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Part D Plan Switching among Medicare Beneficiaries with Schizophrenia

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Abstract

Objective—Most Medicare schizophrenia patients were randomly assigned in 2006 to one of 409 benchmark plans. We examine plan switching and factors affecting switching behavior in schizophrenia.

Methods—Using 2006 Medicare pharmacy data, for three groups of schizophrenia patients: those with Medicaid coverage (dual eligible) (n=93,705), non-dual with LIS (n=56,148), and non-LIS (n=36,107), we examined switching frequency and how patient and plan characteristics affect switching.

Results—The proportions of beneficiaries switching Part D plan at least once were 10.7%, 9.8%, and 5.5% for dual eligible, non-dual LIS, and non-LIS beneficiaries, respectively. Several factors affected the likelihood of switching, including age, geographic region, and the proportion of prescriptions filled by beneficiaries that were covered or requiring utilization review in the original plan.

Conclusions—Plan switching among Medicare beneficiaries with schizophrenia is relatively infrequent, but may be driven by the need for better drug coverage and less restrictive utilization policies.

Introduction

The Medicare prescription drug benefit (Part D) relies on private market mechanisms to deliver care. A typical beneficiary can choose from between 45 and 57 private stand-alone Part D plans (PDPs) in 2009, depending on his/her region of residence. It is known that beneficiaries do not choose plans based on their medication needs (1); and that the ability to choose plans is poorer among beneficiaries with mental disorders (2).

The prevalence rate of schizophrenia is about 2.6% among Medicare beneficiaries enrolled in PDPs, much higher than the 1.1% among the US general population (3, 4). In addition, most PDP enrollees with schizophrenia are eligible for the Medicare Part D Low-Income Subsidy (LIS) program, which provides substantial premium and cost-sharing assistance to qualifying beneficiaries (5). About 93% of PDP enrollees with schizophrenia received the LIS in 2007 (3), compared to 40% among all PDP enrollees (6). The LIS program covers an LIS enrollee's premium up to a "benchmark" amount, which is calculated for each of the 34

PDP regions based on the average premium bid for the basic benefit offered by PDP and Medicare-Advantage Part D plans (5).

To avoid discontinuation in drug coverage, especially among those who also qualified for Medicaid coverage and therefore obtained their drug coverage through Medicaid before Part D, the majority of LIS enrollees were randomly assigned to a benchmark plan in 2006. Once assigned, they can switch plans at any time. LIS enrollees can choose to enroll in any Part D plan and pay the extra premium above the benchmark amount (5).

Random assignment does not assign enrollees to plans based on their medication needs and has caused severe problems including disruptions in plan coverage for 5.9 million between 2007 and 2010 (5, 7), and high beneficiary and government spending for those assigned to plans requiring high copayments (8). Patients with schizophrenia may be even more affected, because their drug expenditures per year on average are over \$7000, much higher than the \$1600 by an average beneficiary and the \$3600 by an LIS enrollee (4, 8).

This study examines plan enrollment and plan switching patterns of beneficiaries with schizophrenia, using 2006 Medicare pharmacy and enrollment data. We were particularly interested in the first year of Medicare Part D because of the high number of beneficiaries with schizophrenia that had been randomly assigned to a stand-alone Part D plan for that year, and switching behaviors out of random assignment are of particularly interesting policy relevance.

Method

We used 2006 Medicare Part D drug event and plan enrollment data for all beneficiaries diagnosed with schizophrenia (ICD9 = 295.XX) in 2006 and 2007. Because of the sample size constraint in our original data request, we requested 20% of schizophrenia Medicare beneficiaries who also received Medicaid coverage (dual eligible), and 100% of non-dual schizophrenia beneficiaries. We constrained beneficiaries to be enrolled in a Part D plan for at least one month in 2006 so we could observe their drug use in Part D data.

Although most Medicare beneficiaries with schizophrenia receive the LIS, we also included those that did not receive LIS (non-LIS). Since they were not randomly assigned to a stand-alone Part D plan in 2006, the switching behaviors of non-LIS beneficiaries may have been quite different compared to those covered by the LIS. Thus, in this report we separately studied three groups: dual eligible, individuals receiving the LIS but not covered by Medicaid (non-dual LIS), and non-LIS. We classified beneficiaries based on whether they had switched plans in 2006 at least once. We also calculated the number of plan switches in 2006 and which month the beneficiary switched.

