Drug Utilization Boosting Nation's Health Tab

BY ALICIA AULT
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WASHINGTON — The nation spent $2 trillion, or $7,000 per person, on health care in 2006. While that was only a small increase from the previous year, America's prescription drug tab increased by 8.5%, fueled largely by the new Medicare Part D drug benefit.

Health spending as a share of the nation's gross domestic product continues to rise, hitting 16% in 2006.

Total spending on physician and clinical services grew 5.9% to $448 billion, the slowest rate of growth since 1999. Physician pay crawled almost to a halt, largely because of the freeze in Medicare's reimbursement rates in 2006. Private insurers seemed to have followed suit, said Cathy Cowan, an economist at the Centers for Medicare and Medicaid Services. Cowan, a coauthor of an annual analysis of the nation's health spending, spoke at a briefing on the report, which was published in the January/February issue of Health Affairs.

Spending on nursing home and home health declined from the previous year's growth. Spending still grew 3.5% in 2006, but that was less than the almost 5% increase in 2005.

Medicare had the fastest rate of growth since 1981, according to the report. Spending increased 19% in 2006 to $401 billion, driven largely by the prescription drug benefit and the cost of administration for that benefit and for Medicare Advantage, a managed care program.

Medicaid spending dropped for the first time since the program began in 1965. The 0.9% decrease was largely due to a large number of Medicaid enrollees who were shifted into Medicare for their prescription drugs.

Overall drug spending grew 8.5% in 2006—a far cry from the double-digit increases seen in the late 1990s, but still an increase from the 5.8% rise in spending in 2005. Half of the 2006 increase was due to greater utilization, not surprising given that about 23 million Medicare beneficiaries took advantage of the new benefit. Prescription prices increased by only a little over 3%, according to an annual analysis by actuaries at the Centers for Medicare and Medicaid Services.

The change in the drug rebate picture also contributed to rising drug costs. Under Medicaid, states received an average 30% rebate from drugmakers. Medicare, however, got only about 5% from manufacturers for the millions of beneficiaries who shifted out of Medicaid.

Medicare spent $41 billion on Part D in 2006, with $35 billion for drug purchases and $6 billion for administration and "net cost of insurance"—that is, the cost of subsidizing premiums for low-income beneficiaries and costs for transferring beneficiaries into private plans. Medicare paid for 18% of all retail drugs, compared with only 2% in 2005. Medicare took on costs that were previously covered by private insurers, Medicaid, and the uninsured. On average, each Part D enrollee received $1,700 in benefits, according to CMS.

The largest increase in drug utilization came from beneficiaries using the Part D benefit. But there was also increased drug use due to new indications for existing drugs, growth in several therapeutic classes, and rising use of specialty drugs such as injectable biologics.

The rising availability of generic drugs—and programs designed to encourage use of generics, such as smaller copays for that category—also drove an increase in pharmaceutical utilization. A $4 generic program offered by Wal-Mart contributed to that trend and also helped keep prices down, according to the CMS authors. Sixty-three percent of drugs dispensed in the United States in 2006 were generic, according to the report.

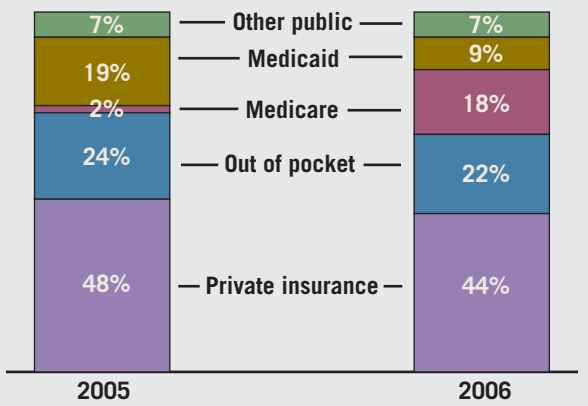
Overall, the CMS analysis shows that the largest category of health spending is still hospital care, which consumes 31% of the nation's health dollars. Other spending, which includes dental, home health, durable medical equipment, over-the-counter medications, public health, research, and capital equipment, consumes 25% of the health dollar. Physician and clinical services follow at 21%, then prescription drugs at 10%, administration at 7%, and nursing home care at 6%.

The authors said the data they had at hand and their analysis did not allow them to determine whether the prescription drug benefit had increased or lowered overall health care spending.

