IMPLEMENTING HEALTH REFORM

Closing the Doughnut Hole

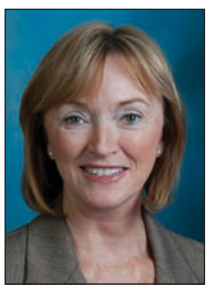
One of the first provisions of the Patient Protection and Affordable Care Act to take effect is the $250 rebate for Medicare beneficiaries who fall into the Part D doughnut hole.

The first rebate checks were mailed June 10. The rebates are the first step in a multiyear effort to trim drug costs for seniors and other Medicare beneficiaries. Next year, patient cost sharing for brand-name drugs will be cut in half, and the doughnut hole will be closed completely by 2020. Just as checks started hitting seniors' mailboxes, the administration launched a $1 million radio ad campaign designed to help patients protect themselves from fraud, as criminals launch scams targeted at the new benefits.

Marilyn Tavenner, acting administrator of the Centers for Medicare and Medicaid Services, answered questions about how the new benefit will be implemented.

Clinical Psychiatry News: How many Medicare beneficiaries will fall into the doughnut hole this year? Will they all get checks this summer?

Ms. Tavenner: About 8 million Medicare beneficiaries are expected to reach the prescription drug coverage gap that we call the doughnut hole this year. Of those, 4 million will be eligible to get a tax-free, one-time rebate check. The remaining beneficiaries already receive assistance through Medicare Extra Help. Beneficiaries who hit this coverage gap do not need to fill out any form, or make any phone call, to receive this benefit under the Affordable Care Act. The one-time $250 rebate checks will be mailed automatically to seniors' homes from Medicare when they enter the doughnut hole. The first rebate checks were sent in June, and checks will sent each month throughout this year as more beneficiaries enter the doughnut hole.



The $250 rebate is immediate relief that marks the first step in completely eliminating the doughnut hole.

MS. TAVENNER

CPN: Will the $250 rebate have a significant impact on patients' out-of-pocket drug costs this year?

Ms. Tavenner: The $250 rebate is immediate relief that marks the first step in completely eliminating the doughnut hole. This year's rebate will help put money back in the pockets of seniors who are too often forced to choose between paying for their groceries or for their medications. Next year, seniors who reach the coverage gap will get a 50% discount on brand-name drugs that will help reduce their costs. In addition, under the new law, actual coverage gap will get smaller and smaller every year, until it completely disappears in 2020.

CPN: Physicians in all specialties spend a lot of time helping patients find affordable medications. How will these changes decrease the burden on doctors?

Ms. Tavenner: Physicians are on the front lines in helping seniors obtain medications that are not only successful in treating the patient, but are also affordable. With the coverage gap closed and care more affordable, Medicare beneficiaries will be able to get the care they need and deserve.

And starting next year, patients with Medicare can get free preventive care services like colorectal cancer screening and mammograms. Medicare also will cover an annual physical, where they can work with their physician to develop a personal prevention plan based on current health needs.

CPN: How can physicians help their patients to take advantage of this benefit?

Ms. Tavenner: Doctors can continue to help their patients by educating them about the Affordable Care Act so they can take full advantage of its new benefits. If patients have questions on their rebate checks, they can call 1-800-Medicare or visit www.medicare.gov. And to receive updates on the health reform law as it is implemented, they can visit www.healthreform.gov.

One important note: Along with the additional benefits provided by the Affordable Care Act come increased threats of fraud.

That's precisely why we're working with the Department of Justice to crack down on scam artists who are trying to procure personal information from Medicare beneficiaries by promising them rebate checks and other benefits under the law.

Patients should never give their Medicare ID number to anyone promising benefits or discounts under the new law. For fraud-fighting tips, please visit www.stopmedicarefraud.gov. ■

The Centers for Medicare and Medicaid Services administers the Part D Medicare benefit and will be responsible for implementing many elements of the new health reform law. Ms. Tavenner previously served as secretary of health and human resources for the Commonwealth of Virginia.

Patients Get New Rights to Appeal Insurance Decisions

BY MARY ELLEN SCHNEIDER

New federal regulations mandated by the Affordable Care Act will give patients new rights to appeal claims denials made by their health plans.

The rules will allow consumers in new health plans to appeal decisions both through their insurer's internal process and to an outside, independent entity. Most health plans already provide for an internal appeals process, but not all offer an external review of plan decisions, according to the U.S. Department of Health and Human Services. The types of appeals processes often depend on individual state laws.

HHS officials estimate that in 2011 about 31 million people in new employer plans and another 10 million people in new individual market plans will be able to take advantage of these new appeals opportunities. By 2013, that number is expected to grow to 88 million. The rules do not apply to grandfathered health plans.

Under the new rules, health plans that begin on or after Sept. 23, 2010, must have an internal appeals process that allows consumers to appeal whenever the plan denies a claim for a covered service or rescinds coverage. The internal appeals process must also offer consumers detailed information about the grounds for their denial and information on how to file an appeal.

The new rules aim to make internal appeals more objective by ensuring that the person considering the appeal does not have a conflict of interest. For example, the health plan is not allowed to offer financial incentives to employees based on the number of claims that are denied. Health plans will also have to provide an expedited appeals process, which would allow urgent cases to be reviewed within 24 hours.

The new federal appeals regulations also standardize rules for external appeals. Currently, 44 states require health plans to have some type of external appeal but those processes vary greatly, according to HHS. Under the federal rules, health plans must provide clear information about external appeals and expedited access to the process. The decisions made through external appeals are binding under the new federal rules. ■

U.S. Health Care System Ranks Last Among Industrialized Countries

The U.S. health care system ranked last, compared with several other industrialized nations, on measures of quality, efficiency, patient safety, access to care, and equity, according to a new report by the Commonwealth Fund.

One of the main reasons for the low ranking is the lack of universal health insurance, according to the report. Although the United States spends the most overall on health care, it fails to provide access for low-income individuals. Furthermore, unlike their counterparts in other industrialized countries, U.S. patients usually don't have a medical home.

The United States ranked first, however, on areas such as preventive care and wait time for specialist care.

One measure on which the United States ranked a "clear last" is equity, according to the study. Compared with their counterparts in Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom, low-income patients in the United States are less likely to visit a physician when they're sick, see a dentist, or receive recommended tests, treatments, or follow-up care.

"When a country fails to meet the needs of the most vulnerable, it also fails to meet the needs of the average citizen," according to the report. The United States "should devote far greater attention to seeing a health system that works well for all Americans."

The report is the result of a compilation of mortality data from several countries and surveys of about 21,000 adults and 6,700 physicians regarding their experiences with care and their ratings of various dimensions of care. The study authors said that despite the differences among the countries, measures such as access to care and emergency department visits are universal.

—Naseem S. Miller

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