We considered a selection of the information captured in the Medicare data files, including patient level demographics, clinical characteristics, and characteristics of the original plans. Demographic characteristics included sex, age category (<35, 35-64, 65-74, >75), and race (White, Black, Hispanic, Asian, Other). We also considered patients' geographic location in terms of the 34 stand-alone Part D regions because Medicare Part D plans vary in cost and coverage by stand-alone Part D region. Clinical characteristics included whether or not the

patient stayed more than 90 days in a Medicare-covered skilled nursing home, total annual number of prescriptions fills standardized by 30 day supply in 2006, and status of 21 chronic conditions based on the Chronic Condition Warehouse definitions (9).

For each individual in his/her original plan, we also calculated percentage of prescriptions filled by the beneficiary that were not covered in the plan formulary and percentage of prescriptions requiring prior authorization, quantity limit, or step therapy.

For each beneficiary group we report the frequency and month of plan switching, as well as descriptive statistics for patient demographics and clinical characteristics. To study the likelihood of plan switching, we conducted a multiple logistic regression model including as covariates the patient demographics, clinical characteristics, and selected plan characteristics including percent of uncovered drugs and utilization review. We report estimated odd ratios of plan switching for each covariate, controlling for the others. All analyses were conducted using commercially available statistical software (SAS, version 9.4 [SAS Institute, Inc.]).

Results

Table 1 in the Appendix compares characteristics among the three groups: dual eligible, non-dual LIS and non-LIS. Most beneficiaries in our study sample were younger than 64 years; especially among dual eligible (81%) and non-dual LIS (75%) compared with non-LIS beneficiaries (56%). Blacks represented about 20% of the dual and non-dual LIS groups, and 11% of non-LIS beneficiaries. Regional variability was also observed in each of our three groups. The PDP region with the highest proportion of dual eligible beneficiaries was California, followed by New York, Florida and Central New England. Non-LIS beneficiaries were mostly from Pennsylvania/West Virginia, Texas, New Jersey and Florida. A wide variety of chronic conditions were also observed across our study sample, with similar rates observed across the beneficiary groups. Among psychiatric conditions, relatively high rates of depression (38%) and Alzheimer's disease, related disorders or senile dementia (16%-21%) were observed. Other prevalent disorders included heart disease (about 40%) diabetes (27%), and rheumatoid arthritis / osteoarthritis (13%-16%). The mean number of co-morbid conditions among the three groups was about 2.

Table 2 in the Appendix shows rates of plan switching behavior as well as the month the switch occurred. Plan switching occurred at about twice the rate among dually eligible beneficiaries (10.7%) and non-dual LIS (9.8%) compared to non-LIS Medicare beneficiaries (5.5%); and the differences between each pair comparison are statistically significant ($P<0.01$). Although dual and non-dual LIS beneficiaries were permitted to switch plans as many times as needed, over 90% of plan-switching beneficiaries in each group did so only once in 2006. Less than 1% switched more than twice. More than 60% switched before June 2006, with February being the most common month among dual (34.3% of switchers) and non-dual LIS (25.0% of switchers).

The Table displays results from a multiple logistic regression model evaluating factors associated with switching behavior, including beneficiary characteristics as well as plan-related factors. Beneficiaries using more drugs were more likely to switch. Some chronic

conditions were associated with greater switching likelihood, including diabetes, glaucoma, depression, and chronic heart failure. Switching was less likely among blacks and other races compared to white beneficiaries. There was considerable regional variation in the rate of switching; for example, regions with the lowest switching rates were Hawaii, Michigan, Oregon/Washington and North Carolina. Finally, individuals assigned to plans with a higher proportion of uncovered drugs were more likely to switch.

Discussion

We found the proportion of dual eligible, non-dual LIS, and non-LIS groups switching at least once to be 10.7%, 9.8% and 5.5%, respectively. Factors associated with switching included age, race, geographic region, high drug utilization, and comorbid chronic condition profile, as well as features of the initial randomly-assigned plan.

A previous study found that among all dual eligibles in the general population randomly assigned to a Part D plan before 2006, about 21.3% chose another plan by January 2006, and among beneficiaries that became eligible during 2006 about 46% switched plans in their first month (10). In comparison, we found the switching rates among duals with schizophrenia were much lower, at 10.7%.

The majority of dual eligibles and those with the LIS can switch plans every month; however, those without the LIS (and therefore not randomly assigned at the beginning of the Part D) could only change plans before the end of the open enrollment period, May 15, 2006. In our data, however, some individuals without LIS did switch after May. This may have been due to several policies which allowed eligible beneficiaries to enroll through the end of the year without penalty, including several state programs and a federal extension for LIS beneficiaries (11, 12).

