Healthy, Wealthy, and Wise

Oncologists say the sequester forces them to turn away patients. Not really, but their pay structure *is* deeply perverse. By Margot Sanger-Katz

When the automatic spending cuts kicked in for Medicare this month, every doctor saw a 2 percent reduction in reimbursement from the government insurance program. But cancer doctors have made the most noise. A front-page *Washington Post* story reported that thousands of cancer patients were being turned away by doctors who could no longer afford to treat them. Members of Congress responded quickly, introducing legislation to reverse the cancer reimbursement cuts and asking the Health and Human Services Department to reinterpret the sequester law to exempt oncologists. "This particular cut itself is so devastating to cancer patients that this is one that we just have to see our way to improving and fixing," said Rep. Renee Ellmers, R-N.C., who sponsored the bill to reverse the cancer cuts. (The doctors are unlikely to find an ally in President Obama, whose budget last week recommended even deeper cuts to their reimbursement.)

Partly, this is political theater. While some oncologists warn that patients will lose access to lifesaving care, others admit they'll simply absorb the cuts and keep treating their ailing charges. Their median compensation was $430,695 in 2011, according to the Medical Group Management Association. But the situation also highlights how problematic the business of oncology has become. Federal-payment policies have distorted the market and perverted incentives for providers.

Like other physicians, medical oncologists are paid to diagnose disease and devise treatment plans for patients. But for years, they have also had a thriving side business buying and reselling the expensive chemotherapy drugs they administer. Instead of paying for compounds directly, or sending patients to buy them from a retail pharmacy, Medicare reimburses cancer doctors for buying the drugs, then pays them a 6 percent markup above an "average sales price" for the medication.

That markup is designed to reimburse practices for the cost of acquiring, storing, and managing the drugs (doctors often buy the medications before they get paid to administer them). But even accounting for those costs, the margin on cancer drugs still represents about 64 percent of the average practice's revenue, according to a survey by the firm Oncology Metrics published in the *Journal of Clinical Oncology*. Cancer tends to strike people later in life, so Medicare beneficiaries make up the majority of patients, but many practices also obtain higher drug markups from younger patients with private insurance.

Not going anywhere: Cancer patients.

PHOTO: ASSOCIATED PRESS/MARY ANN CHASTAIN

The system encourages doctors to prescribe costlier medications, regardless of the medical need. After all, storage and overhead for drugs doesn't typically vary according to the price of the medication, and 6 percent of a $10,000 drug is more than 6 percent of a $200 one. "The more expensive the drug, the more profit you make," says Dr. Peter Bach, the director of the Center for Health Policy and Outcomes at Memorial Sloan-Kettering Cancer Center, who has worked on cancer-payment policy at the Centers for Medicare and Medicaid Services. "We created this problem," he says.

But the system also makes it harder for smaller practices to keep up with the rising cost of medications. Those shops are the least likely to get the best prices on drugs (someone has to pay below the average price, after all), and they often struggle to get cheap loans when buying expensive inventory before they can resell it to patients.

Dr. John Powderly, 43, who runs his one-doctor Carolina BioOncology Institute in Huntersville, N.C., says he was struggling even before the sequester cuts hit—juggling multiple credit cards, taking on outside consulting work for extra income, postponing his student-loan payments, and scaling back his workforce from 12 to nine employees in recent years. "When you go to the medical meetings, the discussions around dessert are not, 'What's the latest cancer treatment?' " he says. "It's, 'How much longer can you survive?' " Additional cuts could spell bankruptcy for his small practice.

Meanwhile, another government program has made chemotherapy a booming business for many nonprofit hospitals. Designed to help facilities that treat poor and uninsured patients, it gives eligible hospitals steep discounts on drugs they buy for in-house pharmacies. And the hospitals don't have to pass those savings along—meaning that, while they might get a chemotherapy drug for 30 percent below the average sales price, Medicare will still pay the normal fee (plus the markup) for every patient. To take advantage, hospitals in the program are now hiring oncologists and offering cancer services, because chemotherapy drugs tend to be the most expensive—and, therefore, the most profitable—drugs in the pharmacy. And independent oncology practices have been merging with hospitals at a steady clip. In addition, Medicare pays more for cancer care in a hospital than it does at a clinic, meaning the confluence of policies may actually be driving up Medicare's costs, even as it cuts oncologists' reimbursements.

The president's proposal is designed to squeeze excess cost out of the cancer-drug system while still protecting vulnerable providers. While it would reduce the margin on cancer drugs from 6 percent to 3 percent, it would allow the Health and Human Services secretary to make exceptions for smaller practices that would otherwise struggle to survive. Still, the overall payment scheme remains the same, encouraging the use of the most expensive drugs in the most expensive settings. That may not be the best thing for oncologists or patients—or the Medicare budget. ■