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Incentives Limit Any Savings in Treating Cancer

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When Medicare cracked down two years ago on profits that doctors made on drugs they administered to patients in their offices, it ended a windfall worth hundreds of thousands of dollars a year for each physician.

The change, which mainly affected drugs to treat cancer and its side effects, had an immediate effect. In all, cancer doctors billed about $4.4 billion for chemotherapy and anemia medications in 2005, down from $5.6 billion in 2004, with Medicare covering 80 percent of the bills in each year. The difference mostly represented profit that doctors had made on the drugs.

But the change did not reduce overall federal spending on cancer care, which increased slightly. And cancer doctors say the change did nothing to reduce a larger problem in cancer treatment.

Some physicians say that cancer doctors responded to Medicare's change by performing additional treatments that got them the best reimbursements, whether or not the treatments benefited patients. Those doctors also say that Medicare's reimbursement policies are responsible.

"The system doesn't value the time we spend with patients," said Dr. Peter Eisenberg, a cancer doctor in Greenbrae, Calif., and a former director of the American Society of Clinical Oncology. "The system values procedures."

The ballooning cost of cancer treatment, one of Medicare's most expensive categories, offers a vivid example of how difficult it may be to rein in the nation's runaway health care spending without fundamentally changing the way doctors are paid.

Cancer patients and their families play a role in rising costs, too, because they understandably want doctors to exhaust every possible treatment, even if the doctors might serve their patients better simply by talking and listening to them.

In general, oncologists make money by providing chemotherapy, even when it has little chance of success. Oncologists naturally dislike telling cancer patients that they have exhausted all available treatments. Ending chemotherapy, after all, means acknowledging that a patient's disease has become terminal.

"There's pretty good evidence at this point," said Dr. Richard Deyo, professor of medicine at the University of Washington and an expert on health care spending, "that there are plenty of patients for whom there's little hope, who are terminally ill, whom chemotherapy is not going to help, who get chemotherapy."

With the new limits on cancer drug profits, some cancer doctors are searching for new income — like performing chemotherapy more often or installing multimillion-dollar imaging machines where they profit when their patients receive diagnostic scans.

They are also putting new pressure on cancer patients to make out-of-pocket drug co-payments, which can amount to hundreds of dollars a month. In some cases, they are requiring patients to get injections of certain drugs at the hospital instead of in their offices.

Some oncologists say that such changes are necessary because Medicare has not raised its fees for chemotherapy enough to make up the difference. They say they are losing money on Medicare patients and are pressing Medicare to reverse the changes.

Unless it does, a number of doctors say they will be forced to close their practices, and cancer patients, especially in rural areas, may not be able to get treatment.

But that does not yet appear to be a problem. An independent federal commission said last year that the Medicare changes had not reduced patients' access to care.

The system under which cancer doctors profit on chemotherapy drugs — and so-called supportive care medications, like anemia medicine that is given to counter the side effects of chemotherapy — came into being more than two decades ago. That was when advances in treatment made it possible for patients to receive

chemotherapy in doctors' offices instead of hospitals.

Instead of writing prescriptions that patients filled at pharmacies, cancer doctors bought drugs themselves, then administered them to patients and billed Medicare or private insurers for reimbursement.

Today, the drugs range from relatively inexpensive treatments like Taxol, a breast cancer drug that costs about $150 a dose, to a new wave of biotechnology therapies like Avastin, a drug for colon and lung cancer that can cost as much as $8,800 a month.

Before 2005, Medicare paid a markup of 20 percent to 100 percent on many drugs, and private insurers paid even more. Doctors pocketed the difference, after certain expenses, as profit.

Because the profits on different drugs varied enormously, doctors had an incentive to prescribe medications with the highest margins. Medicare requires a 20 percent co-payment by patients on chemotherapy medicines, but before 2005 doctors sometimes forgave those co-payments because their profits were so great.

The profits helped drive a vast increase in the amounts doctors billed Medicare for injectable drugs, which soared to $10.9 billion by 2004 from $2.9 billion in 1997. Besides drugs for cancer, the figures include injectable drugs for arthritis and other diseases, though chemotherapy and anemia medications were the largest categories.

