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Schaffner said physicians often do not think about pertussis as a diagnosis when an adult patient seeks care for a prolonged cough.

“Many physicians for adults simply are not aware of this resurgence of pertussis that exists, so the diagnosis in the adult population is often missed,” he explained. Schaffner said unvaccinated adults who are susceptible to pertussis are “a threat to newborn infants who are too young to get immunized” against the bacterium.

“We would like to eliminate that disease,” he added.

Another new boost for adult immunization programs is Merck and Company’s Zostavax. This live vaccine was licensed this year to protect against shingles, a complication of varicella zoster infection, in people age 60 years or older.

Schaffner described the vaccine as a

“great advance that will invigorate adult immunization” in the United States—if the product comes into widespread use.

A major barrier to use of the vaccine is the decision of the Centers for Medicare and Medicaid Services to list Zostavax as a Part D drug instead of providing coverage for the vaccine under Part B, as the agency does for influenza and pneumococcal vaccines.

“This leaves us very uncertain about how widely it will be used,” Schaffner said.

Although most major insurers have not announced whether they will cover the shingles vaccine, Aetna has stated that it considers Zostavax a “medically necessary preventive service to reduce the risk of herpes zoster (shingles) in members 60 years of age and older.” The vaccine is currently covered for this age group and indication under Aetna plans that include preventive services.

Schaffner said payment issues are a barrier to the success of adult immunization programs.

“The payment structure that we have in this country for vaccine administration both . . . in public programs and for private insurance is quite inadequate” for adults, he said. To promote adult immunization, he explained, “we’ll have to create this structure that will enable us to actually purchase the vaccines, administer them, and provide assurance that they will be delivered to the targeted populations in a very effective way.”

But he noted that the barriers are familiar territory for public health professionals, who have dealt with similar obstacles in the past.

“That’s where we were 30 years ago with childhood and adolescent immunization,” Schaffner said. “And gradually, over time, all of the issues have been addressed. They have been addressed not to perfection, but to the point of extraordinary success.”

—Kate Traynor

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Safety nets still overpaying for drugs

Safety-net providers participating in a federal drug-pricing program established by Congress in 1992 to “stretch” federal resources as far as possible are overpaying millions of dollars for their prescription medications, government investigators reported in July.

Entities covered by 340B, including disproportionate-share hospitals, federally funded community health centers, and hemophilia treatment centers, overpaid a total of \$3.9 million for drug products purchased in one month alone, according to the Department of Health and Human Services Office of Inspector General (OIG).

That \$3.9 million in overpayments, investigators declared, “might instead have been used to lower the cost of acquiring

additional drugs to serve indigent patients at low or no cost.”

About one in seven, or 14%, of covered entities’ purchases in June 2005 exceeded the 340B ceiling price—the highest price a manufacturer is permitted by the 340B statute of the Public Health Service Act to charge participating entities for a drug.

Of the 70 covered entities sampled, 68 paid more than the ceiling prices for 2–100% of their total purchases, OIG said.

In fact, inspectors said, 17 of the sampled entities paid above the 340B ceiling prices for 75% or more of their total purchases.

One of those entities paid more than the ceiling prices on 100% of its purchases, OIG Program Analyst Madeline

Francescatti told an audience in July at the 10th Anniversary 340B Coalition Conference in Washington, D.C.

The overpayments per entity in June 2005 ranged from \$0.51 to \$36,730, with a median of \$729, she said.

OIG reported in March 2003 that five manufacturers of 11 prescription drugs had overcharged 340B-program participants \$6.1 million for sales occurring from October 1998 through September 1999.

In a 2004 report, OIG estimated that 340B-covered entities paid \$41.1 million in overcharges in September 2002.

However, Francescatti noted, OIG withdrew the 2004 report a few months after its release after discrepancies were found in the data.

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But, she said, the 2006 report vindicates the withdrawn report and confirms that there is an ongoing problem with 340B-program participants overpaying for prescription medications.

OIG scolded the Health Resources and Services Administration (HRSA), which oversees the 340B program, in a report issued last October for having systemic problems with the accuracy and reliability of its records of 340B ceiling prices and for lacking the oversight mechanisms and authority to ensure that 340B entities pay at or below 340B ceiling prices.

The agency pledged to fix its problems.

In response to OIG's 2006 report, HRSA vowed again to more closely monitor the prices paid by 340B entities and said it was exploring "the possibility" of seeking the authority and resources needed to impose fines and civil penal-

ties for violations of the 340B ceiling price requirement.

The Public Hospital Pharmacy Coalition (PHPC), an organization that represents safety-net providers, called on HRSA to "fix this problem and to implement a suitable remedy for covered entities that have paid too much for their drugs."

The group noted that several of the recommendations made in OIG's 2006 report are "essentially restatements" of suggestions made by investigators last fall, "which HRSA has still not implemented."

The 2006 report, PHPC stated, "demonstrates the continuing need for both further investigation of 340B pricing practices and aggressive pursuit by government of effective enforcement of programmatic standards and pricing requirements."

—Donna Young

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News Brief

- The Collaborative Partnerships and Products of the NIOSH Hazardous Drug Working Group in April received the **2006 National Occupational Research Agenda Partnering Award for Worker Health and Safety**. Members of the working group included **Roger W. Anderson, M.S., Dr.P.H., FASHP; Robert DeChristoforo, M.S.; Joseph H. Deffenbaugh, M.P.H.; Bruce R. Harrison, M.S., BCOP; L. D. King; R. David Lauper, Pharm.D.; Jerry Phillips; Luci A. Power, M.S.; and Charlotte A. Smith, M.S.**