

Episode 249- Dr. Louanne Bakk: Racial/Ethnic Differences in Cost-Related Nonadherence and Medicare Part D

[00:00:08] Welcome to inSocialWork, the podcast series at the University at Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers in lifelong learning and to promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:37] Hi From Buffalo! I know you're wondering where you should move to to save yourself from climate change. Jesse Keenan, climate adaptation expert and Harvard University professor, was quoted in The Guardian and he called Buffalo, New York one of only two U.S. cities as ideal climate refuges. It's not news to us. I'm Peter Sobota. In 2006 Medicare added a prescription drug benefit widely referred to as Medicare Part D. In this episode our guest Dr. Louanne Bakk describes her research examining how this landmark edition changed the lives of recipients. She learned that while the overall population enjoyed health and financial benefits as a result of the addition it didn't help everyone. As you might have anticipated despite the addition of this new benefit the cost born by low income participants appears to have fostered costs related non-compliance with prescription medication use and this appears linked to racial and ethnic disparities. Dr. Bakk discusses what she found in her subsequent research, what she believes are the implications for practice and further questions for ongoing research. By the way, the Medicare annual election period is just around the corner beginning on October 15th continuing through December 7. During this time participants can change their Medicare Advantage or Part D prescription drug coverage. Interestingly a large majority of participants do not change their plan, which doesn't always allow them the best benefit possible. Louanne Bakk, Ph.D. is clinical assistant professor here at the UB School of Social Work and the director of the Institute on innovative aging policy and practice. And Dr. Bakk is without a doubt my favorite inSocialWork podcast host. Dr. Bakk was interviewed in April 2018 by Jackie McGinley Ph.D. LMSW.

[00:02:22] Hello everyone my name is Jackie McGinley and today I'm joined by Dr. Louanne Bakk and we're going to be talking about racial and ethnic differences in cost related nonadherence and Medicare Part D. We'll be looking at some of the studies she's done around that subject. So Dr. Bakk I'm asking you to maybe start by helping our audience better understand what exactly is Medicare Part D?

[00:02:44] Absolutely and thank you so much for inviting me to part of this podcast. First of all when Medicare was signed into law back in 1965 there was no drug benefit that was associated with Medicare. And what happened over time is we have increasing costs of pharmaceuticals as well as the use of pharmaceuticals so perhaps in the 90s or so we started seeing chronic conditions being treated with pharmaceuticals that we weren't necessarily treating that way prior to that point. So it became difficult for older adults to afford. As mentioned the cost of pharmaceuticals continues to increase about roughly three times the rate of inflation each year. And as a result oftentimes individuals become not adherent or they go to other strategies such as going to Canada because they can't afford their medications. So our response to this. In 2003 the Medicare Modernization Act was signed into law. And it went into effect in 2006 and what this law did is it essentially added a drug benefit to Medicare.

[00:03:47] I see. OK. So I'm curious what led to your specific interests and racial and ethnic differences in cost related nonadherence under Medicare Part D?

[00:03:57] Well this goes back to my time when I was a director at an area agency on aging in southeast Michigan. I was served in this role for several years prior to pursuing my Ph.D. And, well in this role, Medicare Part D was signed into law. So there was a great emphasis to help older adults

to enroll in this benefit. But I want to mention something about it. Medicare Part D is only available through private health care plans. And at the time the benefit was signed into law there were over 50 different plan choices for older adults to choose from. And as we think about plans they can vary in terms of cost sharing, copayments, deductibles, premium as well as drugs that are covered. So as you might expect in looking at this benefit it can be quite daunting. Seeing this, our agency was committed to making sure that older adults had the support that they needed to enroll in this benefit. And we did a number of community outreach events. We took laptops out to the community. We sat down with older adults and worked one on one with them. And what we saw is it was great for some but others regardless of having Medicare Part D in place would still continue to struggle with costs. Remember there are still costs with the benefit. We have a benefit there but there is a certain share of responsibility on older adults financially. So groups that it wouldn't help is much more typically more vulnerable. Minority populations, older blacks, older Hispanics. Those that typically had a lower income throughout their life course would struggle more with this benefit.

