Brown Bagging Chemotherapy Drugs

A sack full of problems: Brown bagging is giving private practitioners headaches.

by Astara March

The practice of "brown bagging" chemotherapy drugs is a growing problem for independent oncologists in several areas of the country. The term was coined to describe what happens when 1) an insurance company finds an inexpensive wholesale supplier of oncology drugs, 2) has the supplier ship the drugs to pharmacies near the company's subscribers, and 3) requires its subscribers to pick up the drugs themselves and take them to their oncologist's office in a "brown bag" for infusion. Many oncologists say brown bagging creates so many quality control and patient care problems it should be completely abandoned. In response, insurance companies have developed several brown bagging strategies that address physician concerns, but allow insurance companies to keep their profits.

- **Scenario One** The first scenario gave brown bagging its name. An insurance company finds a supplier with good wholesale prices and asks it to send unmixed chemotherapy drugs to pharmacies near the company's oncology patients. Patients must pick up their drugs from the pharmacy, keep them refrigerated at home, and transport them to their oncologist's office when it is time for an infusion. Temperature-buffering containers are usually not supplied. Since chemotherapy drugs can become denatured in hot weather or precipitate in cold weather, this lack of protection means that the drug's potency can be severely damaged during the trip from the pharmacy to the patient's home. If the trip goes well, the patient still may not place the drug in the refrigerator promptly. Finally, since the drug cannot be mixed until the patient reaches the oncologist's office, brown bag patients have longer infusion times than patients whose chemotherapy solutions can be prepared before their appointment.
- **Scenario Two** The supplier sends chemotherapy drugs directly to the patient by courier, with no guarantee of how the drugs are handled in the process or when they will be delivered. Sometimes the package is left on the patient's doorstep, regardless of the weather.
- **Scenario Three** The patient goes to the oncologist's office for a blood count the day before an infusion is scheduled. If the count shows that the patient can tolerate treatment, the physician orders the chemotherapy drugs from a pharmacy designated by the insurance company. The drugs are couriered to the office the next day. Patients must make an extra trip, and there is no guarantee that the drugs will arrive at the office in time for the appointment or that they will arrive in good shape, since there is no way to tell how they were cared for during transport.
- **Scenario Four** The patient goes to an oncologist who performs an examination and writes a prescription for chemotherapy. The prescription is filled by the insurance company through its preferred supplier, and a nurse hired by the insurance company comes to the patient's home to infuse the drugs.
- **Scenario Five** The fifth scenario is an offer to replace drugs taken from the oncologist's office supply with drugs from the insurer's preferred supplier. The oncologist's drug preferences are not honored, and the payer usually does not ensure adequate expiration dates or compensate the practice for the extra bookkeeping required to maintain a separate drug inventory for one insurance company.
- **Scenario Six** Insurance companies allow oncologists to purchase chemotherapy drugs themselves, but insist that they use a designated manufacturer. If physicians want to use another manufacturer they may, but their practice will be reimbursed at the discount rate of the designated manufacturer, no matter what the preferred drug costs.

Oncologists around the country have been extremely vocal in their objections to any of these scenarios. In some states (Virginia, Maryland, Illinois) physicians have successfully discouraged insurance companies from using brown bagging in their area, usually through united action and strong objections. Other states (south Florida) have not taken united action and are saddled with the process for the time being. Rhode Island is an interim area. Brown bagging is practiced in Rhode Island, but is currently not mandatory, despite plans by carriers to contract with a large pharmacy chain to help them implement the practice. Missouri, Arizona, New York, Massachusetts, North Dakota, Minnesota, and Alabama are not affected, and there has been uneven success in eliminating brown bagging in California.

The oncologists interviewed for this article were all concerned about the same issues when brown bagging was mentioned: quality

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control, liability, the negative impact of the process on patient care, their patients' quality of life, and what the loss of drug mark-ups would mean to the survival of their practice.

QUALITY CONTROL

"Ordinarily, pharmacists obtain chemotherapy drugs in standard sizes and dilute them into standard concentrations for safety," said Patrick Parker, director of pharmacy and IV therapy at Lawrence Memorial Hospital in Lawrence, Kans., and an assistant clinical professor at the University of Kansas School of Pharmacy. "Insurance companies that practice brown bagging may choose another vial size, another diluent, or another volume, which adds several extra steps to the procedure. Extra steps mean extra confusion, and extra confusion means more risk."

