

Migraine in Managed Care

Based on a presentation by Delores Bowman, RN, BSN, CRM

Presentation Summary

Migraine, one of the most common conditions reported by health plan members, receives inadequate attention in most managed care settings. The lack of a consistent and concerted approach to the management of patients with the most severe and intractable varieties of migraine is particularly obvious. Studies in our plan population have documented that the availability of effective new pharmacologic antimigraine agents could reduce both sick days and hospital visits.

Development of new guidelines for management of migraine patients, including a formulary indicating the availability of agents that have been documented to be effective, will be a critical step in educating physicians as to the proper management of patients with migraine. Such guidelines should also provide specific criteria for referral. Studies that document positive outcomes of new migraine protocols will provide a basis for employer-driven expansion of migraine-related health-care coverage.

Assuming an estimated prevalence of migraine of 1 in 9, a health plan such as NYLCare, which covers 1.5 million people, would have a population that included 166,666 cases of migraine. Further assuming that about 30% of migraine cases are acute, such a plan must deal with about 50,000 hard-to-treat cases every year.

This is no small number, yet NYLCare, like most healthcare plans today, cannot say with certainty that it is taking care of migraine

headaches at this level. In terms of diagnosis, migraine sufferers may constitute one of today's largest hidden populations.

Access to Care

How are managed care plans handling migraine these days? In most instances, they are treating migraines as they would treat any other illness or condition. The principal treating physician is the primary caregiver, who in most cases will evaluate the severe headache patient and either

prescribe medication or refer the patient to a specialist.

Most primary care providers are not affiliated with teaching facilities, so the standard for this headache care varies. Treatment protocols for routine headache management, if they exist, are not routinely used. Instead, in most plans treatment protocols are generated for diagnoses that are considered to be chronic or catastrophic, high cost, or high profile. At NYLCare, such treatment protocols do not include a diagnosis of migraine.

Because they lack specific treatment guidelines, most physicians rely on utilization management guidelines to handle migraine. Such tools simply define when a patient can be admitted to the hospital or when a certain procedure or test should be done on an outpatient basis. The health plan has no consensus-based literature to guide primary care physicians in the treatment of migraine.

As a result, most primary care physicians today are treating migraines as standard tension headaches. In such a gatekeeper environment, where the average patient visit lasts between 9 and 11 minutes, complete migraine workups are rare. If patients come in more frequently or if they are especially assertive, they may get more attention or a referral to a specialist, but this is uncommon. Claims data at NYLCare indicate that referrals based on the diagnosis of migraine are almost nonexistent. In most cases, patients leave the primary care physician's office with a prescription for medication.

To some extent, this seemingly enormous level of migraine underdiagnosis may be attributable to the high turnover in managed healthcare populations. The average stay of an individual in a plan today is 2 to 3 years. Employers shift from one insurer to another from year to year, mainly because of cost. As a result, health plans do not have records going back 20 to 30 years on most of

their patients. This means that when a new adult patient says he or she has migraines and needs to have a prescription renewed, the primary care physician does not order a complete migraine workup. Complete diagnostics are usually performed only when a new and persistent symptom presents or when a child complains of headache, which may explain the gaps in NYLCare claims data on migraine diagnosis.

Pharmacy Management

Whether or not the diagnosis of migraine is formal, drug therapy remains the primary treatment for such a complaint. Most physicians will consult the formulary for the available treatment options and routinely prescribe medication based on the diagnosis. As a result, managed care plans today influence migraine therapy primarily through the design of their formularies.

The design of the overall pharmacy benefit package is another, broader way of shaping migraine care. For instance, the health plan policy may provide for oral pharmaceuticals but not for injectables—a benefit package that might make the plan less attractive to patients with asthma. Similarly, a plan that did not cover inhaled drugs might be less attractive to migraine patients who require the newer nasal products. Such a pharmacy policy is essentially a form of adverse risk selection, which makes the plan less attractive to patients with greater needs.

Another pharmacy management practice that has implications for migraine patients is the stipulation that all pharmaceuticals be purchased through the mail rather than at the retail level. If migraine patients prefer the convenience of the drugstore, they may leave that plan. Of course, health plans that offer no pharmacy benefit at all would be extremely unattractive to this patient population. With many small employ-

ers and unions now opting for a self-insurance or an out-of-pocket pharmacy program, the migraine patient is increasingly left outside the mainstream of pharmaceutical care.

How Studies Shape Pharmacy Policy

Given these variations in pharmacy benefit manipulation, how does a managed care plan shape its drug policy? Certainly, the consensus-based advice of experts is crucial, but even more helpful and often more convincing to managed care customers is the evidence generated by internal outcomes studies.

In 1994, NYLCare performed an outcomes study to evaluate the effectiveness of sumatriptan injection, a new and relatively expensive migraine treatment. The study was launched at the request of an employer who was interested in using two pools of funds to pay for extra migraine coverage, workers' compensation and medical benefits money. The study was performed in the plan's second largest group in Houston, Texas.

