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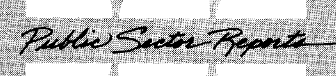

Michigan **COMMENTARY**

Prescription Drug Costs: You Ain't Seen Nothin' Yet

by Peter Pratt
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The hospitals have their PPS (prospective payment system) and now the doctors have their RBRVS (resource-based relative value scale). What cumbersome acronym will the federal government find when it gets around to controlling skyrocketing prescription drug costs? Clearly, something will have to be done as we embark on an era in which the cost of certain new drugs will make recent years' rapid increases in prescription drug costs seem negligible. Pharmaceuticals are the next big explosion in health care costs.

An August 1992 report from the federal government's General Accounting Office sets out today's problems with prescription drug costs. Prices for 19 of 29 widely used drugs increased by more than 100 percent between 1985 and 1991. Some increases even surpassed 300 percent. In comparison, inflation was 26 percent for the same period. Even health care inflation did not approach 100 percent. The report noted that these spiraling costs are most likely to burden the elderly, who, on average, require more prescriptions than the nonelderly and who must frequently pay for prescriptions out of their own pockets because their health insurance does not cover them.

In the coming years, however, the elderly may not be the only people who will be unable to afford some medications. If the 1970s saw the rise of the prescription drug benefit in private health insurance contracts and Medicaid, the 1990s may witness the decline of that benefit. There was wisdom behind the decision to cover prescription drugs. Many drugs, after all, are among the best buys in health care; they often control or cure disease without requiring costly surgeries and hospitalizations. Moreover, their value must be demonstrated in the arduous Food and Drug Administration approval process, which is much more than can be said for an alarming number of medical interventions.

THE PROMISE AND THREAT OF CENTOXIN

This wisdom has come face to face with Centoxin and many other drugs with incredible powers just like it. Centoxin is a new drug used to treat gram-negative septic shock. It saves lives and thus is well worth its estimated cost of $4,000 per dose. Difficulty arises because only 30 to 40 percent of sepsis patients are gram negative, and there is no way to determine the patients who will benefit from the drug before it has to be administered. (Testing for gram negativity takes two to three days; a patient cannot survive septic shock for that long.) As a result, Centoxin must be given to the 60–70 percent of septic shock patients who will not benefit from it.

Centoxin presents a raft of problems for hospitals. Some large hospitals in Michigan envision spending millions of dollars on the drug. Obviously, it must be given to all sepsis patients; a hospital cannot risk excluding a patient who may benefit from the drug, even if the majority of patients will not. To make matters worse, Medicare will not boost DRG payments for Centoxin and drugs like it that are coming on the market. DRG updates are based on two-year old claims, and thus it will be at least two years before Centoxin will be recognized in certain DRG payments. In the meantime, hospitals will shoulder the enormous expense of this newest of wonder drugs.

As genetics ushers in a new era of innovation in prescription drugs, the issues raised by Centoxin will multiply, and they will extend beyond the hospital to the prescription drug benefit in many private health

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insurance policies. Our present system simply cannot afford all these miraculous drugs. Only Gov. Bill Clinton's proposal to reform the health care system and control costs even mentions rapidly rising prescription drug costs. What we desperately need is an agency to look at new drugs and new technology *together* to determine those that are most likely to improve the health of the population. Before now, drugs and technology have been considered independently. We can no longer pay for that luxury.

A NEW MODEL FOR CURBING HIDDEN PRESCRIPTION DRUG COSTS

The prices of existing and new drugs are only partly responsible for the crisis in prescription drug costs. Drugs' incredible powers can do as much harm as good if they are misused. Billions of dollars are squandered when patients fail to take medications as their physicians direct, adverse drug reactions occur, and drugs are improperly prescribed. In these cases, patients fail to derive the full benefit of the drugs or the drugs actually harm rather than help. Often, readmission to the hospital is necessary, which is much more costly than the drug itself.

The hidden costs of drug mismanagement must not be ignored by policy makers. Physicians and pharmacists must work together to ensure that drugs are properly prescribed and taken. The expertise of both professions is necessary if the hidden costs of prescription drug use are to be reduced. Studies of federally funded pilot projects illustrate the value of such cooperation, but the benefits are lost on most payers. As most drugs, until recently, were inexpensive relative to the cost of other health care services, payers were reluctant to pay pharmacists and physicians to talk to patients and each other about drugs and compliance.

That attitude of payers must change. With drug prices crashing through the ceiling, payers can no longer afford to foot the bill for incredibly expensive drugs that are ineffective at best and harmful at worst. The more expensive the drug, the more likely a patient who fails to take it properly will end up in the hospital. It makes much more sense to encourage through reimbursement a pharmacists' and physicians' conspiracy to keep patients on track. To those who argue that these are soft dollars that may not be saved, the answer is simple: Design reimbursement rewards that are based on outcomes, on demonstrable reductions in the number of persons rehospitalized because of noncompliance and other drug mismanagement.

In the end, will reducing the hidden costs of drug mismanagement offset the costs of high-tech drugs? It is difficult to say. Private health insurers and the government may have to make tough decisions about the drugs they will cover. Soon we may have to choose to exclude drugs that we are certain work wonders, but not if we can create a system that rewards the cooperation of health professionals in making certain that patients take the right drugs properly and only when they need them.

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