Cost-effectiveness of medicare drug plans in schizophrenia and bipolar disorder

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Pittsburgh, Pennsylvania (February 19, 2013) – A new study published online today in the American Journal of Managed Care found that in Medicare Part D, generic drug plans are more cost-effective than plans with no gap coverage for patients with schizophrenia or bipolar disorder. Researchers from the University of Pittsburgh School of Medicine, the Pitt Graduate School of Public Health, and Western Psychiatric Institute and Clinic of UPMC note that policymakers and insurers should consider generic-only coverage, rather than no gap coverage, to both conserve health care resources and improve health.

Medicare Part D offers prescription drug coverage for Medicare beneficiaries and since the program's inception in 2006, beneficiaries have paid 100 percent of medication costs out-of-pocket. About one-third of all Medicare beneficiaries enter the coverage gap each year, and once there, they often reduce medication use, which may lead to increases in hospitalization and medical spending.

"Our cost-effectiveness analysis of Part D plans is an unconventional yet instructive way to inform managed care decision-making," said researchers.

Added concerns for mental health patients include:

- Mental health patients are much more likely to enter the "gap" than other Medicare beneficiaries: 62 percent of Medicare beneficiaries with bipolar disorder and 56 percent of those with schizophrenia entered the gap in 2007.
- If they discontinue psychotropic medications, they may relapse to more severe episodes and require psychiatric hospitalization.
- They experience high rates of co-occurring chronic physical conditions such as heart disease and diabetes, which can be exacerbated by untreated mental illness and increase morbidity, medical spending and mortality.

The standard Part D benefit in 2007 included four phases: (1) an initial $265 deductible; (2) a period in which Medicare beneficiaries paid 50 percent of drug costs; (3) a coverage gap in which they paid 100 percent of drug costs; and (4) a catastrophic phase where they paid 5 percent of costs.

Although the standard Part D benefit includes these four phases, some companies offering Part D drug plans modified the benefit to cover only a percentage of the cost of generic drugs used in the gap. In 2007, fewer than 1 percent of Part D plans offered coverage for both brand-name and generic drugs.

Researchers found that generic-only coverage resulted in significantly higher savings compared to no gap coverage, with 95 percent of savings derived from the reduced use of non-generic drugs. The researchers also found that the savings from the reduced use of non-generic drugs would be even greater if non-generic drugs were only partially covered in the gap.
Our objective was to examine differences in health outcomes and costs between coverage groups in patients with bipolar disorder and schizophrenia, and the availability and affordability of care in the gap. We found that the gap can result in worse health outcomes and increased costs for patients in the gap. The gap in coverage can result in higher costs for patients, with the generic group having lower total medical costs and reduced hospitalizations.

In a disabled recipient with bipolar disorder and no coverage, costs were $570 per person more than generic coverage ($25,090 annually for no gap coverage compared to $24,520 for generic coverage).

In an aged recipient with bipolar disorder and no coverage, costs were $563 more per year than generic coverage.

In a disabled recipient with schizophrenia and no coverage, costs were $1,312 more per year than generic coverage.

In an aged recipient with schizophrenia and no coverage, costs were $1,289 more per year than generic coverage.

Costs were lower with generic coverage due to fewer hospitalizations when this coverage was in place. The authors found that this coverage is cost-saving compared with no-gap coverage (the standard part D design) and improves health outcomes.

Collaborators on this study include Seo Hyon Baik, Ph.D., Charles F. Reynolds III, M.D., Bruce L. Rollman, M.D., M.P.H., and Yuting Zhang, Ph.D., all of the University of Pittsburgh. This research was supported by the National Institute of Mental Health grant RC1MH088510; the Agency for Healthcare Research and Quality grant R01HS018657; and the University of Pittsburgh Central Research Development Fund.
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