[00:05:34] So it's clear to me that what you were seeing in practice was really raising a lot of important questions for you. And so I'm wondering if you could tell me a little bit about your research pertaining to this topic.

[00:05:44] Absolutely. The study that I'd like to reference is in regards to racial and ethnic disparities and cost related non adherence under Medicare Part D. And before moving into this I do want to define what cost-related nonadherence can include. It could be not filling a prescription, it could be not taking a prescription or it can include skipping doses of a prescription basically due to costs. And as we think about this it's important to consider because there are certain health consequences as well as higher overall expenditures related to non adherence due to costs. We know that overall after Medicare Part D that there was a decline in cost related nonadherence. So if we compare before and after we do see in the general population of older adults that there was a decline. However we also know that more vulnerable groups such as those with a lower socioeconomic status continue to have disproportionately greater nonadherence due to cost even after the benefit was signed into law. In looking at studies related to nonadherence there wasn't much emphasis however on race and ethnicity. So that's really what prompted me to look at whether or not did this Mitt benefit make a difference for older blacks and Hispanics. Because we know before the benefit that was signed into law that both blacks and Hispanics had higher nonadherence due to costs. So it's really important that we take a look at this benefit now after the legislation to see whether or not there was a change. So in this study what I did is I used a nationally representative sample from the Health and Retirement Study to investigate whether racial and ethnic disparities in costs related nonadherence have changed since the implementation of Medicare Part D. I used the Difference in Difference approach and compare cost related nonadherence among non Hispanic blacks, Hispanics and non Hispanic whites both before and after Medicare Part D.

[00:07:41] Very interesting. And I'm curious was there a theoretical framework that was really helping to shape this area of inquiry for you?

[00:07:48] There was. I used the Cumulative Advantage Disadvantage framework and it's based on accumulations of advantages and disadvantages over a life span. And it suggests that earlier experiences can accumulate and impact later life. So for example individuals might be more economically disadvantaged because of societal or environmental factors in early years. And what happens is these disadvantages accrue over time and they can result in poor health outcomes in later life, which in turn can result in a greater reliance on prescription medications. However at the same time ability to afford and maintain adherence can also be compromised due to lower income or lower socioeconomic status. And this can be more common among older non Hispanic blacks and Hispanics.

[00:08:42] So it sounds like that there's two issues really happening here. The first is that lifelong cumulative disadvantage isn't impacting individuals health in later life. And it's also impacting their ability to access prescriptions whether that be their ability to get to a pharmacy to pay for the medication whatever it might be. So both of those things are combining to make them less likely to be compliant in later life.

[00:09:05] Absolutely. Both of those factors are coming together. So for example if I was throughout the life course I had a lower income, I had other disadvantages that may have impacted me, societal factors that are going to impact my health it's going to impact my demand for prescription medications. But at the same time my ability to pay is far more limited.

[00:09:27] It sounds, It's incredibly complex. I'm wondering if you can share some of the findings from this study that you did using the Difference in a Difference approach.

[00:09:36] Absolutely. So in comparison to not Hispanic whites, both not Hispanic blacks and Hispanics had higher rates of costs related nonadherence both before and after Medicare Part D. So in other words the benefit was in place but we still saw greater nonadherence among these two groups. Additionally cost related not adherents did not significantly change between pre and post Medicare Part D for any of these three groups. However there was a small or a minimal decline in costs related not adherence for both blacks and Hispanics. So in other words we saw that there was a slight decline there. It wasn't significant. And we also saw that regardless of the benefit both blacks and Hispanics had higher rates of costs related nonadherence.

[00:10:24] Really interesting. So what do you think you've learned from this research?

[00:10:28] Well, so as I look at this the findings do suggest that despite having Medicare Part D or this benefit being signed into law both racial and ethnic disparities and cost related nonadherence exist. So in other words we have a benefit but both groups continue to struggle with the costs and as a result have greater rates of nonadherence. This really shows that the benefit might not sufficiently be addressing some of these disparities. Remember as we talked about Medicare Part D in the beginning it's not cost free to individuals, so sometimes individuals think "oh we've got a benefit associated with Medicare now." But again there's costs that are associated. Cost sharing is involved. this cost sharing can disproportionately impact both older blacks and Hispanics because of their overall health status coupled with their lower socioeconomic status.

