A battle now brewing in Washington, D.C., over the new Medicare drug benefit could seriously limit the choice of medications that will be available to physicians and patients. If the approach supported by health insurance plans is adopted, it will open the door for excessive new restrictions on access to medications.

The struggle is centered on guidelines now under development that provide a model of the types (or “categories and classes”) of agents that should be available to senior citizens and people with disabilities under the new Medicare prescription drug benefit.

If the guidelines list too few classes of drugs, insurers will gain more power to limit the number of medications available for each disease or condition. The outcome could determine whether the elderly and the disabled will have access to the medications they need.

Good health policy and medical practice require protecting physicians’ ability to choose from among a broad range of pharmaceutical agents. However, the initial draft of the Medicare guidelines, written by a private organization called the U.S. Pharmacopeia (USP), does not provide this protection.

The USP model, if followed by insurance plans, would leave Medicare patients with many common diseases and conditions more vulnerable to excessive restrictions on their access to medications. Treatment of high blood pressure, which affects more than 50% of all Medicare patients, is just one example, with angiotensin-converting enzyme (ACE) inhibitors being one of the most common types of drugs used for this purpose. Currently, 10 ACE-inhibitors are available to physicians. Because of differences in these drugs and differences in patients’ needs, physicians rely on a range of ACE-inhibitors in caring for patients.

The same is true for selective serotonin reuptake inhibitors (SSRIs). Research shows that although these medications on average are equally effective, they are not equally effective for individual patients. Studies also have found that between 20% and 40% of patients do not respond to a given SSRI and that patients who do not do well with an initial SSRI often are successfully treated with an alternative drug in this class.

In light of these important differences, patients covered under Medicare need safeguards that will ensure that their health care providers can choose from among a range of medications within each class (such as the ACE-inhibitors and SSRIs). Unfortunately, the guidelines drafted by USP lack this basic protection.

In an era of increased health spending, cost containment is important; however, it should not come at the expense of quality patient care. The USP guidelines should be fixed, and they should be fixed now. If the organization truly wants to help Medicare patients, it should go back to the drawing board and devise guidelines that safeguard the ability of a physician to choose the medicine that is best for the individual patient.

As usual, I am interested in your views. You can reach me at david.nash@jefferson.edu.