Patients often stop taking heart drugs during Medicare coverage gaps

April 17 2012

Patients who paid for heart medications solely through Medicare were 57 percent more likely to not take them during coverage gaps compared to those who had a Part D low-income subsidy or additional insurance, according to research published in *Circulation: Cardiovascular Quality and Outcomes*, an American Heart Association journal.

Neither group was more likely to switch to other drugs during coverage gaps.

"Rather than prompting patients to switch to lower-cost alternatives, we found that sudden exposure to 100 percent of drug costs in the Part D coverage gap led to abrupt discontinuation of essential cardiovascular medications," said Jennifer M. Polinski, Sc.D., M.P.H., study lead author and instructor in medicine at Harvard Medical School in Boston, Mass. "Any drug insurance policy that negatively influences essential cardiovascular drug use needs to be changed."

Heart and blood vessel, or cardiovascular disease, is the leading cause of death in the United States. The risk of disease increases with age, but complications often can be prevented with medication and lifestyle changes.

During the study, the Medicare prescription drug benefit, known as Part D, stopped paying for medicine when spending reached a certain amount. Payments resumed when patients' out-of-pocket expenses reached qualifying levels or the benefit restarted in the next calendar

year, but long-term effects of the coverage gap, or "donut hole," on drug compliance and health are unclear.

Patients who did not receive financial assistance during the coverage gap were no more likely to die or be hospitalized for cardiovascular-related conditions than those who did have financial assistance — contrasting with previous research results that looked at the impact of lapses in drug coverage in other, non-Part D settings. The difference could be due to the current study's relatively short follow-up of 119 days, the typical amount of time patients spent in the coverage gap, said Polinski, who is also an epidemiologist at Brigham and Women's Hospital and an instructor in epidemiology at the Harvard School of Public Health. The coverage gap's impact on cardiovascular health outcomes in the long-term remains unclear.

The initial study group comprised 122,255 heart disease patients who reached the Medicare Part D coverage gap in either 2006 or 2007. Researchers then compared drug termination rates between 3,980 Medicare beneficiaries without supplemental insurance to an equal number with additional coverage.

Participants were predominately white, and nearly half were 65 to 74 years old and female. Most had high blood pressure and about one-third had heart failure. Both of these conditions can be fatal without proper medical and prescription drug treatment.

Study limitations include the relatively short follow-up, the small number of hospitalizations and deaths observed, and the observational design that can't control for all possible influences.

Recent reforms include provisions in the Affordable Care Act that will help close the coverage gap over time. As of January 1, 2011, Medicare beneficiaries receive a 50 percent discount on brand name drugs and a 7

percent discount on generic drugs while in the coverage gap. The size of the discount increases over time until the coverage gap is eliminated in 2020. However, efforts to repeal or strike down the Affordable Care Act, if successful, would eliminate these discounts for Medicare beneficiaries, reinstating the coverage gap and once again requiring them to pay all drug costs during the coverage gap.

Provided by American Heart Association