[00:11:20] And by cost sharing, do you mean that that person is responsible for some portion of the cost of that medication?

[00:11:27] Absolutely. It can mean they're responsible for certain proportions, so in other words there may be a drug and there's a certain percentage that the individual was responsible for, or it could be a standard copay amount. And that's going to depend on the plan that they choose.

[00:11:43] So again there's a lot of variance between these plans and cost sharing can look different from one plan to another. As we think about cost sharing. It also includes the premiums so there is a monthly premium associated with Medicare Part D and it can range anywhere from about 20 dollars up to 80 to 90 dollars so they are responsible for that as well. In addition there's a deductible that needs to be met under many of these plans before the benefit can be provided. So as we think about cost sharing, yes it's a proportion of the drug but it can also include other pieces associated with the benefit.

[00:12:19] Have you done any further research on the topic since completing this study on cost related nonadherence?

[00:12:25] I did. When Medicare Part D was signed into law. There was also a provision that added what's known as the low income subsidy. What this does is it provides some assistance with the cost sharing that we reference. So depending on my income in relation to the federal poverty level I'd be responsible still for a certain share but that would be much lower than if I were just enrolling in Medicare Part D plan. While there is this great assistance with cost sharing, unfortunately it's very much under-utilized. A colleague and I assessed whether racial and ethnic differences in awareness of this benefit do in fact exist. What we did find from the study is both blacks and Hispanics are much less likely to be aware of this low income subsidy that's available. When we looked at Hispanics what we found is language largely accounted for this difference. Also in a community based participatory research project with Erie County Department of Senior Citizens Services we looked at current outreach and enrollment strategies to determine if in fact these are effective with older blacks. What we did find is that community presentations increased knowledge slightly as well as awareness of the subsidies but it didn't necessarily lead to greater enrollment in the LIS so it's certainly an area that we need to explore further in research.

[00:13:48] How do you think it's so important for people to understand disparities under the current policy initiatives that are in place?

[00:13:55] Well as we look at the older adult population it's not a homogeneous population. There are a number of differences between and among groups. So when we think about policy we can treat it as if the population were all the same. This needs to be considered within the benefit. So as we think about cost sharing, complexity, health literacy, mechanisms for enrollment, these certainly need to be taken into account to help reduce some of these disparities as we look at this piece of legislation moving forward. Also Medicare Part D does provide assistance but it hasn't solved the problem. The cost of drugs continues to rise and cost sharing is associated with it. So for example if the cost of my medication doubles. Well this is going to also impact the amount that I'm going to pay regardless. Even though this benefit is in place. So again we can't assume that the benefit has solved the issue of prescription drug affordability among the older adult population.

[00:14:57] And what do you think these findings mean for social work practice? You just talked a bit about the disparities that are still evident and Medicare Part D. So what can be done to help reduce those disparities do you think?

[00:15:09] Interventions are really needed in the field of social work to help address some of these disparities. So for example you've seen a patient-centered approach in discussing cost related nonadherence as well as medication concerns or ensuring that we're assessing for cost related nonadherence when we're working with older clients. While we're doing initial intake and assessments for things such as home delivered meals or other services that somebody may be receiving in the home asking whether or not they're having problems affording their medication and if so asking whether or not they're aware of Medicare Part D, the plan that they're enrolled in, that may need to change depending on whether or not it's meeting their needs, and whether or not they're aware of the low income subsidy. This in turn by having these conversations can actually lead to resources and assistance that can really help older adults to afford their medication and hopefully avoid cost related nonadherence. We also need to continue thinking about ways to address the issue of health literacy. As mentioned there are over 50 different plans out there. They can be very complex. They can be daunting to go through and understand this needs to be taken into account as we're working on ways to help individuals to both enroll in that benefit and to choose the benefit that both best meets their needs.

