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## How to Successfully Implement the Medicare Prescription Drug Benefit

*Based on a group discussion of managed care consultants at the Cambridge Healthcare Summit, held February 25-27, 2004, this article examines the new Medicare Prescription Drug Benefit plan and the implications for managed care organizations (MCOs).*

**O**n December 8, 2003, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act into law. At that time, he said, "With this law, we are providing more access to comprehensive exams, disease screenings, and other preventative care, so that seniors across this land can live better and healthier lives."

Accomplishing these goals will require the participation of healthcare providers and Medicare enrollees. But the provisions and operation of the new law are still unclear to many of the interested parties. One working group of managed care consultants at the Cambridge Healthcare Summit analyzed the implications of the Medicare bill and formulated possible solutions to make sense of the new benefits program and what it will mean for MCOs and patients.

### THE UNDERLYING PROBLEM: TOO MANY UNKNOWNNS

Because the Medicare Prescription Drug Benefit plan and its provisions are so new, the analysis was based on the managed care consultants' current understanding of the situation. Many parts of the plan require further clarification, either through refinements in the legislation or expert interpretation. There are 2 phases to the plan. The first phase provides the opportunity for seniors to obtain a prescription drug discount card, and the second is a fully insured medical and pharmacy benefit. The medical benefit covers injectable drugs, and the pharmacy benefit covers other drugs.

Then the bill becomes more unclear. A lack of information and clarity is affecting the decision-making ability of MCOs, employers, and patients. MCOs are cautious about participation because of the unknowns and managed care's previous experiences with Medicare. Similarly, patients are skeptical about participation because they are not sure of their coverage.

**Lack of Clarity: MCOs Are Cautious.** MCOs were "informed" about the Medicare prescription bill after the fact rather than being consulted while it was being written. Not having had the opportunity to give any input, the MCOs do not have good background information about the bill. The environment in which the plan was developed was infused with partisan politics, and the government has yet to adequately educate the stakeholders—MCOs and patients.

MCOs were not given a great deal of time to study the plan either. The program was rolled out quickly, with a short deadline to implement phase 1.

Finally, MCOs are afraid they may not be able to handle logistically or financially an onslaught of new patients if they participate in the drug benefit, especially if the first senior citizens to join are those at highest risk. There is also some concern about the growing numbers of senior citizens seeking coverage in the future (**Figure**).

**Risks of Adverse Selection.** Adverse selection is a big concern for the MCOs. A pharmacy benefit will most likely attract seniors with more illnesses who will be costlier to cover. To make the program feasible, MCOs need healthy, low-risk seniors.



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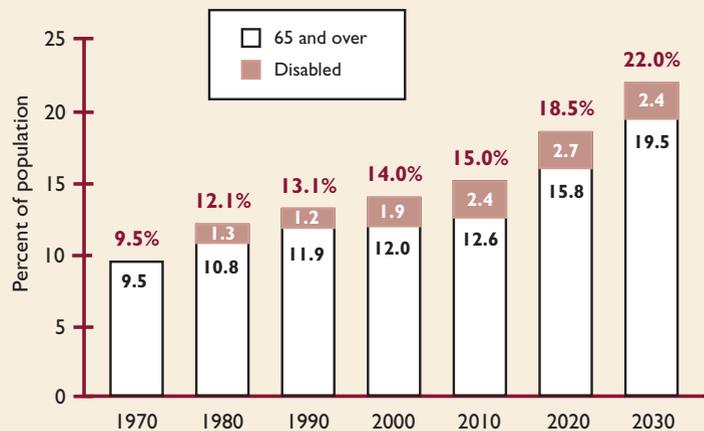
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## FIGURE

Medicare Beneficiaries as a Share of the US Population, 1970-2030



The US population will age rapidly through 2030, when 22% of the population will be eligible for Medicare.

Source: Social Security Administration, Office of the Actuary.

**Financial Stability.** MCOs have no assurance that funding will be adequate to cover the cost of the prescription drug benefits that are being offered. Medicare capitation will need to increase to make the system attractive or even viable for MCOs.

