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SURGERY NEWS

Analysis Tracks Trends in Rising Health Care 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, which was the slowest rate of growth since 1999. Physician pay ground 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. Nursing home prices dropped; spending still grew 3.5% in 2006, but that was less than the almost 5% increase in 2005. Home health services—the fastest growing component of personal health

spending—grew almost 10% in 2006, down from a 12% 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.

THE LARGEST CATEGORY OF SPENDING IS HOSPITAL CARE, WHICH CONSUMES 31% OF THE NATION'S HEALTH DOLLARS.

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%, accord-

ing 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 for rheumatoid arthritis and multiple sclerosis, and anemia drugs for oncology. Hypnotics saw the largest rise in use of any drug class.

The rising availability of gener-

ic 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.

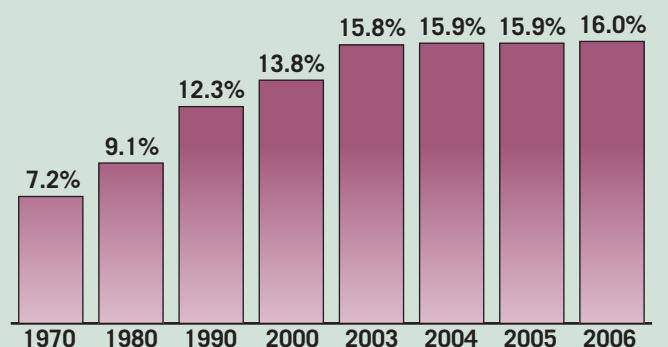
Overall, the CMS analysis shows that the largest category of health spending is still hospital care, which consumes 31% of the nation's health dollars. Other spending, which includes dental, home health, durable medical equipment, over-the-counter medications, public health, re-

search, 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. “Sooner or later, somebody's going to do a dynamite study and figure this out,” said Richard Foster, the chief actuary at CMS.

Mr. Foster told reporters that the study showed that the “overall cost of prescription drugs has changed very little as a result of Part D.”

**National Health Expenditures
As Percentage of Gross Domestic Product**



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

ELSEVIER GLOBAL MEDICAL NEWS

FDA Weighs New Data on Impact of ESA Limitations

BY MIRIAM E. TUCKER
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WASHINGTON — Limiting the use of erythropoiesis-stimulating agents in patients with chemotherapy-induced anemia would greatly increase demand for blood products and impose considerable pressure on the available U.S. blood supply, according to an industry-funded study.

In November, the Food and Drug Administration approved major revisions to the boxed warnings and other safety-related changes in erythropoiesis-stimulating agents (ESA) labels, reflecting evidence associating ESAs with an increased risk of tumor progression and lower survival rates when used to treat patients with

certain cancers. More recently, similar data from two new studies—one involving women receiving chemotherapy for breast cancer, the other for cervical cancer—have prompted the FDA to return to the issue. A public advisory committee meeting is scheduled on March 13 to discuss the new data, and further regulatory action is possible (see February *SURGERY NEWS* Online-Only article for more information).

The study, by Francis Vekeman of Groupe d'analyse, Ltee., Montreal, and his associates, was funded by Ortho Biotech Clinical Affairs, L.L.C. It was presented in a poster at the annual Community Oncology Conference in February. The research modeled the impact of limiting and of discontinuing altogether the use of

ESAs, which reduce the need for transfusions. Between 1989 and 2004, the margin between supply and demand of whole blood has fallen from 1.9 million U (13.9% of supply) to 0.9 million U (6.1% of supply). The situation is further exacerbated by procedures used for qualifying fully screened units: 240,000 U were rejected after screening in 2004, leaving a margin of only 648,000 U available (4.5% of the supply), they noted at the conference.

In 2004 (the most recent year for which data are available), an estimated 492,002 patients with chemotherapy-induced anemia received a total of 372,809 red blood units. Up to a third of the marginal U.S. blood supply would be required to cover the incremental demand for blood that

would arise from a 25% decrease in ESA used (118,602 U). The proportion would rise to 37% if 50% of the ESA supply were reduced (237,203 U) and to 55% if 75% of ESA were removed (355,805 U). And if ESA were pulled from the U.S. market entirely, the demand for available U.S. blood supply would exceed the supply (incremental U 474,407), Mr. Vekeman and his associates said.

“This added pressure on the blood supply does not consider additional exacerbations due to regional and seasonal variation in the number of available units as well as donation frequency variations,” they said in their poster.

SURGERY NEWS and *Community Oncology* are both published by Elsevier.