Medicare Infusion Fees Leave MDs Short

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The new system for infusion therapy payments under Medicare shows how difficult it is to base payment on "average" prices, Rep. Nancy Johnson (R-Conn.) said at a conference sponsored by Elsevier Oncology.

"An 'on average' payment system always means some people are below the average, and the question is, are you below average on every drug?" Ms. Johnson said. "Well, then you'd be out of business. I've gotten letters from people who are closing up shop to Medicare patients. That's a very, very serious problem."

Under the new payment system for infusion therapy, providers have a choice: They can either buy their drugs from vendors that Medicare selects in a competitive bidding process, or they can buy drugs from any vendor and accept Medicare's payment of 106% of the average sales price (ASP).

The ASP is determined by data supplied to Medicare by manufacturers and updated every quarter.

Several audience members complained that 106%—also called ASP plus 6%—was nowhere near enough for them to make any profit on the drugs. "I can't purchase any single drug and make any kind of margin on it," a woman from Alaska said at the meeting. "We send everybody to the hospital [for treatment]; we cannot treat a single person. There's one drug I lose $400 on every time a patient walks in the door."

Elsevier Oncology and this newspaper are wholly owned subsidiaries of Elsevier.

Rep. Johnson said there seemed to be "pockets" of the country where too many drugs had such negative margins, "but we can't see any logic yet. Is it certain size practices? Is it certain regions of the country? We need your information, because in the end we want something that pays for drugs in a reasonable and fair process."

One problem with determining the ASP is that it includes prices received by large-group buyers who get big discounts, as well as others who get 'prompt pay' discounts, Rep. Johnson noted. "Those may be too harsh. That may mean that the little guy who is below the average can't make it."

A big problem with the payment system for drugs is that it is tied to the sustainable growth rate, a target percentage that Medicare sets each year for allowable growth in the Medicare budget, she said. If spending goes above the target, the budget must be cut the following year to make up for it.

Rep. Johnson is sponsoring H.R. 3617, which would repeal the sustainable growth rate altogether and replace it with a payment increase based on the Medicare Economic Index.

That bill is important because increasing payments to physicians is essential for moving toward a pay for performance system, she said. "You can't move ahead on pay-for-performance when you're going to cut reimbursement."

Another area of reimbursement concern was Medicare's oncology demonstration program. Last year, the program paid physicians $130 for each chemotherapy infusion visit as long as participating physicians filled out paperwork stating whether they are following practice guidelines with that particular patient.

This year, the oncology demonstration program is paying $23 per evaluation and management visit, explained Dr. Peter Bach, senior advisor to Dr. Mark McClellan, administrator of the Centers for Medicare and Medicaid Services.

The new oncology system "deemphasizes chemotherapy, removes the incentive for infusions over other treatments such as oral chemo, and it … creates a longitudinal record. The payment for each event is $23 rather than $130, but obviously the number of events is far greater," Dr. Bach said. ■

Proposed Health Savings Accounts' Value Debatable

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

As President Bush puts health savings accounts higher on his agenda, experts continue to debate whether they are a good idea for solving the problems of the uninsured.

"The more I think about these proposals, the more troubling I find them to be," Leonard Burman, codirector of the Urban-Brookings Tax Policy Center, said in a teleconference sponsored by the Center on Budget and Policy Priorities (CBPP). "I don't think the idea [that people will be more cost conscious] is really going to play out."

Health savings accounts (HSAs) are accounts that employees contribute to in order to pay for the first several thousand dollars of their health care costs. The accounts are almost always combined with a high-deductible health insurance plan. Contributions to the HSA are tax free, as is money withdrawn for covered medical expenses. If the money is not used in a particular year, it can accumulate in the account.

The Galen Institute, an organization that supports consumer-driven health care, has a more positive view of HSAs. "HSAs give consumers even more control over their health spending decisions—and provide them an incentive to spend wisely and save for future health care needs," according to a statement from Galen. Critics argue that sick people are not always in a position to shop around for care; that making consumers more cost conscious won't help lower health care costs because most health care spending is for expenses higher than the amount of the deductible, which is out of the consumers' control; and that HSAs tend to attract mostly healthy people, driving up premiums for sicker individuals who remain in more traditional plans.

President Bush highlighted HSAs in his State of the Union address, vowing to "strengthen health savings accounts—making sure individuals and small business employees can buy insurance with the same advantages that people working for big businesses now get."

