Insurers Begin to Crack Down on Imaging Costs

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As the public focuses on problems with the safety and cost of prescription drugs, insurers are training their sights on a different cost issue: imaging procedures.

On average, costs of imaging—especially high-tech procedures, such as MRI, CT, and magnetic resonance angiograms—have been going up 20% per year for the last several years, according to Thomas Dehn, M.D., cofounder of National Imaging Associates, a radiology utilization–management firm in Hackensack, N.J.

"Some will say it's the aging of the population, but the key issue is really demand," said Dr. Dehn, the company's executive vice president and chief medical officer. "Patients are bright. They're good consumers. They want a shoulder MRI if their shoulder hurts."

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Physician demand is also an important part of the equation, he said. "If you have physicians who want increased [patient volume] in their offices, it is possible that rather than spending cognitive time, for which they're poorly reimbursed, they may choose to use a technical alternative."

For example, a doctor trying to figure out the source of a patient's chronic headaches "may get frustrated and refer the patient for an MRI of the brain, just to show them they're normal," Dr. Dehn said. "The treating physician knows in the back of his mind that there isn't going to be anything [there], but it will calm the patient down."

As to which physicians are responsible for the increase in imaging, the answer depends on whom you ask. The American College of Radiology contends that the growth is largely due to self-referral by nonradiologists who have bought their own imaging equipment. But others say that all specialties are doing more imaging, largely because of improved technology and the improvement in care that it brings.

Whatever the reason that more scans are being done, insurers have decided they've had enough. Take Highmark Blue Cross and Blue Shield, a Pittsburgh-based insurer whose imaging costs have risen to $500 million annually in the last few years.

One Highmark strategy for paring down its imaging costs is to develop a smaller network of imaging providers. To be included in Highmark's network, outpatient imaging centers must now offer multiple imaging modalities, such as mammography, MRIs, CTs, and bone densitometry.

"We were seeing many facilities that were single modality—just CT or just MRI," said Cary Vinson, M.D., Highmark's vice president of quality and medical performance management. "They were being set up by for-profit companies to siphon away high-margin procedures from hospitals and other multimodality freestanding facilities. We were seeing access problems for referring physicians because the single modality centers were outcompeting the multimodality centers, and they couldn't keep up."

In addition to credentialing the imaging centers, Highmark is going to start requiring providers to preauthorize all CT, MRI, and PET scans. At first, while everyone adapts to the new system, the preauthorization procedure will be voluntary and no procedures will be denied. But eventually—perhaps by the end of this year—the preauthorization will become mandatory, Dr. Vinson said.

Harvard Pilgrim Health Care (HPHC) of Wellesley, Mass., is taking a slightly different approach. Instead of mandatory preauthorization, HPHC is using a "soft denial" process in which physicians must call for imaging preauthorization, but they can overrule a negative decision if they want to.

"We made a decision based on our network being a very sophisticated, highly academic referral environment, that a hard denial program might not be best way to go," said William Corwin, M.D., the plan's medical director for utilization management and clinical policy. "Instead, we elected to use a more consultative approach." The program started in July, so no concrete results are available yet, he noted.

Plans that start a preauthorization program must first figure out who should be authorized to perform scans. At Highmark, the plan tried to be as inclusive as possible, Dr. Vinson said.

"In some cases within a specialty, we tried to determine who was qualified and who was not," he said. "For instance, for breast ultrasound, we listed radiologists, but we also included surgeons with breast ultrasound certification from the American Society of Breast Surgeons."

Highmark ran into a turf battle as it tried to credential providers. In this case, the American College of Cardiology and the American College of Radiology "definitely have differences of opinion about who's qualified and who's not" when it comes to cardiology-related imaging exams, Dr. Vinson said. "Highmark took the approach of accepting either society's qualifications. They clearly wanted us to decide between the two, and we would not do that."

To design their preauthorization programs, both Highmark and Harvard Pilgrim worked with National Imaging Associates, which now has "more than two dozen" clients nationwide and is active in 32 states, according to Dr. Dehn.