Many oncologists we interviewed thought the only way to solve brown bagging's quality control problems was to have insurance companies start their own infusion centers. Physicians could see no other way to ensure sterility and proper dilution, eliminate the possibility of denaturing or precipitation from temperature changes, or prevent wrong dosing that could lead to ineffective or lethally toxic drug levels.

Oncologists' concerns began with the drug suppliers. Most oncologists investigate their suppliers to make sure they prepare unmixed chemotherapy drugs under laminar flow hoods, prepare them at the correct temperatures, and use drugs that have not reached their expiration date. In the rare instance that a supplier mixes pharmaceuticals for an oncologist, the physician makes sure that the drugs are diluted at the appropriate time before shipment so they will still be potent when the patient arrives. If brown bagging becomes a common practice, many of the oncologists we interviewed would have no control over their suppliers, and would lose patients if they objected to receiving drugs from a supply house that did not meet their personal standards.

If the drugs are mixed by a local pharmacy, another set of worries is introduced. Most pharmacies do not handle substances as temperature sensitive or potentially dangerous as chemotherapy drugs (which the Environmental Protection Agency [EPA] labels toxic waste once they are in solution); and most pharmacists do not have the special training required to work with chemotherapy drugs. Some insurers have tried to solve this problem by asking pharmacies to create special facilities to dispense chemotherapy drugs (along the lines of CVS's Procare pharmacies that supply AIDS drugs). Still, oncologists would have to rely on insurers to police such establishments and guarantee that their state's Board of Pharmacy standards were being met.

Using any sort of commercial courier service to transport drugs from the supplier to the pharmacy, or from the pharmacy to the oncologist's office, raises questions about temperature control during transit, transit time, and delivery procedures. Does the courier service understand the necessity for temperature-buffering containers and will it use them? If the oncologist's office is closed for lunch, will the courier make sure the drug is promptly refrigerated until it can be delivered? Will couriers interrupt their schedule to bring the drug back to the oncologist's office when the office reopens, or make sure the drug is properly stored if delivery must wait until the following day?

If the patient becomes the courier, the problems may be compounded. Certainly patients are highly motivated to protect their own drugs; but what if they live in a rural area and the pharmacy is an hour away by car? What if an emergency greets them on their arrival home and the drug is forgotten on the hall table for several hours? Will patients tell the oncologist about their mistake, or be too embarrassed to admit it? Who is liable if the patient's child or pet opens the package and is poisoned, or the drug is spilled on the patient's floor?

Oncologists say they are being asked to take responsibility for drugs they cannot control and which could kill their patients if mixed, stored, or delivered incorrectly. Since it is impossible to tell if chemotherapy drugs have been denatured or compounded improperly by looking at them, the only way to make sure the drugs are safe is to be there when they are mixed.

Unfortunately, even insurer-run infusion centers cannot eliminate quality control problems. If oncologists are not on site to supervise treatment, they fear for their patient's safety.

"Chemotherapy is a potentially dangerous and highly technical procedure from start to finish—from ordering to administration—and can't be done outside the supervision of a physician/nurse team," said John E. Feldmann, M.D., F.A.C.P., of the Cancer Center of Southern Alabama in Mobile, Ala. "There isn't a week that goes by where an unexpected patient reaction doesn't occur that requires immediate medical intervention. Giving chemotherapy is not a simple process, and requires a highly coordinated effort between physicians and oncology nurses," he said. Feldmann and other oncologists said that they could not vouch for the level of training or the safety of procedures at an outside infusion center and could not provide or oversee emergency care if a problem occurred.

Feldmann said that his practice consists of three medical oncologists, three radiation oncologists, and seven chemo-certified nurses. A medical oncologist is always present when chemotherapy is given, and the nurses work in teams of three: two treating patients and one only mixing so her concentration is not broken by patient demands. Infusions are given seven days a week. Feldmann believes it would be impossible to duplicate that high level of care in an insurance-run facility and did not want his patients to have anything less.

"The only thing I like in brown bags is lunch," said Ralph Levitt, M.D., of the Meritcare Medical Group-Roger Maris Cancer Center in Fargo, N.D., and president of the Dakotas Oncology Society. "The whole concept is ridiculous. Chemotherapy has no standard doses. It's not like Benadryl®, where you prescribe a predetermined amount for an average adult. Each dose must be compounded according to the patient's height, weight, and physical condition. In the best of circumstances there will still be a small number of errors. We can catch those errors, but only

if the quality control is done at the point of service.

