription Drug Improvement and Modernization Act of 2003¹ (Table 1). The plan called “Medicare Part D” offers two major changes to the current system. First, it offers a pharmacy benefit to eligible seniors. An extensive discussion of this part of the Act may be found in a recent edition of the online *Wall Street Journal*.² The second and indirect effect of this reform may be to encourage the organization of Medicare recipients into managed care plans, which would function like other managed care plans.³ For seniors and other Medicare recipients who have diabetes, both aspects will substantially affect their health care. Those of us who render diabetes care to Medicare recipients should prospectively consider how these changes will affect our processes of care and plan accordingly.

Table 1. Primary Effects of Medicare Part D

- Widely varied plans for prescription drug coverage
- Primary emphasis on generic drugs
- Lack of uniformity in formulary coverage from plan to plan, even among those offered by the same company
- Recruitment of enrollees in Medicare insurance products or managed care

Medicare Part D: Pharmacy Benefit Plans

As Medicare Part D is implemented, eligible participants will be offered a variety of plans to cover the costs of prescription drugs. In many localities, the options may be varied and confusing.⁴ They may range from plans with low monthly premiums that provide partial or complete coverage for generic drugs only to plans with much higher premiums that will offer choices and include brand-name products.

No matter which plan patients select, there will be three overall effects of the advent of these programs. The first is that plans with the largest roster of enrollees will have the largest negotiating clout with pharmaceutical companies when deciding which drugs will be included in specific plans. The second is that generic drugs will constitute the backbone of all of these plans. The third is that large managed care or insurance companies will get access to substantial segments of the Medicare population to sell Medicare-related health insurance products or supplements as well as pharmacy benefit plans. Each of these effects will probably exert important influences in reshaping the pattern of health care for senior citizens in the United States.

There is a growing weight of opinion that the advent of Medicare Part D will alter the relative position of pharmaceutical companies and pharmacy benefits providers and insurance companies that plan to offer Medicare Part D services.⁵ The emphasis on generic or low-cost drugs will possibly put substantial pressure on large pharmaceutical companies to alter the pricing on

their premium drugs or face exclusion from pharmacy plans. Analysts suggest that companies such as Pfizer, which depend on brand-name drugs such as atorvastatin for much of their profits, may face growing market worries about the position of those drugs, if, as in the case of atorvastatin, there are credible alternatives available.

Generic drug manufacturers, pharmaceutical companies willing to negotiate discounts on their products, and companies with unique drugs may fare better in the coming market environment. Indeed, analysts cite issues between Pfizer and Express Scripts regarding the inclusion of atorvastatin and other Pfizer products in the formularies offered to Express Scripts customers⁶ as examples of evolving changes in the dynamics of this marketplace.

A constant theme in most predictions is that the importance of generic drugs will increase. Most, if not all, Medicare Part D plans will strongly encourage participants to use generic products. This will be accomplished by limiting most lower-cost Part D pharmacy plans to coverage of generic drugs only or by requiring significant differences in participant copayments for brand-name versus generic agents.⁵ There is some suggestion that the structure of many of these plans will discourage participants from selecting more expensive products. The array of plans has been confusing to many seniors,⁷ and there is appropriate skepticism among them about whether these programs will actually save them money.⁸ There is some worry about opportunities for fraud in this market, as well.⁹

Implications for Medicare Beneficiaries and Providers

The provision of services through large health care insurance or benefits companies will strengthen their presence in the Medicare marketplace. Enrollees in pharmacy plans will be targets for health insurance products of those pharmacy plan companies or of companies with which the pharmacy plans become affiliated.¹⁰ A growing percent of the Medicare population will become enrolled in managed care plans.

At the same time, Medicare has authorized a series of initiatives to assess the clinical outcomes of treatment of beneficiaries in specific disease-state areas, including diabetes.¹¹ This will present insurers with enhanced opportunity for disease-state management programs to reduce the costs of services to these participants and to impose stricter standards of care on the providers who serve these populations.¹² These sorts of contracts are being specifically advocated for diabetic Medicare recipients.¹³

These changes may profoundly affect the process of care for diabetic Medicare recipients. The possible impacts of specific changes are worrisome for both patients and providers. Patient advocates, provider organizations, and national advocacy groups such as the American Diabetes Association should observe these changes with concern and care.

In a previous commentary,¹⁴ I raised concerns over whether changes in the terms of service for Medicare patients were making that group an unattractive population to providers. As more and more of these patients become enrolled in managed care organizations, they will become subject to the growing trend to monitor the outcomes of care. Performance indicators, such as hemoglobin A_{1c} will be used to measure outcomes.¹³

As more pressure is placed on providers to achieve clinical goals, they will likely prefer the most effective drugs for treatment. These may be the most expensive treatments, which may not be covered by their patients' pharmacy plans. Providers will then have to devote significantly increased time and effort to obtaining approvals from the managed care formularies for those drugs. Such pressure may cause providers to exclude Medicare recipients from their patient base. In the end, these pressures are just as likely to harm diabetic Medicare patients as these plans are to help them.

Therefore, the rush to more highly organize the care of Medicare patients should be considered with some eye toward the pressures this effort may generate on the provider base that serves this population. One possible outcome would be highly undesirable: that managed care plans require providers to achieve positive clinical goals in diabetic patients with the least expensive formulary possible. In that scenario, a disproportionate amount of clinical and financial risk will be transferred from insurers to providers. It is just this type of pressure that could encourage providers to avoid treating diabetic Medicare recipients.

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