Richard Foster, the chief actuary at CMS, told reporters that the study showed that the "overall cost of prescription drugs has changed very little as a result of Part D." A study by Consumers Union, however, seemed to refute that claim. (See box.) ■

DATA WATCH

Funding for Retail Prescription Drugs



Note: Based on data from the Centers for Medicare and Medicaid Services.
Source: Health Affairs

ELSEVIER GLOBAL MEDICAL NEWS

Consumers Union: Drug Prices Up

Government economists have concluded that the Medicare Part D prescription drug benefit did not affect the price of pharmaceuticals in 2006, the program's first full year, but Consumers Union has issued a study charging that drug prices are indeed rising under the program.

Each month since December 2005, the consumer advocacy group has tracked the prices of five common drugs used by Medicare beneficiaries in one ZIP code in each of five states—California, New York, Illinois, Florida, and Texas. The data are taken directly from Medicare.gov. According to Consumers Union, the data show that most private insurers have consistently raised prices, often at 2-3 times the rate of inflation.

Medicare beneficiaries might be bearing the brunt of price increases, because they usually are liable for a percentage of the drug's price as a copayment. "We're seeing a lot of inflation," said Consumers Union Senior Policy Analyst Bill Vaughan in an interview.

The group also found that prices generally rise the most from December to January—after a beneficiary has locked into a plan for the upcoming year. The average increase for the five drugs as a package (Lipitor, Celebrex, Zoloft, nifedipine ER, and Altace) was $369 from December 2007 to January 2008, according to Consumers Union. "Most of these Medicare drug plans are increasing costs [at] double or triple the rate of inflation, which really torpedoes the insurance industry's claim that they are getting the best deal for seniors," said Mr. Vaughan.

MedPAC Recommends 1.1% Physician Fee Increase for 2009

BY ALICIA AULT
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WASHINGTON — The Medicare Payment Advisory Commission has voted to recommend that Congress increase Medicare physician fees by 1.1% in 2009.

The recommendation will be included in MedPAC's final report to Congress next month but was discussed and voted on at a panel meeting in January.

The panel believes that physician fees should not be cut, said MedPAC chairman Glenn M. Hackbarth. "That's a very important message for us to convey to Congress."

Before the vote, Mr. Hackbarth said the commission struggled each year to come up with the right numbers. "We try to zero in on the most appropriate update," he said, adding that cost reports, physicians' access to capital, and beneficiaries' access to physician services all go into that calculation.

MedPAC staff member John Richardson told commissioners that it appears that most physicians continue to accept new Medicare patients, but there has been an increase in beneficiaries who said they had trouble finding a new primary care physician, according to a MedPAC survey. In 2006, 24% said they had trouble; by 2007, 30% of beneficiaries reported difficulty.

Medicare fees also are staying fairly steady as a percentage of private insurance fees, said Mr. Richardson. In 2005, Medicare paid 83% of what private insurers did, and in 2006, that had slipped slightly to 81%.

In December, Congress passed and the President signed a last-minute fix to the 2008 fee schedule, granting a 6-month, 0.5% increase for 2008. The fee increase, which included incentives for rural physicians, will cost about $3.1 billion, Mr. Richardson said.

Under current law, Medicare will cut physician fees by 5.5% in 2009. But when fees are renegotiated in July, the 2009 update could change.

MedPAC recommended that fees be increased in 2009 by the projected change in input prices (2.6%) minus the expected growth in productivity (1.5%), for a 1.1% increase. The cost: about $2 billion. The commission projected that spending would increase by another $8 billion out to 2011.

The commission also urged Congress to set up a system to measure and report physician resource use. The reporting should be confidential for 2 years. After that, the Centers for Medicare and Medicaid Services should establish a new payment system that takes into account both resource use and quality measures.

Dr. Ronald D. Castellanos, a physician in a group practice in Port Charlotte, Fla. and a MedPAC commissioner, said a recommendation for an increase was better than a cut, but that the 1.1% "doesn't keep up with our costs." Physicians would not look happily on the recommended update. "Quite honestly, it's insulting," he said. "The update is a blunt tool for trying to constrain costs," said Dr. Castellanos, who voted against the update.

Dr. Nicholas Wolter, a commissioner who practices at a clinic in Billings, Montana, also said that he was not comfortable with the recommendation. "Unless we start focusing on other tactics, we're not going to get a handle on costs," he said.

Mr. Hackbarth said the panel's recommendation should not be taken to mean that the commission believed that everything was fine with the reimbursement system, adding, "it's way bigger than that." ■