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COST-CUTTING STRATEGIES USED BY PATIENTS ENROLLED IN MEDICARE PART D: THE TRANSLATING RESEARCH INTO ACTION FOR DIABETES (TRIAD) STUDY O. Duru¹; N. Steers¹; C. Tseng²; V. Fung³; S. Ettner¹; J. Schmitt¹; N. Turk¹; E. Quiter¹; B. Swain³; C.M. Mangione¹; J. Hsu³. ¹University of California, Los Angeles, Los Angeles, CA; ²University of Hawaii, Honolulu, HI; ³Division of Research, Kaiser Permanente Northern California, Oakland, CA. (Tracking ID # 190267)

BACKGROUND: The introduction of Medicare Part D in 2006 provided an outpatient drug benefit for thousands of seniors with diabetes who previously had no coverage. However, the design of the Part D benefit also included a coverage gap for many patients after exceeding a spending threshold of \$2250 in total drug costs. Prior studies of increases in cost sharing and/or drug benefit caps in Medicare + Choice showed that after reaching the cap, patients used several different cost-cutting strategies to lower their out-of-pocket costs, including inconsistent medication use or discontinuing their meds. To date however, there have been no studies describing cost-cutting strategies within Medicare Part D.

METHODS: We used data from a 2007 computer-assisted telephone interview survey of Medicare Part D enrollees with diabetes. Enrollees were part of the Translating Research into Action for Diabetes (TRIAD) Study, a multicenter study of diabetes care in managed care. Respondents were randomly drawn from a non-profit HMO and a health plan with both Medicare Advantage Prescription Drug Contracting (MAPD) and stand-alone Prescription Drug Plan (PDP) products. Members with drug coverage after reaching the spending threshold (either generic-only or generic + brand coverage) were classified as having no coverage gap. Low-income qualifiers were excluded from the sampling frame. We used multivariate logistic regression models adjusted for age, gender, race/ethnicity, education, income, comorbidity score, number of medications, and health plan, to examine the association between coverage in the gap and the use of any of 11 different cost-cutting strategies.

RESULTS: Our analytic sample included 504 patients with no coverage gap and 1080 patients with a gap in coverage. Of the 11 strategies, 5 were more common among patients with a coverage gap compared to those with no gap in coverage: 1) using medication less often than prescribed (OR 2.1, 95% CI 1.4–3.2), 2) switching to cheaper medications (OR 1.6, 1.2, 2.2), 3) using a mail-order pharmacy (OR 1.4, 1.1–1.9), 4) using formulary rather than non-formulary medications (OR 1.5, 1.0–2.2), and 5) calling different pharmacies to compare prices (OR 2.1, 1.5–2.9). No differences were seen between the 2 groups in the odds of borrowing medications from family or friends (OR 1.8, 0.8–3.2), substituting over-the-counter medications for prescription medications (OR 1.2, 0.7–1.9), obtaining free samples (OR 1.0, 0.7–1.4), splitting pills according to a doctor's advice (OR 1.3, 0.9–1.9), going without necessities such as food or rent (OR 1.3, 0.8–4.4), or having family or friends pay for medication (OR 1.5, 0.95–2.5).

CONCLUSIONS: Medicare Part D beneficiaries with diabetes who have a gap in coverage are at greater odds of using several different cost-cutting strategies, including using their medication less often than prescribed. Patients with gaps in coverage also have higher odds of using price-conscious cost-cutting strategies such as comparison shopping and buying in bulk through the mail. Health plans that provide some coverage after patients reach the spending threshold of \$2250 may prevent medication underuse.

CURRENT AND FUTURE TRENDS IN THE GROWTH OF HOSPITALISTS IN CALIFORNIA E.E. Vasilevskis¹; R.J. Knebel¹; R.M. Wachter¹; A.D. Auerbach¹. ¹University of California, San Francisco, San Francisco, CA. (Tracking ID # 189476)

BACKGROUND: The number of hospitalists is growing rapidly, even though managed care – one of the field's major initial stimuli – is abating in California. There are few data which examine the current factors responsible for the continued growth and utilization of hospitalists.

