Generics Help Curb Health Spending

Overall spending has dropped to a 6-year low, but out-of-pocket expenses continue to increase.

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 the total was $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.

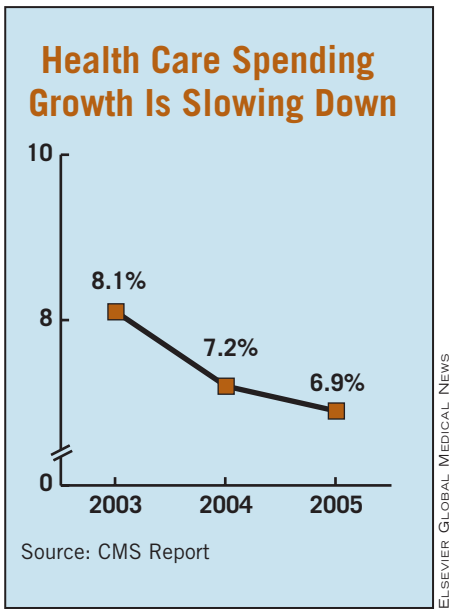
Both CMS and America's Health Insurance Plans said that increasing use of multitiered drug formularies—which require consumers to pay more for higher-cost medicines—also contributed to the slowdown in drug spending.

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.

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%. Though 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.



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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. ■

Small Offices Not Using EHRs To Improve Care

BY TODD ZWILLICH
Contributing Writer

WASHINGTON — A growing number of small medical practices are turning to electronic health records to help the office run more smoothly, but few are using them to directly improve patient care, according to findings from a small study presented at the annual symposium of the American Medical Informatics Association.

Christopher E. West, Ph.D., and his colleagues at the University of California, San Francisco, surveyed 30 doctors, nurses, and physicians' assistants working in solo or small group practices. They were working in 16 offices spread across 14 states.

All but one said they use the electronic health records system for documenting patient care at least 75% of the time, and half said they use it all the time. At least 80% said they use the system most of the time for visit coding, writing prescriptions, or viewing lab results, Dr. West reported.

That kind of "basic functionality" of electronic health records software seems to have largely replaced paper in those offices, he said.

But the researchers also found that offices were not as quick to adopt more advanced functions for improving patient care.

Only 13% said they took advantage of functions capable of generating lists of patients in need of follow-up care. Only about one-quarter used features enabling patient self-management plans or doctor visit summaries.

"Doctors are still not using electronic health records for quality improvement," Dr. West said.

Still, the study suggests that stubbornness may not be to blame.

Half of respondents said their software came with adequate training, but the other half called their training fair or poor. ■

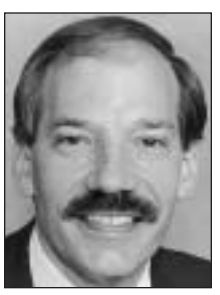
Price Setting May Not Be the Answer for Medicare Part D

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Rhetoric aside, it's not clear whether lifting restrictions on the government's ability to negotiate pharmaceutical prices for the Part D benefit will have any real impact, experts said at a forum on the future of Medicare sponsored by the Association of Health Care Journalists.

In January, the House of Representatives passed H.R. 4, which would require the Secretary of Health and Human Services to negotiate drug prices directly with manufacturers, similar to what is currently done by the Veterans Affairs system. Over in the Senate, Sen. Edward Kennedy (D-Mass.), who chairs the powerful Health, Education, Labor, and Pension Committee, has placed this legislation near the top of the committee's agenda.

"I'm a little perplexed at how this issue is going to play out," said Paul Ginsburg, Ph.D., president of the Center for Studying Health System Change. "In a sense, if you really want the government to negotiate with manufacturers, you might as well repeal, not the benefit, but the whole structure of delivering it."



The Part D program is based on the concept that the different plans would compete with each other based on price, said Marilyn Moon, Ph.D., vice president and director of the health program at the American Institutes for Research.

"If you hand them a price list, there's really no reason for them to be there. It's very difficult to imagine how you would do this," Dr. Moon stated at the forum.

"This is going to be much more of a morass than people think. I think it's a mistake on the part of a lot of the Democrats to have been promising that's what we're going to do," she said.

Setting prices for prescription drugs is far more complicated than setting prices for something like procedures.

DR. GINSBURG

Medicare already sets prices for physician services and many medical procedures, but setting prices for prescription drugs is far more complicated than setting prices for something like procedures, which can be based on hospital expenses, Dr. Ginsburg said.

"Setting prices for pharmaceuticals, given the fact that the actual production costs of pharmaceuticals are a very small part of the total cost of pharmaceuticals—most of it is in R&D for that drug and for the drugs that didn't make it—that's a much more challenging job to do well," he said.

However, Democrats argue that negotiating drug prices will help solve other problems with Part D.

Giving the government the ability to negotiate discounted drug prices will lower expenses for seniors and yield savings for Medicare that can be used to fill the gap in coverage known as the doughnut hole, according to a statement from Sen. Kennedy's office.

But the new Congress could design a workaround to fill the doughnut hole without adding money to the program, Dr. Moon said.

"My concern about the doughnut hole is that who it really hits are the people who are taking maintenance drugs, who are also the main ones who can save costs over time" by keeping their health problems in check, she said. ■