**Lack of Clarity: Perplexed Seniors.** Senior citizens are often confused about benefits under any sort of plan, and this one is especially unclear. They may also be apprehensive about joining a program that has not yet fully evolved.

### SOLUTIONS: COMMUNICATE, MANAGE, AND EDUCATE

The managed care consultants outlined specific steps to overcome the problems of the lack of clarity in the new prescription benefits, MCOs' hesitation in entering the program, and senior citizens' skepticism.

### ◆ MCOs Need a Voice

**Communicate with the Federal Government.** MCOs need a voice in the further design and refinement of the drug benefit provisions. The first step is to establish a project team that can do an analysis of the needs of all affected departments within managed care plans. Once done, this team will then be the voice of the MCOs to communicate with the Centers for Medicare and Medicaid Services (CMS), to obtain details about the drug plan, and to advance managed care's concerns.

Industry associations, such as America's Health Insurance Plans and the Blue Cross Blue Shield Association, may provide lobbying functions as well as representation to the government. In addition, they could develop educational materials so MCOs could better understand the drug benefit.

By lobbying congressional representatives, the MCOs can make



their concerns heard among people with the power to affect change. A consistent message will help to present a unified front on the issues.

**Communicate with the Public.** MCOs must reach the public as well as regulators and legislators with their messages. Through media campaigns, they must focus on the positive aspects of the drug benefit program to overcome any negative perceptions among the public.

Public relations does not end with the mass media. Every interaction with the public is an opportunity for enhancing the relationship. Therefore, customer service representatives need to be trained to deal with questions from seniors who are or may become members.

Some form of government endorsement would lend credibility to HMOs' participation in the Medicare drug benefit. A government rating system may help the public compare plans, evaluate how well they deliver, and assess the likelihood of their continued participation.

**Communicate with Existing and Prospective Patients.** The MCOs are not the only group that are unsure about the plan; the public is as well. While the government touts the benefits to the public, specifics are few. The managed care industry needs to communicate to potential members about what their coverage will be.

All the usual channels of marketing, education, and communication should come into play, such as mailings, Web sites, partnering with pharmaceutical companies and pharmacy benefit managers, and the CMS Web site.

Physicians and their staff will be a key component of educating patients about the new benefits. They are the only real "face" of an MCO for many patients—

the place they often turn for answers—and providers can engender the most trust. In the course of business, MCOs may have to limit benefits, and a good way to avoid or dispel distrust among patients is to be clear about policies. Preemptive education in simple terms may help patients understand their coverage.

◆ **Plans Are Cautious:  
Need to Manage Risk**

The deadline for entering phase 1 of the prescription drug benefit has passed. A cautious approach may be to decide to participate only once phase 2 is established, when the specifics may be clearer.

But an overriding problem is that plans are reluctant to enter any Medicare plan in general, and specifically the drug benefit, because of the risk of adverse selection. One technique to minimize risk is to attract healthier senior citizens through benefit design, network configuration, and targeted marketing/advertising.

A low premium with a lean benefit, such as a yearly cap, a high copayment, or coinsurance, may attract healthier senior citizens and discourage high-risk senior citizens. Other suggestions to attract healthy patients are to cover "lifestyle" drugs such as sildenafil and to provide health club reimbursements (both indicators of a more vigorous senior) and incentives for nonsmokers.

Benefits could be designed for large employers to attract their healthier, younger workers while retirees get less. Tiered benefit options for current workers and retirees may minimize adverse selection or at least make it economically feasible to cover anyone who wants to join. Any benefit plan design has to be analyzed to make sure it can be implemented and passes legal scrutiny.

Network configuration can also avoid high-risk seniors, but this technique may be controversial. The senior HMO may be configured differently from the plans offered to other patients. Any consideration of network configuration warrants caution: problems lurk with provider relations, contracting, and interinstitutional politics, especially involving (expensive) tertiary care centers. Plan administrators have to be sure that there will be a market for what is ultimately offered.