"Quality control problems can create havoc in how you interpret a patient's response to therapy. Have they progressed because the drug doesn't affect their disease or because it was frozen in transit, contaminated, mixed incorrectly, or the dose was wrong?"

Levitt practices in a multispecialty group of 350 that includes seven medical oncologists and three radiation oncologists. The practice has its own pharmacy on the premises.

HAVING TIME TO SMELL THE ROSES: QUALITY OF LIFE

A cancer patient's existence is both a roller coaster and an obstacle course. Another errand or appointment makes life even harder, as does the strain of safeguarding a dangerous drug in an unpredictable setting. Longer infusion times are burdensome for both patient and oncologist, and unreliable couriers can wreck havoc with patient scheduling and the timing of chemotherapy protocols. Even if insurer-run infusion centers were established, the patient's doctor would not have privileges there, which would break continuity of care.

Although some physicians we interviewed thought patients should become activists on their own behalf and confront insurance companies about brown bagging, political activism is usually not on most cancer patients' list of non-stressful activities, no matter how potentially empowering it might be.

KEEPING THE OFFICE FINANCIALLY HEALTHY

Economic issues are central to any discussion of brown bagging. Since insurance companies do not reimburse providers for the cost of administering chemotherapy, the profit made on drug mark-ups is a mainstay of most private practices. The Health Care Financing Administration (HCFA) has determined that each chemotherapy administration costs about $200—a number that many oncologists think is too low. This amount covers the nurse's time, the cost of the facility, billing costs, the time and equipment needed to properly store the drugs, the costs of adjunctive treatments such as heparin line flushes, and the large inventory of materials chemotherapy requires including the drugs themselves, anti-nausea compounds, and IV fluids and tubing. Since providers receive from one-quarter to one-third of that $200 from insurance companies, there is a significant shortfall, which has been partially filled by drug mark-ups. If that profit is taken away and the expense of longer treatments is added, many practices would be forced to close.

"Most of us feel uncomfortable about making profits on drugs," said James T. May III, M.D., F.A.C.P., of Columbia Chippenham/Johnston-Willis Hospitals, Inc. in Richmond, Va. and president of the Virginia Association of Hematologists/Oncologists, "but until we are paid what it costs us to administer chemotherapy infusions, we have to depend on those profits if we want to keep our office open. If I mix the drug, I want our office to get paid for the time and equipment it takes to do that.

"Third-party payers need to triple our reimbursement for infusion services. Medicare can't do that without taking the money from other programs, and those other doctors will scream bloody murder."

Every physician we interviewed remarked that if the insurance companies thought they were going to save money by practicing brown bagging, they were mistaken.

"The wastage is tremendous," said Thomas Marsland, M.D., of Florida Oncology near Jacksonville and president of the Florida Society of Clinical Oncology. "One of my colleagues says he actually does better with brown bagging in south Florida because he gets a lot of drugs for free. If the company delivers two months of drugs for patient X and patient X dies, the company, by law, can't ask for the drugs back." South Florida has one of the largest populations of people over age 65 in the country, with Pennsylvania in second place.

Joseph DiBenedetto, Jr., M.D., F.A.C.P., of Oncology Hematology Associates in Providence, R.I., and president of the Society of Rhode Island Clinical Oncologists, explained that if patients pick up their drugs from the pharmacy on the day before treatment, and then are unable to use them because their counts are low or their cancer has progressed and the regimen is abandoned, the drugs are usually thrown out. Many insurance companies consider the drugs the patient's personal property and will not allow oncologists to store them or use them for anyone else. Also, once some chemotherapy drugs are mixed, they must be used immediately or discarded. If patients arrive with a pre-mixed drug and then cannot use it because their counts have nosedived, the drug (metaphorically) goes down the drain.

Many chemotherapy drugs come in multi-dose vials. For instance, a vial of Herceptin® contains 440 mg of the drug. According to Edward L. Braud, M.D., F.A.C.P., of the Springfield Clinic in Springfield, Ill., if the patient only needs 200 mg, the rest will go to waste. Likewise, G-CSF comes in ten-vial packs. If the patient only needs five vials and the remaining five cannot be used for another patient, they are discarded.

Santo Di Fino, M.D., F.A.C.P.,

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of Hematology Oncology of Central New York in Syracuse, suggested that if insurers really want to save money on drugs, they should insist that physicians order their pharmaceuticals directly from the manufacturer and cut out the middle mark-up.