Results of the Houston study showed that sumatriptan injection led to a slight decrease in emergency room visits and use of other drugs associated with the treatment of migraine. In addition, migraineurs who took the serotonin antagonist had fewer sick days and less nonproductive time at work.

Based on these positive findings, a follow-up study was performed in 1996. After a reimbursement modification that allowed members with migraine to receive sumatriptan, the number of emergency room visits per 100,000 was reduced by 2.7 from 7.3 per 100,000 to 4.6 per 100,000 (unpublished data).

Priorities

Clearly, managed care plans do not have the resources to perform internal outcomes studies on every new

headache therapy. Nonetheless, these results demonstrate the potential power of outcomes evaluations to show the value of improved migraine care to those who pay the bill.

If the epidemiologists are correct and migraine appears on the list of the top 100 diagnoses (and many would suggest that it is actually among the top 50), why aren't managed care plans doing more? What will it take to improve the level of care in this environment?

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Recommendations for making migraine a priority in managed care include:

- Initiating more US clinical studies to form the basis for better evidence-based guidelines on migraine treatment and referral.
- Encouraging accreditation bodies such as the National Committee for Quality Assurance to include migraine on their list of priority diagnoses.
- Expanding the way in which migraine's economic consequences are seen to include days lost from work and reduced work productivity. In part, this involves educating clinicians and health-care administrators so they realize that although migraine does not produce the types of high-priced outcomes normally associated with a prevention-oriented

call to action (for example, bypass surgery or a liver transplant), it still leads to tangible indirect costs in terms of quality of life for the patient and lost productivity for the employer. Another aspect involves educating those who pay

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for migraine benefits regarding the substantial amount they are already paying for migraine in terms of absenteeism, lost productivity, and self-referrals to alternative care providers.

- Educating primary care physicians as to the prevalence, pathophysiology, and treatment opportunities for managing migraine.
- Informing patients about the availability of effective treatments and their responsibility to aggressively pursue the best treatments in this environment of managed care.

... DISCUSSION HIGHLIGHTS ...

After Ms. Bowman completed her presentation, a discussion ensued among the symposium participants.

Dr. Gallagher: I would agree that migraine does not seem to be a high priority for employers or providers. This is unfortunate, because primary care physicians who are equipped

with the drugs we have now—whether a triptan or a dihydroergotamine—can do a very good job for a large number of patients. The situation is analogous to that which existed years ago when family doctors were able to prescribe steroid creams and became very good at treating dermatologic conditions, to the point where dermatologists were involved less often.

Now, even if we treat the majority of these migraine patients in a cost-effective way, there will still be a small population of sufferers of more severe migraines that require the attention of a specialist. I would urge the development of protocols or disease management programs directed at treating this much smaller population of problem patients.

Ms. Bowman: Most health plans would be willing to endorse such a guideline, distribute it among providers, and monitor its effectiveness.

Dr. Gallagher: Many managed care companies already have guidelines, but they often apply only to the routine patient and guide the decision as to whether to treat the patient with an over-the-counter drug or a triptan.

Ms. Bowman: None of us has created a guideline for such a small group of intractable migraine sufferers.

Dr. Gallagher: Implementing such guidelines would probably not result in added cost, because this smaller percentage of patients represents most of the cost of both healthcare and lost time to the employer.

Dr. Mondell: Guidelines for the high-acuity patient can benefit everyone concerned. This is where primary care needs help; it is dissatisfied patients who consult the offices of the medical director.

Dr. Stewart: The AASH (American Association for the Study of Headache) and the IHS (International Headache Society) are developing guidelines, and there has been some discussion with the AHCPR (Agency for Health Care Policy and Research), so work is already ongoing.

Dr. Mondell: The AAN (American Academy of Neurology) is also developing guidelines, which very likely will be combined with the others.

Dr. Parham: Consistency among the guidelines produced by separate societies will be very helpful. Inconsistency, such as we have now in mammography screening, causes untold difficulty. To me, there is nothing more debilitating than sitting down with physicians and seeing 3 or 4 competing sets of guidelines.

Dr. Stewart: The NIH (National Institutes of Health) asthma guideline provides a good example of directives for chronic episodic conditions. They have a way of stratifying patients according to their level of severity.

Dr. Lake: How clear are the current treatment guidelines when pharma-

ceutical care is not working and a referral is necessary?

Ms. Bowman: For most diagnoses, the number of visits to the primary care provider over a period of time will trigger a referral to a specialist. We might also establish criteria for which tests to perform first and then for which specialist to select. For migraine, I would argue that if a primary care physician has seen someone for severe headaches 3 times in 6 weeks, something is wrong.

Dr. Mondell: I would add that if you see a number of different prescriptions in a very short period of time, the primary care physician would do well to get his or her opinion validated and select another treatment option.

Ms. Bowman: That leads to the question: How do health plans identify experts in headache and migraine?

Dr. Mondell: Correct. Even in the headache field and in our societies, there are no absolute criteria for what makes a physician a "headache specialist."