A less controversial method is targeted marketing and advertising to reach healthier senior citizens where they are and in what they read and see. An advertisement in the health club or the exercise room at a senior living community will reach active seniors who may not be high risk. Magazines and groups for people with active lifestyles (eg, Elderhostel, golf or running clubs) could reach low-risk seniors.

Another aspect of financial risk for plans is that Medicare premiums are fixed. One fear is that if a plan is well run and shows a certain level of profit, the government may reduce capitation fees. Eventually, plans may be squeezed out of the business, essentially being "punished for doing well." The managed care consultants identified this issue as a major reason why plans are reluctant to get involved in Medicare and its prescription drug benefit to begin with.

The managed care consultants proposed several possible solutions. Plans can reduce medical loss by continuing their effective business practices, including case, disease, and utilization management, as well as provider profiling and incentives. Disease management (eg, diabetes, heart failure, or emphysema) can show positive return on investment even in the



short term.<sup>1</sup> Pharmacy costs may rise for these conditions, but effective disease management can reduce costs overall.

**Implementation.** Implementing a plan for senior citizens is more difficult and expensive than for younger patients. Beyond risk analysis and management, there is the issue of customer service for these patients. Service is more demanding; explaining benefits can be time consuming; and staff has to be trained to handle senior citizens' needs. Behind the scenes, human resources, budgeting, information technology, and communication functions need to be up to the task, as well.

Scaling up presents further, conflicting challenges. The preferred situation would be to phase in enroll-

ment so that the system is not overwhelmed and deficiencies can be worked out. But plans need to enroll many people at once to better spread risk, so a dilemma exists.

#### ◆ Patients Are Skeptical

Patients are skeptical about participation. They may distrust MCOs to provide the care they expect or be wary because of experiences with rising costs. Furthermore, they may have negative feelings based on past participation in a Medicare HMO that went out of business. Better communication will be critical to entice senior citizens to join the new benefit plan.

Tactics that could be implemented are to survey patients to assess their expectations and

then to communicate with them according to these expectations, possibly reshaping them through education. Printed materials must be written at an appropriate level and in large enough type for the senior audience.

Communications need to emphasize positive aspects of the benefit plan. Specifically, it may be worth saying that the plan is designed and "endorsed" by CMS, a government agency. Positioning the program as new and an enhancement to traditional Medicare may help make it attractive.

Publicizing a plan's quality and performance may also give prospective patients more confidence. Quality assurance measures, accreditations, official recognitions and awards, and measures of provider and patient satisfaction are all indicators of value.

Plans also need to meet patients' realistic expectations for care. Again, a challenge for plans will be to scale up and implement benefits in a smooth and timely manner to avoid patient dissatisfaction.

#### SUMMARY

The mainstay of dealing with the new Medicare drug benefit is good communication. Plans will need to communicate with CMS, consultants, and their own trade organizations to figure out the provisions and requirements of the new Medicare benefit.

They will need to get feedback from their own departments about how to best implement the plan if they decide to participate. Finally, they will need to educate, reassure, and attract seniors into the program in large enough numbers to spread risk (Table). ■

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#### TABLE

##### Medicare Prescription Drug Benefit: Action Plan for MCOs

###### 1. MCOs Need a Voice

- Create a voice for plans through trade associations, lobbyists, etc
- Establish effective public relations to work through the media and reach the public
- Communicate with patients and prospective patients via various media

###### 2. Plans Are Cautious About Participating

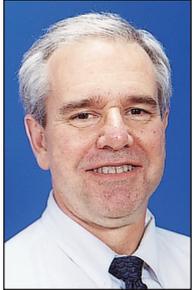
- Minimize adverse selection
- Survey patients to assess expectations
- Communicate with patients to reinforce or reshape expectations
- Make preparations to allow smooth implementation of drug benefit and serve increased membership
- Implement techniques to minimize financial risk: case, disease, and utilization management; provider profiling and incentives; possible future drug price controls; reinsurance
- Investigate increasing funding, supplemental premiums, maintaining capitation levels