JUST SAY NO! HOW TO TAKE ACTION

"The only way insurance companies will listen is if patients complain—not physicians, physician organizations, or physician management groups," said DiFino, who believes patients should actively oppose brown bagging.

Nevertheless, several states have defeated brown bag plans, and the physicians who participated urge others to follow suit. Braud said that five years ago, Humana of Illinois suggested that chemo drugs be mixed at an outside pharmacy, shipped to the patient's home, and brought to the office by the patient. Braud remarked that the plan was "put together by a low-level employee who had no idea of the medical issues involved." Doctors in Illinois vehemently objected, explained the risks to Humana, and the plan was dropped. Although Braud said that his practice in central Illinois was too small to carry much clout with insurers, when he banded together with physicians from the five teaching hospitals in Chicago and others around the state, they carried their point. Braud said that Illinois physicians presently tolerate the brown bagging of the recombinant biologics (G-CSF, GM-CSF, Procrit®, Leukine®, interferon, Neumega®, and Neupogen®), but "are not happy about it."

Group action seems to be the key. Marsland said that brown bagging is a fact of life in south Florida because the community is extremely competitive and practitioners do not work together. When insurance companies told physicians that their contracts would be cancelled if they didn't comply with proposed brown bagging plans, Marsland said that everyone was so frightened of losing their business they agreed to whatever the insurance companies demanded. South Florida insurers are now trying to float a pilot project on brown bagging the recombinant biologics.

May said that one third-party

Trouble in Texas

Judy R. Stone, administrator and chief operating officer of Texas Cancer Associates, L.L.P, an independent private practice in Dallas, has had multiple difficulties with the Prudential/Aetna insurance company and its policies surrounding injectable drugs (primarily Procrit® and Neupogen®). Although Prudential and Aetna have combined to form one commercial entity, each side has its own way of working with providers.

Last year, when Stone's senior referral coordinator called Prudential to get a pre-cert for a Procrit shot, she was asked whether the practice was part of a well-known nationwide oncology organization. When she said no, the Prudential representative told her that Texas Cancer Associates would no longer be allowed to use injectable drugs it had purchased itself. Instead, the practice had to order Procrit and any of the other injectables (Neupogen®, Lupron Depot®, Zoladex®, interferon, and Lovenox®) exclusively from Chronimed, Prudential's pharmacy of choice.

Stone had not been notified of the change in drug ordering procedures and said she was angry at being presented with a *fait accompli* instead of being given an opportunity to negotiate. She realized that what Prudential had actually told her was that it was allowing physicians associated with the large network to give patients drugs from their office stock whenever the drug was needed (which is appropriate patient care); but patients seen by her group had to wait to be treated, which endangered their health.

Calls to Prudential brought no response, but Stone eventually met with an Aetna medical director. He said that the Prudential side of the company would not be expanding operations and might even cut back provider panels, so she should not expect much change in drug ordering procedures. He assured Stone he would pass her concerns along and someone would call her, but no one ever did. Stone interpreted the medical director's statement and the company's lack of response as a possible warning from Prudential not to rock the boat unless she wanted to find the physicians in her practice "non-renewed" for the Prudential panel.

Texas Cancer Associates then contacted Aetna about its injectable drug policy to see if it was the same as Prudential's. Aetna told the practice that, although it didn't have to use a designated drug provider, Aetna would reimburse the practice only at the designated provider's rates. When Stone asked what those rates were, she was told the information was not available. The practice was also told that Aetna preferred patients to self-inject these medications so the company didn't have to pay for daily or weekly office visits.

MULTIPLE CONCERNS

Stone is worried for a variety of reasons. "We are asked to take on liability for patient care using drugs over which we have no control," said Stone. "Self-injected Neupogen is an excellent case in point. It is highly temperature sensitive and may be ruined if not properly stored. If the drug *is* ruined and the patient injects it later, it will do the patient no good and, conceivably, the patient could become septic and die as a result.

"In addition, if the patient doesn't understand or follow the dosing directions, doesn't inject correctly using aseptic technique, or delays the dose, there are risk issues for the practice, but bigger risks for the patient. Even having to wait to start the drug until it arrives from the supplier can jeopardize the patient's health.

"Insurers who place us at risk for the consequences of improper self-injections, or make us use drugs from a source not of our choosing, put *all* our patients at risk. One lawsuit resulting from the death of a patient for any of these reasons could put our practice in jeopardy, even though the

insurer gave us no choice about the circumstances that led to the patient's injury."