Our study has several limitations. First, we only examined switching in 2006; for the majority of non-LIS beneficiaries, switching may have occurred in January 2007. First year switching patterns do not represent switching patterns in the later years, especially as the Part D benefit design changes under the Affordable Care Act – for example, the Part D coverage gap has been gradually filled since 2010 and will be closed by 2020. However, since the majority of beneficiaries with schizophrenia were randomly assigned at the beginning of 2006, this year in particular provided a good opportunity to study whether and how often individuals with disabling schizophrenia switched plans after random assignment. Second, our study merely reported how patient characteristics are associated with switching plans, as we do not evaluate causal factors affecting switching behaviors. Third, we were not able to study other factors such as the plans' customer services that could potentially affect plan choice but are not available in Medicare data.

Current CMS marketing guidelines prohibit non-relatives from providing suggestions for specific plans, even though some individuals in this position (e.g. social workers, nursing home providers) may possess the ideal combination of knowledge regarding the patient's needs with the ability to effectively navigate the plan choices (13). Policy revisions might

take into consideration the unique disadvantage of this population with respect to their ability to make choices independently.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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Table

Factors Affecting Switching Behavior among Medicare beneficiaries with schizophrenia in 2006, Results from A Multiple Logistic Regression

Variable (Reference Level)	OR	95% Wald CI
PDP Regions (Wisconsin)		
Alabama, Tennessee	1.18	.80–1.74
Alaska	.74	.20–2.84
Arizona	.69	.38–1.25
Arkansas	.67	.37–1.21
California	.69	.48–1.00
Central New England *	.78	.53–1.16
Colorado	.84	.45–1.55
Florida	1.01	.70–1.46
Georgia	.55	.35–.87
Hawaii	.23	.06–.92
Idaho, Utah	1.07	.56–2.05
Illinois	.68	.46–1.00
Indiana, Kentucky	.67	.44–1.03
Kansas	.89	.48–1.63
Louisiana	.92	.57–1.47
Michigan	.46	.30–.70
Mid-Atlantic **	.75	.47–1.19
Mississippi	.81	.47–1.37
Missouri	.60	.38–.97
Nevada	.88	.44–1.76
New Jersey	.67	.43–1.03
New Mexico	.62	.29–1.31
New York	.75	.52–1.08
North Carolina	.53	.33–.85
Northern New England ***	.61	.32–1.14
Ohio	1.03	.70–1.51
Oklahoma	.81	.47–1.38
Oregon, Washington	.51	.31–.84
Pennsylvania, West Virginia	.87	.60–1.27
South Carolina	.65	.38–1.11
Texas	.94	.65–1.36
Upper Midwest and Northern Plains ****	.55	.36–.84
Virginia	.82	.53–1.28
Age (75 years)		
34 or Less	.77	.60–.98
35 – 64	1.08	.89–1.31
65 – 74	1.14	.93–1.39

Variable (Reference Level)	OR	95% Wald CI
Race (White)		
Asian	1.04	.69–1.55
Black	.81	.72–.92
Hispanic	1.11	.93–1.33
Other	.64	.52–.78
Income (Non-LIS)		
Dual Eligible	5.88	4.98–6.95
Non-Dual LIS	3.44	2.89–4.11
Institutionalized > 90 Days in Skilled Nursing Home	.69	.49–.95
Number of 30-day Rx fills	2.02	1.98–2.05
CCW 21 Chronic Conditions		
Acute Myocardial Infarction	1.12	.59–2.12
Alzheimer's Disease, Related Disorders, or Senile Dementia	1.43	1.21–1.70
Atrial Fibrillation	.90	.63–1.29
Cataract	1.40	1.19–1.66
Chronic Kidney Disease	1.24	1.03–1.49
Chronic Obstructive Pulmonary Disease	1.37	1.19–1.58
Heart Failure	1.49	1.27–1.75
Diabetes	2.20	1.96–2.47
Glaucoma	1.60	1.29–2.00
Hip / Pelvic Fracture	.78	.43–1.41
Ischemic Heart Disease	1.37	1.19–1.56
Depression	1.51	1.36–1.67
Osteoporosis	1.48	1.21–1.81
Rheumatoid Arthritis / Osteoarthritis	1.41	1.22–1.63
Stroke / Transient Ischemic Attack	1.05	.83–1.34
Cancer, Breast	1.16	.67–2.01
Cancer, Colorectal	.73	.30–1.76
Cancer, Prostate	.88	.47–1.67
Cancer, Lung	.49	.15–1.67
Cancer, Endometrial	.52	.11–2.46
Uncovered Rx (%)	2.19	2.14–2.23
Prior authorization (%)	.89	.87–.91
Quantity limit (%)	1.01	1.00–1.02
Step therapy (%)	.99	.96–1.02