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Letters to the Editor

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LETTERS TO THE EDITOR

In Defense of the ABMT/NCI Trials

I read Lee Mortenson's editorial on ABMT NCI trials (see the Winter 1991 issue) and, to use his own assessment, I did find it cynical as well as rather narrow-focused. Though specific criteria were not set out, the implication is that we already know exactly who qualifies for ABMT in breast cancer and that we have the optimum recipe for treatment, and know that the outcome in terms of survival and quality of life is clearly worth the cost morbidity and mortality. Mr. Mortenson certainly must know something that I don't know, since I don't think any of these cardinal features are pinned down at all.

The other premise seems to be that the Blue plans somehow have a vast reserve of money that they can print up at any time and that the cost is only $100,000 per transplant. (The last one of my patients was charged over $250,000 at Johns Hopkins.) Using that adjustment, Mr. Mortenson's figure of 6,000 ABMTs comes out to a cool $10 billion per year. Let's do take that into the public square, because that's the square that's got to pay for this. The Blue Cross and private health insurance system is already at the limit of what they can do and the main reason for Mr. Mortenson's gripe is the lack of Federal funding for biomedical research. The reason the Blues have lost in the courts is the inability of judges and juries in a specific individual case, for example, Mary Smith cachectic and in tears in the back of the court room, to deny her even a shred of hope.

As I mentioned above, the real problem here is with the tight Federal budget and constraints on funding of clinical research. The Blues, over the years, have, on balance, done an outstanding job in supporting shortfalls in research (for example, when you consider chemotherapy, it must be that 95 percent of oncologic drug use is "off label"). But now we are talking big bucks and we need big help and a thoughtful approach to the problem—*Charles P. Duvall, M.D., Chairman, Board of Trustees, Blue Cross and Blue Shield of the National Capital Area, Washington, DC.*

Editor's Response: *The article in this issue by Ted Wieseman clearly documents the effectiveness of ABMT for breast cancer. This is particularly evident in the second article which presents indepth testimony from a recent Baltimore suit in which expert witnesses presented data on total remissions, disease-free-survival, and improvements in quality of life.*

Coding Inconsistencies

I was intrigued by the "Letter to the Editor' in the Fall 1990 issue of the journal, entitled "A Different View of Coding." As a small firm specializing in cancer-related reimbursement, we have sat across the negotiation table with many of Dr. Egger's counterparts and their reimbursement managers. It has become very apparent that the level of education of the third-party payors is severely lacking in the area of modern day cancer treatment.

Not only are correct codes being denied, some carriers have refused to pay any chemotherapy-related charges and view all cancer therapy as "experimental." The inconsistencies in code recognition from state to state and even within a single state cause setbacks in the forward movement of bringing cancer therapy "out of the closet." While the technology in administering cancer medicines has surged ahead, the payors are being dragged kicking and screaming into the present to allow for patient access to acceptable cancer treatment. These inconsistencies further discriminate against the cancer patient by dictating who can receive treatment and where.

When a cost analysis is completed, insurers, especially Medicare, will realize the more therapy done outside of the inpatient setting, the more health care dollars saved. Isn't it past time the providers of care, the payors of care, and the patients receiving the care reach an honest consensus about present and future trends in cancer therapy and keep cancer treatments out of the closet? This major issue will make or break the future of office and outpatient-based cancer treatment.—*Kim R. Johnson, Senior Consultant, Neltner Billing & Consulting, Inc., Tigard, OR.* ■

ASSOCIATION NEWS

ACS Endorses ACCC's Uniform Legislation

At a March meeting, the Public Issues Committee of the American Cancer Society (ACS) formally endorsed the Association's attempts to enact uniform state legislation to ensure adequate reimbursement for state-of-the-art cancer therapies. Local chapters of the ACS will be working with the ACCC and other interested state-level organizations to promote enactment of the legislation in a number of states.

The ACCC's uniform legislation will mandate that insurance plans meet the following minimum standards:

- Coverage for any drug or biological approved by the FDA and selected by a physician.
- Coverage for all FDA-approved drugs for all indications listed on the drug label and all indications listed in the following authoritative medical references:
  - The *U.S. Pharmacopeia Drug Information for the Health Care Professional (USPDI)*
  - The American Medical Association's *Drug Evaluations (AMA DE)*
  - The American Society of Hospital Pharmacists' *American Hospital Formulary Service Drug Information (AHFS-DI)*
- Coverage for all drugs or biologicals established by appropriate, peer-reviewed scientific literature.
- Coverage of medically necessary services associated with the administration of a drug that is deemed appropriate treatment under the legislation.

The legislation will also create a panel of physician specialists who will advise the state insurance commissioner of new drugs and indications as they become "accepted medical practice."

ACCC Publishes Reimbursement Aid for Cancer Patients

The ACCC has published a brochure, *Cancer Treatments Your Insurance Should Cover: Information for Patients and Their Families*, to be distributed to