Generic Drugs Keep Health Cost Spiral in Check

BY ALICIA AULT
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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).

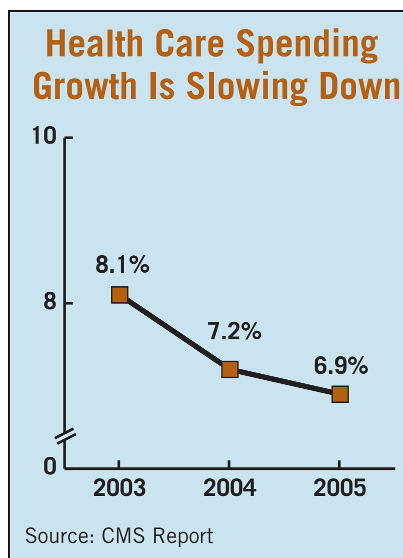
Medicare was the biggest spender, accounting for $342 billion of the $2 trillion total. The figure does not include the Part D drug benefit, which did not begin until 2006. Medicaid spent $311 billion in 2005, a 7.2% increase from the previous year. But that growth rate was on par with 2004, when spending 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 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.

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. ■

Report Urges Medicare to Help Reduce Health Disparities

BY ALICIA AULT
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WASHINGTON — As one of the biggest and most influential payers in medicine, Medicare should use its clout to help reduce and eliminate the disparities in care for racial and ethnic minorities, according to a report from an independent panel of the National Academy of Social Insurance.

The report, along with an updated survey on health plans' progress in identifying disparities, was released at a press briefing sponsored by the journal Health Affairs. NASI, a Washington-based nonprofit organization of experts in Social Security, Medicare and social insurance, made 17 recommendations on how Medicare can improve quality of, and access to care for minorities, educate health care providers in cultural competence, and hold them accountable for reducing disparities.

About 9 million of Medicare's 42 million beneficiaries are minorities. Those minority beneficiaries generally are in poorer health, according to NASI.

Medicare is uniquely positioned to influence practice patterns, and has a duty to ensure that its recipients get care on a fair and equitable basis, said Bruce C. Vladeck, Ph.D., chairman of the NASI panel and Interim President of the University of Medicine and Dentistry of New Jersey, Newark.

NASI's report was funded by the Robert Wood Johnson Foundation, the California Endowment, and the Joint Center for Political and Economic Studies.

The panel recommended that the federal government start addressing gaps in care by creating incentives to improve quality. Incentives should be carefully structured to avoid exacerbating disparities, however, said Mr. Vladeck.

To increase access, Medicare should ensure that minorities are enrolled in Medicare supplemental insurance—or Medigap—plans, said the report. Health systems should increase the number of minority providers and staff, and enhance cultural competence training. Providers should collect data that will help identify minorities and assess their special needs, according to the panel.

Health plans already collect such data, according to Karen Ignani, president and CEO of America's Health Insurance Plans. AHIP, with funding from the Robert Wood Johnson Foundation, queried 260 plans on how and why they collect data on minority enrollees. According to the responses—from 156 plans, covering 87 million people—there has been a 500% increase in data collection since a previous query in 2001, said Ms. Ignani.

Overall, 58.2 million of the 87 million enrollees are in plans that collect race and ethnicity data. Medicare and Medicaid plans were most likely to collect that data. Race and ethnicity data were collected on 94% of enrollees in Medicare and Medicaide plans, compared with 63% of enrollees in commercial plans.

Although more plans are collecting data, "we think we have much more to do," Ms. Ignani said, adding that with more data, health insurers can focus on how to eliminate disparities. But barriers to data collection exist. Six states—California, Maryland, New Hampshire, New Jersey, New York, and Pennsylvania—have laws or rules that prevent insurers from collecting race and ethnicity data, although only as part of an application process. However, those laws have led to the mistaken perception that any data collection is illegal, said Ms. Ignani.

Title VI of the federal 1964 Civil Rights Act prohibits discrimination on racial or ethnic grounds, which has led to some concern that data collection might be seen as illegal. But a June 2006 analysis by the George Washington University School of Public Health and Health Services found that not only is it legal for insurers to collect and report health quality data by race and ethnicity, but that it might be seen as proof of complying with Title VI when it is used to improve quality of care. The researchers asked the Department of Health and Human Services' Office of Civil Rights to issue guidance in this area, but have not gotten a response yet, according to Sara Rosenbaum, chairman of the university's health policy department. ■

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