

# Rebates are not the whole story

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*We need balanced payment reform as well as transparency in treatment.*

**M**embers of the media and even some members of Congress have been piling on the bandwagon to indict oncologists, using limited information to make their judgments.

*The New York Times* article cited by Dr. Klepper reports that, according to its recently departed business manager, a physician group in the Pacific Northwest reaped huge profits from rebates on Amgen drugs for anemia—erythropoiesis-stimulating agents (ESAs). Unfortunately, the article failed to mention the number of patients treated, reasons for the treatments, or the outcomes. Neither was there an analysis of the overall cost of the drugs: what was the price paid by the practice initially, minus the rebate? How much was the practice reimbursed for the drug by the insurer? How much co-pay was received? The *Times* article implied that the rebates are pure profit—but this simply is not the case. Only with all of the relevant payment information can we know the actual profit margin for that treatment.

In addition, there is no mention made or references given for the many studies of the cost effectiveness of anemia medications in cancer versus the costs incurred when those drugs are *not* used and patients require transfusions, experience treatment delays, or suffer from increased toxicities.

Furthermore, the assertion that rebates induce doctors to overtreat is not supported by any evidence. Health plans and Medicare have reimbursed physicians for anemia therapies based on detailed evidence-based guidelines

that recommend initiating therapy for hemoglobin levels below 10–11 g/dL or below 11–12 g/dL based on specific risks or symptoms and the need for transfusion.

While rebates may provide incentives for doctors not to undertreat, there are severe penalties for overtreatment. Medicare has the right to perform, and does conduct post-payment chart reviews. When therapy is given above guideline hemoglobin levels, refunds and penalties are assessed retroactively. The practice standard is careful analysis of risk versus benefit to the individual patient, ongoing monitoring of hemoglobin levels, and discontinuation of therapy when hemoglobin levels rise to 12 g/dL or between 12 and 13 g/dL if other qualifying diagnoses are documented.

Confusion over the issue has also been generated by results of a careful clinical trial on head and neck cancer patients.<sup>1</sup> This study tested whether treating with ESAs to produce higher hemoglobin levels in these patients was beneficial, but the therapy turned out to cause unexpected and unacceptable toxicities. However, this was a research trial; prescribing ESAs in this way is not the standard in clinical practice nor part of our practice guidelines.

### Welcome to our world

In oncology, the reality is that Medicare, the biggest payer for our services, has historically used drug reimbursements as a way to defer compensating oncologists adequately for their true and documented costs. Most private payers have followed Medicare's lead, using the

same payment method, which emphasized drug reimbursement. However, all of this changed when Medicare altered its model and substantially reduced drug reimbursement by switching from AWP (average wholesale price) to ASP (average sales price). Under the old AWP system, rebates were unaccounted for. But the current ASP system fully considers the effect of any rebates given by the manufacturers. Rebates are calculated into ASP and lead to lower reimbursements for those drugs through the quarterly price analysis. As a result, the impact of rebates is neutralized through the ASP model. [Editor's note: For more on this, see *Washington Update*, page 419.]

In many surgical fields, for example, training, expertise, and practice costs are considered more fairly by Medicare than in oncology. Delivering cancer care is time-intensive: Knowledge changes monthly; treatment plans, complex care coordination, and new therapies are continually being integrated into evidence-based guidelines to ensure the best outcomes. A large discrepancy has developed in establishing proper billing codes and related reimbursement rates.

Medicare's billing codes and reimbursement for non-drug services have also failed to acknowledge a key shift in healthcare delivery: Private oncology practices were bearing the costs as they moved most cancer care from the higher priced hospital-based service to the lower priced, more convenient and accessible outpatient clinic setting. Private practices were (and are still) funding the intensive services of physicians, nurses, and administrators

with the margins on drug reimbursements. They invested the difference between AWP-based reimbursement and the costs of enhancing their services and expanding access to care.

However, even with rebates figured into the mix, the Medicare Modernization Act essentially eliminated drug margins by shifting reimbursement to ASP—but without establishing proper codes and reimbursement for practice costs that previously had been subsidized through drug payments. Oncologists, oncology nurses, administrators, and cancer patients have been advocating, for a legislative solution to appropriately fund balanced payment reform.

In the past 10 years, outpatient costs (personnel, malpractice and other liability insurance, salaries, supply costs, and inventory carrying costs, including financing costs) have all risen dramatically. Typically it takes Medicare about 30 days to process and pay claims; other payers take about 60 days. Facility rents and maintenance are another huge cost. At each of our community offices, for example, rent has doubled in the past 7 years. All of these costs need to be ap-

propriately reimbursed and cost of living adjustments kept current. Otherwise, community oncology caregivers will be forced to scale back services significantly. In fact, this has already started happening; rural practices are closing and care is shifting back to the more costly hospital setting.

## Policy change

Oncologists continue to work for changes in the reimbursement model so that practices would be reimbursed based on their service delivery, quality, and performance/outcomes, and not based on a drug utilization/retail store concept. Oncologists welcome and seek the opportunities to collaborate and coordinate efforts with all payers to achieve this goal.

As proof, HR 1190, the Community Cancer Care Preservation Act of 2007, is a bill currently before the House of Representatives. It has been offered as an interim step by a broad coalition of cancer experts and would fix Medicare billing codes to compensate cancer experts appropriately for their care, planning, coordination, management, and

oversight while reimbursing them for the costs of the medications they deliver—effectively and safely in the outpatient clinic settings.

If you too are concerned about the need for payment reform raised by the recent headlines, I encourage you to take action by joining the efforts of cancer professionals who are urging your House member to co-sponsor HR 1190. A companion Senate bill is coming. We all want such reform so that no one can ever question the commitment of oncologists whose dedication and passion for treating cancer patients have so improved the quality of life and survival rates of people with this disease in the United States.

## Reference

1. Henke M, Laszig R, Rube C, et al. Erythropoietin to treat head and neck cancer patients with anaemia undergoing radiotherapy: randomised, double-blind, placebo-controlled trial. *Lancet* 2003;362:1255–1260.

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