Generic Drug Use Helps Curb Health Care Costs

A 6.9% hike in health care spending is the lowest since 1999; pharmacy-benefit control tools are cited.

BY ALICIA AULT
Associate Editor, Practice Trends

Overall health spending growth for 2005 hit the lowest level since 1999, largely because of a continuing slowdown in retail prescription drug sales and an increased use of generic drugs, according to a report issued by the Centers for Medicare and Medicaid Services in January.

The CMS report, the official government tally, found that overall, health care spending grew 6.9% in 2005, compared with 7.2% in 2004 and 8.1% in 2003.

"It is unclear whether this is temporary or indicative of a longer-term trend," lead author Aaron Catlin, a CMS economist, said in a statement.

Even with the slowdown, the United States spent slightly more per capita in 2005—$6,697 per person—than in 2004, when expenditures were $6,322 per person.

The percentage of personal income devoted to health care is rising as well. Out-of-pocket spending grew from $235 billion in 2004 to $249 billion in 2005, with prescription drugs accounting for 20% of that expense.

Total spending in 2005 hit $2 trillion, according to the CMS (Health Affairs 2007;26:142-53, and Health Affairs 2007;26:249-57).

Medicare was the biggest spender, accounting for $342 billion of the $2 trillion total.

The figure does not include the Part D drug benefit, which did not begin until 2006. Medicaid spent $311 billion in 2005, a 7.2% increase from the previous year. But that growth rate was on par with 2004, when spending rose 7.5%.

Cost-containment efforts by the Medicaid program helped hold down the nation's overall drug bill, according to the report. For Medicaid, drug spending grew only 2.8% in 2005.

The nation's total drug tab in 2005 was $200 billion, an increase of 5.8% over the previous year, when drug spending rose 8.6%.

Most drugs—about 73%—were covered by private sources in 2005. Private spending grew only 6%, down from 7.2% in 2004.

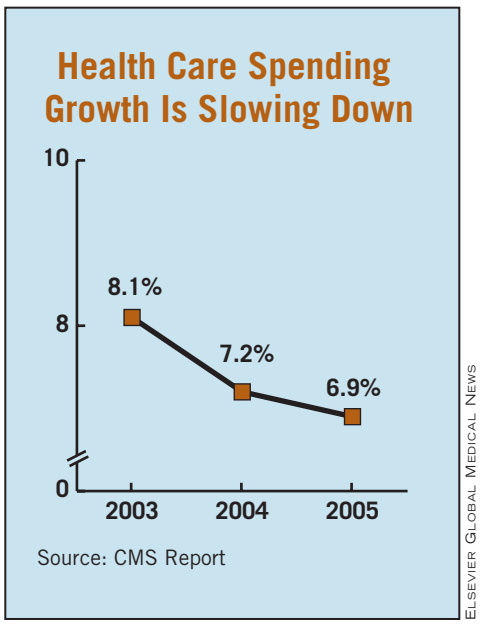
Drug price increases remained stable from 2004 to 2005, at about 3.5% overall and 6% for brand names.

The pharmacy benefit management industry took credit for helping to keep a lid on spending, noting that industry tools such as formularies, rebates, generic drugs, and mail-service are being used by both private and public payers.

"PBMs have played a huge role in helping to drive prescription drug trends to an historic low," Mark Merritt, president of the Pharmaceutical Care Management Association, said in a statement.

Both CMS and America's Health Insurance Plans said that increasing use of multitiered drug formularies—which require consumers to pay more for higher-cost medicines—also contributed to the slowdown in drug spending.

Spending on physician and clinical services hit $421 billion in 2005, which made it the second biggest category of spending, after hospitals. That represented a 7% increase from 2004, when spending rose 7.4%. Medicare, however, spent 9.5% more on physician services in 2005, which was a slight decline from the 10.4% growth in 2004.



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Hospital spending grew about 8% in 2005 and 2004, hitting $611 billion.

The fastest growing component of health spending was freestanding home health care, rising 11% in 2005 to $47.5 billion.

At least three-quarters of home care is covered by public payers.

Spending for nursing home care grew 6% in 2005 to $121 billion. That was a larger increase than in the previous year, when spending rose 4%.

Although Medicaid is the largest payer, accounting for 44% of funding for nursing home care, its expenditures increased by only 4% in 2005, compared with Medicare's 12% rise.

Growth in the cost of health insurance premiums also declined. In 2005, premiums increased 6.6%, compared with 7.9% in 2004. It was the third consecutive year that premium increases dropped.