Stone also said that Prudential's injectable policy increases practice costs while potentially decreasing her patients' quality of life.

"If we get an injectable from their supplier, we have to make a separate call to order the drug. We still have to get a referral and get the dose pre-certified, but in addition we must wait one to several days for the drug to arrive instead of pulling it from our stock and giving it to the patient the moment we learn they need it. The patient must also make a special trip for the injection.

"Prudential's supplier sends the drug in a different shipment than my regular drug order, so we have to log in an extra box with a separate packing slip that must be filed in the patient's chart. The Prudential drug must be loaded into the inventory management system differently so it doesn't hit our practice billing.

"When we give the injection we have to pay for the syringe, the nurse's time, the pharmacy technician's time, the file clerk's time, and the time of the referral coordinator who made the calls to order the drug, get the referral, and get the pre-certification. Since the only code we can bill covers the nurse's visit (even the injection code is bundled with the nurse's visit!), we get about $12 to $15 for all that work, *and all that risk*. You can imagine what our malpractice carrier says. Somehow we have to make the insurers understand that they potentially endanger all our patients. It's just poor patient care."

Stone and her associates say they have "Explanations Of Benefits" from Prudential denying reimbursement for injectables purchased and given by her office.

PRUDENTIAL/AETNA RESPONDS

Walt Cherniak, Aetna's media relations manager, gave us the following statement.

"This characterization of Aetna's policy toward injectable chemotherapy drugs is simply incorrect.

"Aetna does have contracts with Chronimed, Priority Healthcare, and Nova Factor to obtain chemotherapy drugs at a discount, in most cases via overnight shipment. These vendors ship the drugs directly to the physician's office and bill Aetna directly. Oncologists are in no way required to use these vendors. They are free to purchase chemotherapy drugs from any vendor they choose.

"However, Aetna will reimburse oncologists for those drugs at the contracted rate. Prescription drug costs have been soaring over the past few years, and chemotherapy drugs in particular can be very expensive. It would be irresponsible for Aetna to ask its employer customers to pay more than the best available price for these drugs.

"Using the contracted vendors also simplifies administration for physicians, because they do not have to make the initial cash outlays to purchase the drugs and do not have to submit claims to be paid for them.

"Similarly, the suggestion that Aetna 'requires' patients to inject themselves with chemotherapy is absurd. Aetna does encourage patients to gradually become more comfortable giving themselves injections, much as many diabetics [do]. But any patient who is uncomfortable with the process can go to a physician's office as frequently as necessary to have the drugs administered, and Aetna will cover the office visit.

"Patient safety is Aetna's primary consideration in these cases. Some patients can easily understand the directions and prefer to self-medicate, saving them the inconvenience of traveling back and forth to a physician's office. Others are less comfortable, and prefer to have others administer the injections. Aetna makes provisions for both groups."

After reading Aetna's statement, Texas Cancer Associates replied that, since the problems Aetna mentioned were with the Prudential side of the organization not the Aetna side, the practice's concerns had not been addressed.

Cherniak's response was that, "Aetna's and Prudential's policies are identical."

carrier in Virginia tried to make his organization approve Scenario Four, where the insurance company supplies the drugs and hires a nurse to infuse them in the patient's home. May and his colleagues insisted that the trial run occur in their office, and May said it was a "fiasco." The drug arrived 72 hours late. The nurse had no oncology training and was taught how to operate the pump by May's staff. May and his colleagues told the carrier that they refused to even consider making this form of brown bagging part of their treatment plan, and would turn away the carrier's patients if the company did not abandon the idea.

"The carrier is a very, very tough customer," May said, "but I think they quickly realized that this was a non-starter. The incremental savings they might enjoy from getting a bulk wholesaler would be eliminated by just one lawsuit, which would undoubtedly ask for seven or eight figures. This wasn't a nasty fight; we simply sent them a letter saying that if they went ahead we wouldn't participate with them, and they backed off—at least for the moment. Their reimbursement in Virginia is pretty low, so they probably don't feel the need to push it."

Although the carrier's plan was backed by the oncology department at the Medical College of Virginia, cooperative action on the part of other Virginia physicians has so far kept brown bagging out of the area.