METHODS: Via email, telephone, and fax we surveyed hospital leaders (e.g. chief medical officer) at all non-federal, general acute care hospitals in California (N=326) about whether and how they employed hospitalists. Surveys were performed between 2006 and 2007. For purposes of the survey, a "hospitalist" was defined as a doctor whose majority of work is in the care of hospitalized patients. We asked hospital leaders to indicate: 1) if they had a hospitalist service, 2) if yes, the year they started the service and, 3) if yes, factors influencing the decision to

implement the hospitalist service (e.g. cost/efficiency, care for patients without a primary doctor or uninsured, primary care physician demand, patient satisfaction, 24-hour coverage, quality measure performance). We collected data regarding other potential predictors of hospitalist service implementation (such as bed count, teaching status) from California Office of Statewide Health Planning and Development hospital utilization files (2006); we also flagged those hospitals involved in the voluntary California Hospital Assessment and Reporting Taskforce (CHART) quality reporting project. We used multivariable logistic regression to identify hospital factors associated with the presence of hospitalists at the time of the survey. Next, to capture recent trends, we divided the hospital leader cited factors associated with implementation into three time periods: 1) before 2002, 2) between 2002–04, and 3) 2005 or later. We then used tests of trend to examine recent changes in factors cited by hospital leaders influencing hospitalist introduction.

RESULTS: 54% (N=175) of hospitals in California responded to the survey. Respondent hospitals were similar to non-respondents among all characteristics, except for fewer responses from for-profit hospitals (15% vs. 29%). 63% of hospital leaders identified the presence of at least one hospitalist group within their hospital. 59% expected continued growth in the number of hospitalists, and none expected to decrease or eliminate their hospitalist service. Among hospitals without a hospitalist program, 44% stated one would be introduced within 5 years. In multivariable models, increasing number of hospital beds (each increase in 50 beds, OR=1.6, 95% CI 1.1–2.4) as well as participation in CHART (OR=3.0, 95% CI 1.3 – 6.7) were independently associated with having a hospitalist service in 2006–07. Among recently implemented programs, the need for 24 hour coverage (P-trend=0.05) was associated with implementation, while quality improvement goals were of borderline significance (P-trend=0.09).

CONCLUSIONS: There is widespread use of hospitalists in California, especially among larger hospitals and those participating in a voluntary quality reporting initiative. Continued growth appears likely. From the perspective of hospital leaders, the need to provide 24 hour coverage and for quality improvement are strong rationales for sustaining and growing hospitalist groups, even as cost pressures have ebbed.

CURRICULA FOR CLINICAL PRACTICE GUIDELINES IN US INTERNAL MEDICINE RESIDENCY PROGRAMS: A NATIONAL SURVEY STUDY E.A. Akl¹; R.A. Mustafa¹; M.C. Wilson²; A. Moheet³; H.J. Schünemann⁴. ¹University at Buffalo, Buffalo, NY; ²University of Iowa, Iowa City, IA; ³ViaHealth, Rochester, NY; ⁴McMaster University, Buffalo, NY. (Tracking ID # 190377)

BACKGROUND: Research has shown that implementing clinical practice guideline (CPGs) improves patient outcomes for a number of diseases. At the residency level, teaching CPGs can help achieving 3 of the 6 general competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) outcome project: patient care, medical knowledge and practice-based learning and improvement. The objective of this study was to determine the characteristics of curricula to teach CPGs in Internal Medicine residency programs in the US and the barriers to teach CPGs.

METHODS: We conducted a national survey of directors of Internal Medicine residency programs in the US. We based the survey questionnaire on the ACGME definition of curriculum. We mailed program directors the initial invitation to participate in the survey in April 2007. We included a non-monetary incentive consisting of a Jeopardy-like game to teach CPGs in a Microsoft PowerPoint file format. We sent a follow up mail and a follow up fax respectively 5 and 9 weeks after the initial invitation.

RESULTS: The survey response rate was 51% (195 out of 383). The table below shows the detailed results. 15% of programs reported having written goals and objectives; the mostly taught aspect was the content of specific CPGs (74%); the mostly used educational activity was didactic sessions (69%); and about 40% of programs conducted no evaluation. The mostly reported barrier to teaching CPGs was time constraints on faculty (54%). Both female sex and a higher number of years as program director were consistently associated with positive curricular characteristics.

CONCLUSIONS: Curricula to teach CPGs in US Internal Medicine residency programs could be better defined and developed in terms of scope, educational activities, and evaluation. Time constraints on faculty are the major barrier to teaching CPGs.