He predicts at least one more specialty will join in, as more molecular imaging is done to design tumor-specific antibodies. "You may have immunologists who are doing diagnostic imaging," he said. ■

POLICY & PRACTICE

Trading Choice for Savings

More patients are willing to limit their choice of physicians and hospitals to save on out-of-pocket medical costs, the Center for Studying Health System Change (HSC) reported. Between 2001 and 2003, the proportion of working-age Americans with employer health coverage willing to make this trade-off increased from 55% to 59%—after the rate had been stable since 1997, the study found. Low-income consumers were the most willing to give up provider choice in return for lower cost. In addition, the proportion of chronically ill working-age adults with employer coverage who are willing to trade choice for lower costs rose from 51% in 2001 to 56% in 2003. The study's findings were based on HSC's Community Tracking Household Survey. In 2003, the survey included 20,500 adults aged 18-64 with employer-sponsored health coverage; in 2001 it included 28,000 working-age adults with employer coverage.

Physicians Prefer Paper

When it comes to recording patient health information, most physicians and hospitals still prefer paper to the computer, the Centers for Disease Control and Prevention reported. Ambulatory medical care surveys conducted from 2001 to 2003 revealed that only 17% of physicians' offices had electronic medical records to support patient care. Less than a third of hospital facilities (31% of hospital emergency departments and 29% of outpatient departments) had electronic records. Physicians who were younger than age 50 years were twice as likely as their older counterparts to utilize computerized physician order entry systems, the CDC reported.

Part B Costs Expected to Rise

Payments for Medicare Part B services—coverage for physician visits and outpatient services—are expected to grow at an annual average rate of about 6.9% over the next 10 years, the program's trustees announced in their annual report. More use of services such as office visits and lab and diagnostic tests account for the accelerated growth in Part B costs—and needs further detailed examination, said Mark McClellan, M.D., administrator of the Center for Medicare and Medicaid Services. Medicare's hospital fund in the meantime currently isn't expected to dry out until 2020, 1 year later than estimated in last year's report. "However, if you look at historical projections, President Bush has presided over an unprecedented drop in solvency," countered Rep. Pete Stark (D-Calif.), ranking Democrat on the House Ways and Means health subcommittee, in a statement.

Medicare and Smoking Cessation

It's official: Medicare is adding coverage for smoking and tobacco cessation counseling for certain beneficiaries who want to kick the habit. The coverage decision applies to Medicare patients whose illness is caused or complicated by smoking, such as heart disease, cerebrovascular disease, lung disease, or osteoporosis—diseases that account for a large proportion of Medicare spending. It also applies to beneficiaries whose medications are compromised by tobacco use. "It is our hope that Medicare's decision to pay for smoking cessation counseling will encourage and help seniors quit smoking once and for all," Ronald Davis, M.D., trustee with the American Medical Association, said in a statement. Of the 440,000 Americans who die annually from smoking-related disease, 300,000 are aged 65 and older, according to the Centers for Disease Control and Prevention. The CDC in 2002 estimated that 57% of smokers aged 65 and older reported a desire to quit smoking.

FDA Guidance on Drug Risks

The Food and Drug Administration has released three guidance documents to help industry improve its methods of assessing and monitoring the risks associated with drugs and biological products in clinical development and general use. One document addresses risk minimization action plans (RiskMAPs) that industry could use to address specific risk-related goals and objectives. How the new guidance protocols would specifically address a drug with red safety flags like Vioxx (rofecoxib), "is hard to speculate," Paul J. Seligman, M.D., director of the Office of Pharmacoepidemiology and Statistical Science with the FDA's Center for Drug Evaluation and Research, said at a press conference. "It would be difficult for us to come up with a drug that would allow us to walk through the guidances," as all drugs need to be evaluated on a case-by-case basis, Dr. Seligman said.

Report on Health Care Disparities

Disparities related to race, ethnicity, and socioeconomic status continue to plague the health care system, according to the 2004 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality. Using comparable data from 2000 and 2001, researchers analyzed 38 measures of effectiveness for health care and 31 measures of access to care. Of the measures tracked for these two consecutive years, AHRQ found that blacks received poorer quality of health care than whites for about two-thirds of the quality measures and had worse access to care than whites for about 40% of access measures. Hispanics, Asians, American Indians, and Alaska natives also scored lower than whites on quality measures and access to care. Low-income groups received lower quality of care for about 60% of quality measures and had worse access to care for about 80% of access measures, than those with high incomes.

—Jennifer Silverman