The increase in spending, and concerns about the perverse incentives created by the system, caused Congress to change the reimbursement system to more closely tie Medicare payments to what doctors actually pay for the drugs.

Now, drug reimbursement is supposed to amount to only 6 percent more than the average price of the drug paid by all doctors. Because of the change, the overall amount that doctors billed Medicare for injectable drugs fell 6 percent from 2004 to 2005, to $10.3 billion.

Doctors who buy large quantities of medicine can still get big rebates from drug companies, so they can continue to make money on prescriptions — even if it is not at the levels of the past. But those who buy only small quantities get no rebates. And once expenses are calculated, they may actually lose money on certain drugs for Medicare patients.

Private insurers are slowly reducing their reimbursement levels as well, though for most cancer patients they are still paying more than Medicare does.

As a result of the Medicare cutbacks, some doctors say they have been forced to refer patients to hospitals for chemotherapy treatment. Because of the complexities of Medicare rules, hospitals can make money providing chemotherapy for patients even in cases when doctors cannot. But it can be a serious inconvenience for people who are very ill and may have a few months to live.

Dr. Arthur Hooberman, a Chicago oncologist, said his group had sent seven patients to hospitals for treatments in the last few months.

"Our feeling is if we break even on chemotherapy, we'll give it," Dr. Hooberman said. But, he added, "we're not going to pay for people's chemotherapy." Dr. Hooberman said Medicare needed to start paying doctors more for other care to make up for their lost drug profits.

Geraldine Lotrich, a lung cancer patient of Dr. Hooberman who has had to receive chemotherapy treatment at a local hospital, said she would rather have remained in his office, where the nurses know her and the doctor can stop in during her five-hour infusion.

"It's kind of upsetting," Ms. Lotrich said.

Ari Straus, the chief operating officer of Aurora Healthcare Consulting, which works with doctors to increase their profits, said Medicare's changes had squeezed oncologists. "Five years ago, many physicians were earning over $1 million per year on drug sales alone," Mr. Straus said. "It created a perception problem for oncologists that they earn an enormous amount on drugs, but that's not true anymore. Today, the majority of oncologists break even, and some lose money on drugs."

A few oncologists and their colleagues see the professional situation as worse. "We're seeing the dismantling of the community oncology system," said Steve Coplon, chief executive of the West Clinic, a group of cancer centers in Tennessee that has 28 doctors and sees about 5,000 new patients a year.

Mr. Coplon said his practice had lost $3 million in 2006 on Medicare patients. But invoking confidentiality, he declined to explain how the group had calculated that figure, how much money it made on privately insured patients, how much money it made over all, or how much its doctors earned.

For now, even the oncologists most critical of the 2005 rule changes do not say that patients are being denied treatment, rather that they are being inconvenienced by being forced to receive it in hospitals. And no hard statistics exist to show how many patients have been affected in this way.

In testimony to Congress in July 2006, Mark E. Miller, executive director of the Medicare Payment Advisory Commission, said his group had found that “access to chemotherapy drugs remained good” and had “no evidence that quality of care declined” as a result of the reimbursement changes. The commission is an independent federal group that advises Congress on issues affecting Medicare.

Now, oncologists are lobbying Medicare officials and members of Congress to reverse some of the changes and again raise the prices the government pays for drugs.

But Dr. Robert Geller, who worked as an oncologist in private practice from 1996 to 2005 before leaving to become senior medical director at Alexion, a biotechnology company, said that increasing drug reimbursement might raise oncologists’ profits but would not relieve the system’s deeper flaws.

As long as oncologists continue to be paid by the procedure instead of for spending time with patients, they will find ways to game the system, however much money they make or lose on prescribing drugs, he said.

“People go where the money is, and you’d like to believe it’s different in medicine, but it’s really no different in medicine,” Dr. Geller said. “When you start thinking of oncology as a business, then all these decisions make sense.”