However, the CMS researchers noted that employees are still paying more for their health care through higher coinsurance and deductibles and other out-of-pocket costs.

Consumers are taking a big hit on health costs, agreed Karen Davis, president of the Commonwealth Fund, a private nonpartisan foundation that is working toward a health system that offers better quality and more access.

"Even the slower spending growth of 6.9% continues to outpace inflation and growth in wages for the average worker in the United States," Ms. Davis said in a statement. ■

Gainsharing Arrangements Held Back by Hospitals' Legal Fears

BY MARY ELLEN SCHNEIDER
New York Bureau

Hospitals are reluctant to offer physicians a portion of the savings generated by reducing clinical costs—a concept known as gainsharing—because of legal fears, D. McCarty Thornton, said during an audioconference on gainsharing sponsored by the Integrated Healthcare Association.

"It's clear, I think, that gainsharing is not on the fast track," said Mr. Thornton, a partner with the law firm of Sonnenschein, Nath, and Rosenthal LLP, based in Washington.

In the long run, gainsharing approaches that can save money without impacting patient care are likely to take hold, he said, but first hospitals need clarification from Congress, the Health and Human Services secretary, and the Office of Inspector General about what arrangements are allowed.

In 1999, the HHS Office of Inspector General issued a special advisory bulletin saying that the civil monetary penalty provision of the Social Security Act prohibits most gainsharing arrangements. Under that provision, hospitals are prohibited from making payments to physicians to reduce or limit services to Medicare and Medicaid beneficiaries.

The bulletin said that these types of arrangements could also trigger the anti-kickback provision of the Social Security Act, which prohibits arrangements used to influence the referral of patients in federal health care programs.

"Historically, the office has been somewhat leery of gainsharing arrangements," said Catherine A. Martin, OIG senior counsel.

Since the 1999 bulletin, the OIG has issued a number of advisory opinions which outline gainsharing arrangements that would be allowable.

In general, in order to give the green light to a gainsharing arrangement, the OIG looks for transparency and accountability, quality of care controls, and safeguards against kickbacks, Ms. Martin said.

In order to be transparent, any actions taken to save costs need to be clearly and separately identified and fully disclosed to patients. Hospitals must also put in place controls to ensure that cost savings do not result in the inappropriate reduction of services. OIG officials also want to see ongoing monitoring of quality by the hospital and an independent outside reviewer, Ms. Martin said.

Before it approves a gainsharing arrangement, the OIG looks for transparency and accountability, quality of care controls, and safeguards against kickbacks.

But OIG is not the only regulator that hospitals and physicians need to consider when embarking on gainsharing arrangements, Ms. Martin said. Hospitals and physicians must also keep from running afoul of the Stark self-referral prohibitions, which fall under the purview of the Centers for Medicare and Medicaid Services.

Gainsharing arrangements must also meet Internal Revenue Service rules, and hospitals are at risk for private lawsuits, she said.

But the industry is keeping an eye on two demonstration projects that test the gainsharing concept in the Medicare fee-for-service program. Both projects are set to begin this year.

The first project, which is required under the Deficit Reduction Act of 2005, will involve 6 hospitals and will focus on quality and efficiency in inpatient episodes and during the 30-day postdischarge period. The DRA provision waives civil monetary penalty restrictions that would otherwise prohibit gainsharing.

The second project will focus on physician groups and integrated delivery systems and their affiliated hospitals.

The demonstration will include inpatient episodes, as well as the pre- and posthospital care over the duration of the project. This demonstration was mandated the Medicare Modernization Act of 2003.

Participants in both demonstrations will be required to standardize quality and efficiency improvement initiatives, internal cost savings measurement, and physician payment methodology, said Lisa R. Waters, a project officer with the division of payment policy demonstrations at CMS.

But CMS officials are looking to test various gainsharing models so participants will have flexibility in how they choose to target savings from reducing the time to diagnosis and treatment to improving discharge planning and care coordination.

There are some alternatives and variations on gainsharing that are occurring in the marketplace, Mr. Thornton said.

For example, hospitals can move forward with nonmonetary gainsharing, in which the savings are earmarked to improve physicians' work lives by upgrading surgical suites or through better scheduling.

Another option is to proceed with standard gainsharing but to carve out Medicare and Medicaid patients, who fall under federal statutes. However, the OIG has been skeptical of carve-out scenarios, Mr. Thornton said. ■