Medical Groups Pledge Cost Cuts to Obama

BY JOYCE FRIEDEN

Leaders of several health care and labor organizations met with President Barack Obama at the White House on May 11 and proposed ideas to reduce the growth in health care costs by up to $2 trillion over the next decade.

In a letter sent to the president, the six organizations—the American Medical Association, the American Hospital Association, the Pharmaceutical Research and Manufacturers of America, the Advanced Medical Technology Association, America's Health Insurance Plans, and the Service Employees International Union—vowed to work as a group to help achieve the cost reduction. Among their proposals:

► Cutting costs by focusing on administrative simplification, standardization, and transparency.

► Reducing overuse and underuse of health care by aligning incentives so that physicians, hospitals, and other providers are encouraged to work together toward the highest standards of quality and efficiency.

► Encouraging coordinated care and adhering to evidence-based best practices and therapies that reduce hospitalization and manage chronic disease more effectively.

► Implementing proven prevention strategies.

► Making common-sense improvements in care delivery, health information technology, workforce development, and regulatory reforms.

The American Medical Association told the president that although evidence-based guidelines will be helpful in reducing costs, the reductions could be enhanced if physicians had more liability protection.

OFFICIAL WHITE HOUSE PHOTO BY PETE SOUZA

President Obama (left) called the White house meeting "a watershed event in the long and elusive quest for health care reform."

"For example, if everyone who walks into the emergency room gets an MRI for a headache, it's a costly procedure," Dr. J. James Rohack, AMA president-elect, said in an interview. "We know that in some areas of the country [that test has] been done because people sued when they didn't get the test. If we create scientifically based guidelines that say not everyone needs to have the MRI for a headache, physicians have got to have liability protection so they don't get sued if they follow that guideline."

Dr. Rohack said he felt the president heard what the AMA was conveying. "Clearly the message of defensive medicine costing dollars in the health care system was received, as was the recognition that prior attempts at tort liability by just creating global caps hasn't been successful. We are going to have to work at other creative ways of achieving the goal."

The president called the White House meeting historic. "[This is] a watershed event in the long and elusive quest for health care reform," he said after the gathering. "And as these groups take the steps they are outlining, and as we work with Congress on health care reform legislation, my administration will continue working to reduce health care costs to achieve similar savings."

Reaction to the meeting varied.

"If the savings described today truly occur, this may be one of the most significant developments in promoting meaningful health care reform," Ron Pollack, executive director of Families USA, a liberal consumer health organization, said in a statement.

"These savings would cut projected health care costs for families and businesses, and they would enable adequate subsidies to be offered so that everyone has access to high-quality, affordable health care."

Others were less impressed. "We are very cautious about the particulars of the voluntary effort that groups proposed to the White House," said a statement from the National Coalition on Health Care, a progressive advocacy group. "Most of the measures that they cited would help to make the health care system more efficient over time, but, as the Congressional Budget Office has indicated, should not be counted on to produce substantial savings soon. … We are heartened by the sector's growing acceptance of responsibility to engage constructively in a search for solutions, but we believe that those solutions will need to be embodied in law," the group said in its statement.

Further, Rep. Michael Burgess (R-Tex.) noted that although he was glad the groups were trying to work together, they weren't taking the correct approach.

"From what I can tell, the announcement by the health industry leaders misses the mark in several areas," he said in a statement. "It promises no protections against a Washington takeover of health care, no guarantees that Washington bureaucrats won't stand in the way of Americans getting the treatment they need when they need it, no promises that patients will be able to control their health care decisions, and no assurances that Americans will have their choice of doctors or hospitals. Until more details are revealed, I would encourage Americans to be circumspect about today's announcement." ■

Medicare Part D 'Doughnut Hole' Hard on Diabetic Patients

BY ROBERT FINN

LONG BEACH, CALIF. — About one-quarter of diabetes patients receiving Medicare Part D drug benefits enter the coverage gap—the so-called doughnut hole—that comes after using $2,250 in medications during a single year.

Although some of these patients have supplemental drug coverage that pays for medications in the gap, many do not. Of diabetic patients with no supplemental coverage, 22% report forgoing medications after entering the coverage gap, and 12% report going without food or withholding rent payment to pay for their drugs, Dr. Carol M. Mangione reported at a meeting on diabetes sponsored by the Centers for Disease Control and Prevention.

"Papers in the literature have shown that cost-related nonadherence can lead to increased hospitalizations and mortality with diabetes," said Dr. Mangione of the University of California, Los Angeles.

She discussed several studies she and her colleagues conducted using data from surveys of Medicare Part D beneficiaries who were enrolled in free-standing or managed care–based plans in eight states during 2006.

Beneficiaries who entered the coverage gap were 17% less adherent with respect to their oral diabetes medications than were nongap beneficiaries.

Two of the studies focused on patients older than age 65 with evidence of diabetes, and a third included all Medicare Part D patients enrolled in those plans. The investigators focused on drugs for three chronic conditions: diabetes, high blood pressure, and high cholesterol.

In all, 22%-29% of the patients with diabetes entered the gap, and having a coverage gap was associated with a 4%-7% reduction in total drug costs. This is explained at least partly by nonadherence. Beneficiaries who entered the gap were 17% less adherent with respect to their oral diabetes medications than were nongap beneficiaries.

"Some patients have no coverage in the gap, others have generic-only coverage, and some people have full coverage in the gap," Dr. Mangione said. "Usually the people with full coverage had a retirement benefit that was filling in that gap coverage."

Having generic-only gap coverage helped somewhat. Significantly fewer patients with such coverage, 17%, reported nonadherence because of cost, compared with 22% with no gap coverage, but the difference in those who reported going without food or not paying rent between those with and without generic-only gap coverage was not significant, at 10% and 12%, respectively. In contrast, only 1% of the patients with full gap coverage reported nonadherence because of cost, and 1% reported going without food or rent.

Patients also engaged in "rational" approaches to contain costs, said Dr. Mangione. Fifty percent of the patients with no gap coverage and 54% of the patients with generic-only gap coverage used mail-order pharmacies because of costs. In contrast, only 9% of patients with full gap coverage used mail-order pharmacies, a significantly smaller proportion.

Similarly, 44% of the patients with no gap coverage and 45% of those with generic-only gap coverage reported switching to generics, compared with 16% of patients with full gap coverage.

In the third study, the investigators asked whether an earlier switch to generic medications could reduce expenditures enough to keep patients out of the gap.

This analysis included all patients who entered the gap during 2006 (with and without diabetes) from one for-profit plan in eight states.

The investigators found that 87% of patients enrolled in free-standing Part D plans and 78% of patients enrolled in managed care Part D plans had at least one possible cost-saving therapeutic substitution.

If generics had been substituted for brand-name medications, the average patient in a free-standing plan would have saved $377, and the average patient in a managed care plan would have saved $293 in the pregap period. Moreover, this switch would have delayed gap entry by slightly more than 1 month.

Dr. Mangione disclosed no conflicts of interest related to her presentation. ■