###### 3. Address Patients' Skepticism About Participating

- Focus on positive aspects of current plan to overcome previous negative experiences with Medicare HMOs
- Emphasize quality distinctions of specific MCOs
- Continue to improve quality
- Provide ongoing PR: internal PR departments, outside consultants, trade associations
- Institute direct-to-consumer advertising
- Explain plan policies
- Develop educational materials for patients and prospective patients



# The Rising Costs of Medical Technology: Is There a Solution?



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In 2002, Paul B. Ginsburg, PhD, president of the Center for Studying Health System Change, told a congressional committee that in his opinion, “Advances in medical technology drive healthcare costs up more than any other single factor, accounting for perhaps as much as one half to two thirds of cost increases.”<sup>1</sup>

Rising costs for technology diffusion—the development of technologies and their introduction into medical practice—is considered by many in the managed care industry to be one of the strongest drivers of healthcare costs.<sup>2</sup>

On the other hand, countless lives are saved through the advances in medical technology and Americans expect the best care from their managed care companies. So where does a managed care organization (MCO) draw the line? How does a company decide when a new technology provides sufficient value? Are there any methods that can determine value?

Steven Wolinsky, MD, a senior medical director at Empire Blue Cross Blue Shield, discusses some of the issues MCOs are facing due to the high cost of medical technology.

● *Are the costs of medical technology, in your opinion, one of the stronger drivers in the rise of healthcare costs?*

Yes. One of the problems, ironically, is that many of the technolo-

gies are better, and more effective than past treatments. There are now treatments for certain diseases that never had a treatment before. But they’re all expensive because

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**There is no  
market mechanism  
to determine  
the value of  
medical technology.**

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many are based on biotechnology, or immunology, or synthesis of materials genetically, or genetic testing, or advanced imaging. These technologies are very costly to produce.

Some of the new technology being introduced is most applicable, in some cases, to very rare conditions. So by looking at risk in an insured population, a few patients who need the high technology use a disproportionately large amount of the medical resources compared with the whole pool.

Technology is also used a lot for older patients, and patients who are dying. These patients consume tremendous healthcare resources, a great deal of which are high-tech treatment or high-tech diagnostic studies, whereas the average patient doesn’t require much. In an employer group, for example, the majority of the people are paying for those few who use the technology.<sup>3</sup>

● *What are the contributing factors to the high costs of medical technology?*

It is a combination of factors. The pharmaceutical industry, physicians, and patients all contribute to the escalating costs.

Pharmaceutical companies only have to prove the safety and efficacy of their product to get it approved and on the market. Often expensive technology is adopted because of its superiority over other technology, but it is difficult to judge how it could be used cost-effectively or which patients it is most appropriate for. There is no market mechanism to determine the value of medical technology.<sup>4</sup>

Physicians concentrate on providing good care for their patients. They order a lot of tests to diagnose their patients and often use expensive technology. It would help if they ordered tests and treatments that are cost-effective, but there are no incentives for the physician to do that.

Patients contribute to the problem because they have no concept of the costs involved in their testing but they want the best medical care possible.

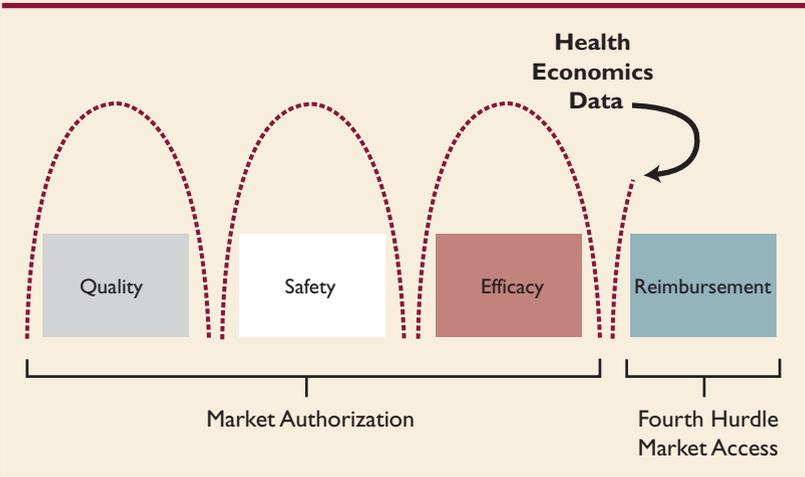
● *Do you see any solutions to slowing down the increasing costs of medical technology?*

