U.S. Spending on Prescriptions Spiked in 2006

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 hike from 2005, America's prescription drug tab grew by 8.5%.

Health spending as a share of the nation's gross domestic product hit 16% in 2006.

Total spending on physician and clinical services grew 6% to $448 billion, the slowest 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. Ms. Cowan, a coauthor of an annual analysis of the nation's health spending, spoke at a briefing on the report.

Nursing home prices dropped; spending still grew 3.5% in 2006, less than the almost 5% increase in 2005. Home health services grew almost 10% in 2006, down from a 12% increase in 2005.

Medicare spending increased 19% to $401 billion, driven largely by the prescription drug benefit, the administration cost for that benefit, and Medicare Advantage.

Overall drug spending grew 8.5% in 2006—an increase from the 5.8% rise in spending in 2005. Half of the 2006 increase was due to greater utilization, not surprising since 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 costs. Under Medicaid, states received an average 30% rebate from drugmakers. Medicare, however, got only about 5% from manufacturers for the 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"—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, versus only 2% in 2005. Medicare took on costs previously covered by private insurers, Medicaid, and the uninsured.

On average, each Part D enrollee received $1,700 in benefits, according to CMS.

Generics accounted for 63% of drugs dispensed in the U.S. in 2006, according to the report.

The largest category of spending is hospital care, which eats up 31% of U.S. health dollars. ■

Consumers Union: Private Insurers Are Gouging

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 another in a series of studies, this one making charges that drug prices are indeed rising under the program.

Each month since December 2005, the consumer advocacy group has tracked the prices of five drugs commonly used by Medicare beneficiaries in a single ZIP code in each of five states—California, New York, Illinois, Florida, and Texas.

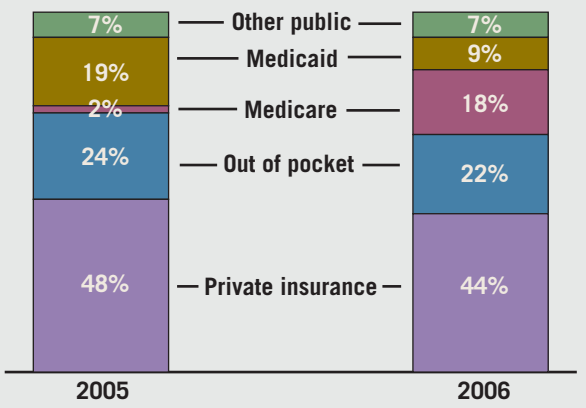
The data are taken directly from Medicare.gov. According to Consumers Union, the data show that the majority of private insurers have consistently raised prices, sometimes at 2-3 times the rate of inflation.

Consumers Union Senior Policy Analyst Bill Vaughan said in an interview the group 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.

Mr. Vaughan also noted: "These continual price hikes are Exhibit A for Congress to give renewed attention to negotiating drug prices on behalf of America's taxpayers and seniors, and offering the option of a Medicare-run drug benefit."

DATA WATCH

Funding for Retail Prescription Drugs



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

USP Asks Physicians' Help in Heading Off Medication Errors

BY BRUCE K. DIXON
Chicago Bureau

Soaring numbers of drugs with similar names have prompted the U.S. Pharmacopeia to ask providers to include an "indication for use" on prescriptions.

The recommendation is in U.S. Pharmacopeia's eighth annual MEDMARX report, which is based on a review of more than 26,000 records submitted to the MEDMARX database from 2003 to 2006.

The records implicate nearly 1,500 drugs in medication errors due to brand or generic names that could be confused. From these data, U.S. Pharmacopeia (USP) compiled a list of more than 3,000 drug pairs that look or sound alike, nearly double the number of pairs identified in USP's 2004 report, said Diane Cousins, R.Ph.

USP also operates, in conjunction with the Institute for Safe Medication Practices, the Medication Errors Reporting Program (MER), which allows health care professioals to report confidentially potential and actual medication errors directly to USP.

USP reviewed both MEDMARX and MER to summarize the variables associated with more than 26,000 look-alike and/or sound-alike (LASA) errors, of which 1.4% (384) resulted in harm or death. More than 670 health care facilities contributed 26,000 records, according to the report.

"We looked at lists of the top 200 drugs prescribed and used in hospitals, and virtually every time, all of the top 10 appeared within the USP similar names list," said Ms. Cousins, USP's vice president of health care quality and information.

"Although pharmacy personnel, who are generally technicians, made the majority of errors, pharmacists as a group identified, prevented, and reported more than any other staff," she said.

The report also identifies an emerging trend of look-alike drug names in computerized direct order entry systems. She added the LASA-related error problem is further compounded by the indiscriminate use of suffixes, as well as look-alike packaging and labeling.

Over the 3-year period, the drug most commonly confused with others was Cefazolin, a first-generation cephalosporin antibiotic. "We found it to be confused with 15 other drugs, primarily antimicrobials, which might be explained by the fact that this is the most frequently used class of medications," said Ms. Cousins.

Drug mix-ups led to seven reported fatalities, including two due to confusion over the Alzheimer's drug Reminyl (galantamine) and the antidiabetes drug Amaryl (glimepiride).

In 2005, recognizing the high risk of confusion and subsequent fatal hypoglycemia, Ortho-McNeil Neurologics Inc. announced that the name Reminyl had been changed to Razadyne to avoid confusion with Amaryl. In another case, a physician was preparing to intubate a patient and calculated the dose for rocuronium (Zemuron), a preintubation agent used to assist with the procedure. The physician gave orders for the nurse to obtain the medication and indicated the volume to administer to the patient. The nurse obtained and administered the neuromuscular blocking agent vecuronium (Norcuron) instead, leading to a fatal heart arrhythmia.

Other deaths involved mix-ups between the anticonvulsant primidone and prednisone; the antiepileptic drug phenytoin sodium and the barbiturate phenobarbital; and Norcuron and the heart failure treatment Natrecor (nesiritide recombinant).

Errors occur with over-the-counter medications, too. Ms. Cousins described the aural confusion when an order for Ferro-Sequel 500 mg—an iron replacement—was transcribed as Serrosequel 500 mg and the order was misread as Seroquel 500 mg—an antipsychotic.

The rate of mix-ups involving brand name versus generic drugs was about evenly split, 57% and 43%, respectively, Ms. Cousins said, adding that while most errors were made in pharmacies, many are due to confusion over the prescribing physician's handwriting.

"Errors also are due to physicians using short codes for medications, such as 'clon,' for clonazepam or clonapine," she said, adding that electronically written prescriptions using a computer or label machine would eliminate many errors.

It would also be helpful if the FDA were given more authority to force name changes during the drug review process.

The recommendation that physicians include indications for use in their prescriptions is not an attempt to impose on privacy, Ms. Cousins said. "All that is needed are simple inclusions, such as 'for sinus,' 'for heart,' or, 'for cough,'" she said. This also would help patients avoid confusion.

USP also recommends that "tall man lettering" be implemented in pharmacy software, labeling, and order writing to say, for example, "acetaZOLamide" (glaucoma) and "acetoHEXamide" (diabetes).

Where risk exists, USP recommends:

- ► Consider the potential for mix-ups before adding a drug to your formulary.
- ► Physically separate or differentiate products with similar names while they are being stored on the shelf.
- ► Disseminate information about products that have been confused at your facility, to build awareness among staff.
- ► Prohibit verbal orders for sound-alikes that have been mixed up at your facility.

"Physicians' offices should always require a read-back from pharmacists, making sure that they both say and spell the drug name," Ms. Cousins said. ■