Sources of drug coverage among Medicare beneficiaries with end-stage renal disease

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Unemployment

Introduction
By the end of 2006, there were 5,18,572 individuals with end-stage renal disease (ESRD) in the United States, and 422,087 (78%) were covered by the Medicare program.1 The expected remaining lifetime for an ESRD patient ranges from 3 to 5 years, and about 30% of patients die within the first year of ESRD.1

Management of ESRD sequelae requires extensive medication use, ESRD dialysis patients are prescribed, on average, between 6 and 12 medications at any one time.1,2

Starting in 2006, all Medicare beneficiaries were invited to enroll in Medicare Part D.

Medicare Part D is a voluntary prescription drug program offered through private insurers.

Relatively little is known about ESRD patient participation in Part D prescription drug plans (PDPs).3

Objectives of this research were (1) to describe the sources of drug coverage in the ESRD beneficiary population and (2) to explore beneficiary Part D plan preferences regarding premiums, deductibles, and the coverage gap.

Methods
Linked data from the Chronic Condition Warehouse and the United States Renal Data System were used. A 20% random sample of Medicare beneficiaries who were alive and had ESRD in December 2007 were included.

Patients were classified as having no known coverage, Part D coverage (with or without the Low-Income Subsidy [LIS]), coverage from a former employer, or coverage from other creditable sources.

To describe stand-alone PDPs in which ESRD patients voluntarily enrolled, we included patients who self-enrolled and excluded patients eligible for auto-enrollment via LIS.

Plan characteristics considered included deductibles (Y/N), gap coverage (Y/N), and premiums (by quartile).

X-tests were performed on observed proportions between ESRD and non-ESRD patients, and chi-squared
tests were used for categorical data. Statistical significance was defined as P < 0.05.

Results

By the end of 2007, 17.1% of ESRD beneficiaries had no known source of creditable drug coverage; 46.2% were enrolled in a PDP with LIS and 18.1% in a PDP without LIS; 8.9% received former employer coverage; and 9.7% received coverage from another creditable source (Table 1).

The proportions of patients with various sources of medication coverage were much different in ESRD as compared to non-ESRD Medicare beneficiaries.

Rates of no known coverage were higher in those under age 65 years and lower in those over age 65 years. Rates of no known coverage varied by race/ethnicity, with black, Hispanic, and Asian individuals having lower rates than white, Native American, & other/unknown race/ethnicity individuals.

The percent of ESRD beneficiaries enrolled in PDPs with LIS was highest in those < 65 years and in minorities.

ESRD beneficiaries who enrolled in standalone PDPs without LIS showed a greater preference toward plans that had no initial deductibles and toward plans that offered some kind of drug coverage in the coverage gap than those without ESRD (Table 2).

ESRD beneficiaries without LIS assistance were also more likely to enroll in plans with higher monthly premiums.

Preferences in ESRD beneficiaries toward plans without gaps in coverage and toward higher premiums were stronger in whites than in blacks and other minorities.

Conclusions
This research provides the first comprehensive description of prescription drug coverage sources for Medicare ESRD beneficiaries since Part D implementation.

In 2007, a large proportion of ESRD Medicare beneficiaries lacked a known source of creditable drug coverage.

A sizeable proportion of ESRD beneficiaries had Part D coverage with LIS; this appears to have been an important mechanism to help ESRD beneficiaries obtain prescription coverage.

Among beneficiaries who self-enrolled in PDPs, there was a preference for more comprehensive and expensive plans.

The Centers for Medicare and Medicaid Services and other health advocates should continue outreach work to ensure that beneficiaries who lack coverage are obtaining the coverage that they need, and that ESRD beneficiaries are joining the best plans for managing their conditions.