[00:16:29] The final piece we want to think about is advocacy because if we take a step back we look at whether or not this benefit is really achieving what it was intended to improve access to

medications. In some ways it is, but it's not addressing the area of disparities adequately. And this is a public health concern as we think about moving forward with this. We need to educate that it does help to address disparities in health among more vulnerable groups so that individuals have access to the medications and the health services that they need.

[00:17:02] And as I heard you talking about that it seems as though there has been some evidence of some gains from this but that perhaps those haven't been fully realized yet, so that there remains some significant gaps that are contributing to public health concerns whether that be aging, whether that be access, whether that be overall health status and wellness of individuals. Am I understanding that correctly?

[00:17:23] Absolutely. Absolutely. Because if we think about the benefit addressing some of those concerns, if we take a step back and we look at overall health status, adherence to medications is part of that health status picture. Access is also a piece of that greater picture, having equal access to this benefit. As mentioned we have disparities in awareness. This again is a public health concern because we're not achieving equal access to the benefits. So we need to think about strategies moving forward to help really through both policy and through interventions that we're doing in the field to help really establish more of an equal playing field. So there is more equal access to this benefit and health care services.

[00:18:08] So where would you like to see the research in this area go in the future.

[00:18:12] So there are a couple different areas that I'd like to see us assess moving forward in regards to research. One is in regards to knowledge of the benefit. So thinking about outreach and education strategies that we're using with different groups. Are they culturally appropriate, are they linguistically appropriate, do they take health literacy into account. We need to think about these strategies to make sure that individuals have an awareness of the benefit, that they understand the benefit, as well as its complexities as well as they understand the cost sharing that's associated with this before they enroll into a certain plan. The other area that I really think we need to continue doing is looking at cost related nonadherence. And I reference my study, that post tests was done shortly after the implementation of Medicare Part D. So we want to continue to assess this over time because what's happening is the cost of medications continues to rise as well as the cost of the benefit. We want to see whether or not this trend continues or in fact if certain pieces of the benefit have actually improved access to medication. So again continuing to look at cost related nonadherence over time to see whether or not we truly are seeing an improvement in disparities or whether or not the trend towards these disparities continues.

[00:19:33] So it sounds like for you in terms of going forward there's two critical areas. The first being evaluating interventions that are currently in place to make sure that they're appropriate and effective. And then the second being looking at some of these issues longitudinally because we know that how people respond can change over time. We know that prescription drugs that they're selecting are needing are changing costs over time and the policies are changing constantly. And so for you personally what do you see as your next step in terms of looking at research in moving the field forward?

[00:20:06] Absolutely. When I see myself as continuing to work with certain agencies that are looking at outrage to see whether or not it's effective. So that's really where I'd like to see my personal research continue, is to partner with community based organizations, look at some of the strategies that they're currently using and how well are these working for older adults. Isn't increasing awareness of the benefit of low income subsidy piece for example. What issues are individuals still having in regards to cost related not inheritance, maybe doing some qualitative work with them to better understand how this looks for them. What are they struggling with under the

benefit, whether or not they continue to struggle with nonappearance if that is in fact an issue. And what strategies are they using when they can't afford to perscription medication.

[00:20:56] That brings me to the end of my questions. I want to thank you so much for your time today. I recall when I was in the field sitting down with someone who had a bunch of pamphlets about Medicare Part D and was trying to pick the best plan for them and what a challenging moment that was to help guide them through that process. And as I remember watching people make really really hard choices. Am I going to eat today or am I going to buy my medication. So this to me and to our listeners is clearly important important work. So I want to thank you for your contributions and for the work that lies ahead.

[00:21:26] Well thank you and thank you so much for your time and for interviewing me for this podcast.

[00:21:32] You've been listening to Dr. Louanne Bakk discuss Medicare Part D and racial and ethnic differences in cost related nonadherence on inSocialWork.

[00:21:49] Hi I'm Nancy Smyth Professor and Dean of the University at Buffalo School of Social Work. Thanks for listening to our podcast. We look forward to your continued support of the series. For more information about who we are as a school, our history our online and on ground degree and continuing education programs we invite you to visit our website at www.socialwork.buffalo.edu. And while you're there check out our technology and social work resource center. You'll find it under the Community Resources menu.