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POLITICS AND POLICY

Deep in Medicare Bill, a Drug Fight

Doctors Mobilize Over Their Latest Plan to Cut Reimbursements, but This Time They May Lose

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Last week, Steve Coplion, the president of a large cancer clinic in Memphis, Tenn., led several doctors, nurses and patients on an early morning field trip to the local offices of Senate Majority Leader Bill Frist. After barging in unannounced, they demanded a telephone audience with the Republican lawmaker, who was in Washington.

Their goal: to protest congressional efforts to slash Medicare spending on chemotherapy drugs by billions of dollars a year. While they didn't reach Mr. Frist that day, they aren't giving up -- nor are their allies across the country who are bombarding lawmakers with telephone calls and e-mails asserting that the proposed cuts would result in clinic closings and other problems.

How the government pays for oncology treatments is a side issue in the much broader debate over Medicare legislation pending in the House and the Senate.

But the conflict, which involves the cancer lobby, one of the most formidable in the health-care arena, is emblematic of an array of high-intensity, special-interest fights being waged just off center stage. The outcomes will dictate who emerges as Medicare winners and losers.

CANCER DRUGS

- [New Cancer Treatments Offer Hope, but Pose Questions of Cost](#)¹
06/18/03
- [Last Hope for Lymphoma Costs \\$28,000 per Dosage](#)²
06/18/03
- [Health-Care Poll](#):³ Most Americans believe life-saving treatments should be covered by health plans regardless of cost.

CHEMOTHERAPY COSTS

The gap between what doctors pay for cancer drugs and what Medicare reimburses them for administering the drugs is drawing fire from lawmakers.

DRUG	COST TO DOCTORS*	WHAT MEDICARE PAYS DOCTORS*
Dolasteron mesylate (injection)	\$15.76	\$42.77
Epoetin alpha for non-ESRD use	10.95	12.26
Heparin sodium	0.28	0.40
Ondansetron HCl (injection)	5.59	6.09
Dexamethasone sodium phosphate	1.24	1.37

*Per dose

Source: General Accounting Office

Medicare, the government health plan that covers about 40 million elderly and disabled Americans, generally doesn't cover outpatient prescription drugs. But it does pay for a limited number of drugs, mostly cancer treatments, administered in doctors' offices. A Justice Department investigation in 2000 and subsequent congressional hearings found some drug makers report artificially inflated list prices for medications.

• **Waldholz on Health:**⁴ The ins and outs of plans in Congress to add drug benefits to Medicare.

The companies then sell the products to doctors at far lower prices. Since Medicare reimburses doctors based on the list price, the result is hefty profits for the physicians. The government's annual overpayments have been

estimated at \$1.9 billion by the Health and Human Services Department's Office of Inspector General.

The cancer doctors have always blocked efforts to pare back reimbursements, arguing that the overpayments make up for gross underpayments they receive for administering the often-toxic drugs, which require the hiring of specialized nurses and pharmacists.

But now, chances for change are the best in years: While the House and Senate bills take different approaches, both would sharply reduce reimbursements for cancer drugs, partly because lawmakers want to use the savings to pay for other things -- rural hospitals, for example. Moreover, Medicare head Tom Scully, who has called the current system "one of the great taxpayer abuses going on in Medicare," says he will slash rates himself if lawmakers don't act. Even cancer doctors, tired of criticism, now admit the system is flawed and needs to be fixed -- but they want guarantees that most of the savings will be funneled back to them as increased Medicare reimbursements for patient services and administering medicines.

Lobbying on the issue is reaching a fever pitch. At the recent annual meeting of the American Society of Clinical Oncology, which represents 10,000 cancer doctors, two black telephones were set up with direct lines to the Senate and House. Sitting by the phones were stacks of talking points for doctors to use. "I am a cancer doctor in your state," the script said. "This kind of action would be devastating to my practice and patients."

Physicians who run community cancer clinics, frustrated with old-fashioned lobbying efforts by cancer advocates, recently formed the Community Oncology Alliance to take a more gloves-off approach. With a budget of \$1.6 million, the group hired two familiar names: Republican Bob Livingston, the former House Appropriations Committee chairman, and Democrat Harold Ford Sr., a former congressman whose son is now a member of the House.

One strategy involves getting lawmakers to visit private oncology clinics. Ted Okon, a COA organizer, estimates some 200 visits already have occurred. "We're in overdrive," Mr. Okon says. "Once they see the clinics, they'll understand that administering chemo is not like giving Tylenol."

Both ASCO and COA are pushing a bill, sponsored by Reps. Charlie Norwood, a Georgia Republican, and Lois Capps, a California Democrat, that would cut drug payments but require Medicare to pay for work done by oncology nurses, pharmacists and support staff who offer counseling to sick patients.

Generally, Medicare pays physicians 95% of the "list," or published average wholesale price, for drugs. But numerous studies by Congress, the Justice Department and HHS have found that the average wholesale price doesn't reflect the wholesale price or any other transaction price. Some 450 drugs are reimbursed this way, but about 35 of them -- mostly chemotherapy medications -- account for the bulk of the program's spending. In all, the government spends an estimated \$8.5 billion a year reimbursing doctors for the drugs they buy for Medicare patients.

The oncologists and patient groups have fought off efforts to cut reimbursements in the past. In June 2000, after a Justice Department investigation of pricing issues, the Clinton administration

tried to reduce payments by instructing Medicare's claims processors to reimburse doctors based on lower, more-accurate drug prices. That summer, doctors and patient groups went into action. They lobbied lawmakers to pressure the administration to reverse course, taking sick patients to Capitol Hill to say they would lose care. Three months later, the Clinton administration backed down.

The cancer groups swung into action again last month when they fought an eleventh-hour amendment to the tax bill introduced by Senate Finance Committee Chairman Charles Grassley. The Iowa Republican's proposal would have lowered Medicare reimbursement to 85% of the average wholesale price. He wanted to use the savings to fund rural health-care programs. Although Mr. Grassley's measure wasn't expected to be included in the final tax bill, the cancer lobby mobilized anyhow.

Within 24 hours, ASCO had organized a "fly-in" of top cancer doctors from more than 30 states. In one afternoon, the doctors made 80 visits to lawmakers. Meanwhile, nurses and patient groups worked the phones. Aides to Sen. Bill Nelson, a Florida Democrat, estimated that they received more than 200 calls in two days saying the Grassley amendment would dismantle the world's best cancer-care system. ASCO also took out a full-page ad in Roll Call, a Capitol Hill newspaper. The provision was cut from the tax bill.

"That does not mean the issue has gone away," the former ASCO president, Dr. Joseph Bailes, told the doctors who crowded into a hotel conference room during the ASCO convention to discuss the issue.

In fact, the Senate returned to its approach for the Medicare bill, setting reimbursement at 85% of average wholesale prices, while moderately increasing fees for services.

House Republican leaders are taking a different tack. Legislation by the Ways and Means and Energy and Commerce committees is likely to take drug purchasing out of cancer doctors' hands entirely. Insurers or pharmacy-benefit managers would bid for contracts to supply a given drug to Medicare at a certain price, and doctors would buy from them.

Doctors hate that idea, because the medications would have to be ordered from government-designated suppliers on a per-patient basis -- which would prevent clinics from keeping the drugs on hand. That means patients would have to visit the clinics for evaluation, and then come back a few days later for chemotherapy. Oncologist Dean Gesme, who runs a clinic in Cedar Rapids, Iowa, says such an arrangement would put a huge strain on patients in rural areas. "It would be totally unworkable," he says.

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