One solution would be for pharmaceutical and biotech companies to provide medical appropriateness criteria for when and in what situations to use their products. It would really help MCOs to have a market mechanism in place



FIGURE 1

## The Fourth Hurdle



Source: Adapted from Wait S. Cambridge University Seminars. 2002.

to determine the value of a new technology.<sup>4</sup>

One idea that MCOs may want to consider is joining together to form one independent consortium organization that would evaluate technologies.

Another idea would be to reward physicians for cost-effectiveness. MCOs could profile physicians to find out who orders the most expensive treatments and reward those physicians who order less expensive treatments and have better outcomes. That kind of profiling though, requires sophisticated claims and computer systems. But even if such sophisticated claims and computer systems were in place, they might be useful only for a handful of high-volume situations where physician-to-physician comparisons could be made with accuracy.

Another answer may be medical education. We could train the physicians to interpret clinical trials more accurately and use technologies more effectively, as well as educate them on the costs of medical technology.<sup>5</sup>

In the end though, I think it will be the consumer who regulates the market. As healthcare prices rise,

consumers are being asked to contribute more to their healthcare premium. If the consumer has one of these plans that require more cost sharing, the consumer eventually will regulate the cost.

I think that will ultimately help regulate the market and the costs for very expensive technology. Patients who are well informed and have a limited amount of money in their consumer spending account won't choose treatments that aren't cost-effective.

● *Can the government institute any controls?*

Yes, and they're doing it partly through Medicare. Medicare has already reduced the pricing on drugs, including biotechnology drugs, to 15% below wholesale, and Medicare is applying medical appropriateness criteria to different drugs, tests, and diagnostic studies. Most plans are following Medicare.

● *Healthcare systems in other countries are also dealing with the rising costs of drugs and medical technology. What can we learn from them?*

Traditionally, there have been 3 hurdles to market a pharmaceutical product; quality, safety, and efficacy—but in Europe, a fourth hurdle has been added, reimbursement<sup>6</sup> (Figure 1).

Some countries in Europe are now requiring that pharmaceutical companies prove the cost-effectiveness of their product before it is added to the formulary. This has been difficult for the pharmaceutical companies because the clinical trials they set up for approval rarely include the types of comparative measurements needed to prove cost-effectiveness. But if a pharmaceutical company can't prove cost-effectiveness, the product may not be put on the formulary, and in a single-payer healthcare system, this would prove to be detrimental to the success of their product.<sup>6</sup>

● *Is this trend growing in Europe?*

Pharmacoeconomic analysis is used to determine the price or give prescribing advice to physicians in Denmark, the Netherlands, Ireland, Finland, Sweden, and Portugal. Greece has published health economic guidelines and is considering requesting cost-effectiveness data. Both Hungary and Poland are instituting pharmacoeconomic guidelines.<sup>6</sup> Great Britain, however, is considered to have the best model in determining cost-effectiveness.

● *Can you describe this model?*

The National Institute of Clinical Excellence (NICE) is a regulatory body set up by Great Britain in 1999. One of the responsibilities of the committee is giving guidance on technology of uncertain value and issuing clinical guidance on it. The National Health Service (NHS) begins the process by directing NICE to review a new drug or technology.<sup>7</sup>

The committee assesses the evidence of all clinical and other health-related benefits of a new intervention, including impact on quality and



length of life; relief of pain or disability; estimates the costs; and decides whether the intervention is a cost-effective use of NHS and Personal Social Services resources. If a cost-effective treatment for the condition already exists, this is used as a benchmark in determining both the benefits and costs of the new technology.