In a more detailed statement, White House officials said that the president "proposes making premiums for HSA-compatible insurance policies deductible from income taxes when [these policies are] purchased by individuals outside of work. In addition, an income tax credit would offset payroll taxes paid on premiums paid for their HSA policies."

The president is also proposing to allow any spending on out-of-pocket health expenses incurred by HSA enrollees—up to $10,500 per family—to be tax free, not just expenses pertaining to the deductible, as allowed under current law.

Such changes would make HSAs even more tempting to some people, said Jason Furman, senior fellow at the CBPP. "HSAs are already an unprecedentedly favored tax vehicle. This proposal now takes a system already tilted and adds a new tax credit."

If enacted, these proposals could make HSAs so attractive financially that they could begin to rival 401(k) plans as retirement savings vehicles, Mr. Furman said.

For example, suppose a family in a 25% tax bracket contributed the maximum $10,500 to an HSA that is invested at a 3% interest rate. Under the president's proposal, they would owe a payroll tax of $1,607, but they would also get a tax credit for that amount, so the entire $10,500 would stay in the account. If they contributed the same amount into a 401(k), they would still owe the payroll tax, but would not get a tax credit, so only $8,893 would be deposited into the 401(k) account. As a result, the HSA account would end up with $25,486 in it by 2036, versus $21,587 for the 401(k), Mr. Furman said.

Barry Barnett, a principal in PricewaterhouseCoopers' human resource solutions practice, acknowledged that the proposal would result in substantial tax incentives, but said he did not think that employers were going to get rid of their 401(k) offerings because of it.

Ever since employers have switched to defined contribution retirement plans, "there has been enough noise in the system by employees feeling they've lost the entitlement to a defined benefit plan in retirement," Mr. Barnett said. "If employers start canceling 401(k) plans and instead offer HSAs, I think there will be a major outcry by employees and Congress or some other body of people saying, 'There's got to be some form of retirement benefit,' especially as the government tries to cut back on Social Security entitlements and Medicare entitlements as the president is talking about." ■

Medicare May Skip Charité Disk Coverage

BY ALICIA AULT
Associate Editor, Practice Trends

Medicare might not pay for implantation of the Charité artificial spinal disk if a proposed coverage decision becomes final in May.

According to the Centers for Medicare and Medicaid Services proposal, the evidence is not adequate to conclude that disk replacement with the Charité "is reasonable and necessary."

CMS is accepting comments through April, and will make a final decision on May 6. The agency said it found little data in patients older than 65 years and, in addition, that the results of the pivotal Charité study "are unconvincing as a demonstration of net health benefit."

Several specialty societies—including the North American Spine Society, the Scoliosis Research Society, and the Spine Arthroplasty Society—have commented, mostly saying that the jury is still out on older patients.

The Charité was approved by the Food and Drug Administration last November, but it has not been widely adopted and is rarely being paid for by insurers. So far, 176 procedures have been covered by insurers; Medicare has paid for a few cases as well, said Dr. Richard Toselli, worldwide vice president for research and development at DePuy Spine Inc. of Raynham, Mass., which makes Charité. The disk is indicated for 18- to 60-year-old patients with degenerative disk disease at one level, either L4/L5 or L5/S1. It has not been studied in patients older than age 60.

CMS began its coverage review at the request of Dr. Richard Deyo, an internist and professor of medicine and health services at the University of Washington, Seattle. In an interview, Dr. Deyo said he was concerned about the safety of the Charité in an older population partly because osteopenia and osteoporosis are contraindications.

Dr. Deyo also said the Charité had shown in trials only that it was not inferior to a type of fusion—Bagby and Kuslich (BAK) cages with iliac crest bone graft—a procedure he called "largely discredited."

The disk is not intended to be implanted in patients older than age 65, so Medicare's proposal did not come as a great surprise, said Dr. Toselli. DePuy Spine is hoping that Medicare will pay for Charité implantation in its disabled beneficiaries, he said.

A split coverage decision would not be unprecedented. A CMS spokesman said the agency has in the past covered procedures or therapies for subgroups of the Medicare population, or has imposed restrictions on the prescribing or use of a device or therapy. In its Charité proposal, however, CMS said the data did not seem to support using the disk in the disabled, either. ■

Pages 46a—46b