The technology is assessed by independent researchers, and the final decision is made by NICE from their assessment, submissions from the manufacturers, and patient and professional groups (Figure 2).

● *Once the guidance is issued by NICE, what is the next step?*

Once NICE approves a product, it is then adopted by NHS. The entire process takes about 62 weeks. In the past, NICE has turned down some products but more often will put constraints on new products, issuing guidance as to when it should be used and by whom.

As a result, patients in Great Britain are put on waiting lists to receive expensive technological treatment. There are age limits for care. For example, at a certain age, a person cannot receive an organ transplant or a bone marrow transplant. The British population understands that, and they accept rationing of care.

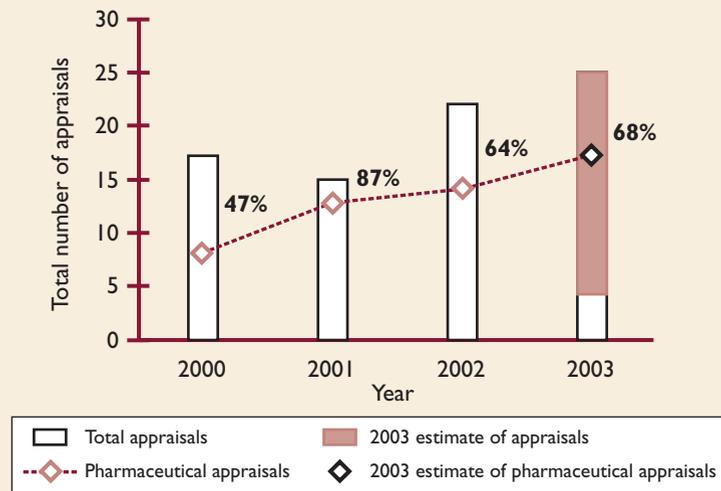
● *How does NICE impact Europe?*

Europe watches to see what guidance NICE issues on different products. Products close to launch may have their pricing and reimbursement negotiations affected in Europe. Some countries like Sweden are close to adopting a system similar to NICE. The European countries are also working together informally to try to avoid duplication of effort.<sup>6,8</sup>

● *Can you envision that America would ever have this type of health system?*

FIGURE 2

Total and Pharmaceutical-related NICE Appraisals Per Year, 2000-2003



NICE has three functions: Evaluating new pharmaceutical products; giving guidance on treatment for certain diseases; and deciding on the safety of interventional procedures.

Since its inception, the number of appraisals published annually by NICE has increased, as has the proportion of pharmaceutical-related appraisals.

Source: The Pharmacoeconomics Outlook, 2003.

Americans have a strong sense of entitlement when it comes to health-care. If they are paying for it, they want the best. They also believe that we can cure any disease if we put our minds to it. In the future, Americans may have to accept rationing and lower their healthcare expectations for their medical insurance coverage to continue. ■

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**Learning Objectives:** Upon completion of this CME/CE activity, the reader should be able to:

- Discuss some of the underlying issues of the new Medicare Prescription Drug Benefit plan and the implications for managed care organizations (MCOs).
- Describe some possible solutions in implementing the plan to ensure its success for MCOs and their patients.
- Understand the reasons behind the rising costs of technology and the methods other countries are utilizing to control them.

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	<i>Article 1</i>					<i>Article 2</i>				
	<i>Implementing the Drug Benefit</i>					<i>Rising Costs of Technology</i>				
	Strongly Agree		Strongly Disagree			Strongly Agree		Strongly Disagree		
	5	4	3	2	1	5	4	3	2	1
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Overall, the presentation of the article enhanced my ability to understand it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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I found the material objective and free of commercial bias.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Street \_\_\_\_\_ Specialty \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ Daytime phone \_\_\_\_\_ Fax \_\_\_\_\_