Cary Presant, M.D., F.A.C.P., of the California Cancer Medical Center in Los Angeles, and president of the Medical Oncology Association of Southern California, said his group successfully negotiated with a powerful California HMO and does not have to brown bag, although other practices weren't so lucky. "We found a drug supplier for our practice who was reputable and allowed us to offer prices similar to those the HMO's supplier was using. The HMO was afraid we abused the drugs because we made a profit on them. We convinced them that this was not so and told them we would keep strict accounts, which they could oversee if they liked. We also told them that they would have to pay us a large facility fee to cover bookkeeping costs if we had

to use their drugs, and put a 'hold harmless' clause in our contract. Now we talk to the HMO more often and have some extra accounting to do, but we still run our own shop."

Presant said the people to negotiate with inside an HMO are the administrative director, the medical director, and the director of the pharmacy. He thinks the keys to his practice's success were good homework, a hard line, and positioning the oncologists on the same side as the HMO on the issues of utilization and pricing, which they now watchdog together.

DiFino thought a national independent physician's association (IPA) for oncologists would help. Doctors cannot unionize and DiFino said the AMA membership is too diversified to make a united front on this issue. A national IPA, said DiFino, would keep one part of the country from bearing the burden of a bad practice while another went free.

James B. Albertson III, J.D., C.P.A., F.H.F.M.A., a consultant who specializes in health care reimbursement, has a special interest in brown bagging and suggested the following strategies when negotiating with an insurer who insists on using one of the brown bagging practices.

First, bring up the patient care issues that make you oppose the insurer's decision. If the company is not interested in patient care concerns, stress the liability issues you face when dispensing drugs over which you have no control. Insist that the payer insert an indemnity/hold harmless clause in the provider agreement, and make sure the clause states that your practice will be reimbursed for all litigation costs that may occur from claims stemming from the brown bag drug in question. Albertson said that if physicians say they will not sign the contract without this clause, the payer may drop its demand for brown bagging.

The second strategy is to request higher rates for the 96400 series codes. In other words, the administrative code increase is the *quid pro quo* for the lower AWP. Albertson, who is director of integration services for ProSTAT Resource Group, has provided a revised schedule of payments and a sample hold harmless clause to assist providers in their negotiations (see "Playing Hardball with the Insurers"). For a copy of the hold harmless clause, contact ACCC at writer@accc-cancer.org.

The only legislative action taken on brown bagging the ACCC is aware of occurred in Maryland. Two bills were presented to the state legislature in 1998 and 1999 (S.B. 643 and H.B. 280, respectively) promoting the scenario where insurers pay for providers' drugs only at the discount prices offered by their special suppliers. Although both bills were signed by the governor, determined action on the part of oncologists led by Peter Graze, M.D., defeated the measures, which were never passed into law.

THE INSURERS SPEAK, BUT THE GOVERNMENT DOESN'T

Oncology Issues attempted to conduct a number of interviews with insurers around the country, including the insurers specifically mentioned in this article. Trigon Blue Cross/Blue Shield, Kaiser Permanente, and the American Association of Health Plans refused to be interviewed.

When we spoke to CareFirst Blue Cross/Blue Shield in Washington, D.C., Michelle DeFoe, media relations specialist, made the following statement for her organization. "When brown bagging was discussed by CareFirst physicians, they decided against it because chemotherapy drugs are so unstable and temperature sensitive the physicians felt the transportation process should not be left up to our members."

Richard Nissenbaum, director of pharmacy management and staff models for Humana in Florida, told *Oncology Issues* that Humana's brown bagging system (begun in 1994) works. Humana operates 21 pharmacies in south and south central Florida, but chemotherapy drugs are dispensed only from two sites in Tampa and one in Ft. Lauderdale where laminar flow hoods are installed. The company makes sure its pharmacists are trained to handle and mix chemotherapy drugs by having them attend continuing education courses on the subject and sending them for instruction to the H. Lee Moffitt Cancer Center and Research Institute in Tampa.

Humana offers participating physicians two options. Humana will either replace the drugs a physician uses for a particular patient with the physician's choice of unmixed pharmaceuticals (and pay the physician for doing the mixing), or it will send mixed drugs to the physician's office. The second practice is employed only if the patient's appointment time is stable. In both cases, Humana provides tubing, syringes, and other administration equipment, and pays administration costs.

Nissenbaum said that Humana's pharmacies operate under strictly sterile conditions. Chemotherapy drugs are transported in Styrofoam containers with refrigerants (if necessary), and mixed drugs are delivered well before they lose their potency.

"Initially, all the physicians wanted to mix the drugs themselves. Now some do and some don't. We had a lot of complaints about the economic issues, but now practices realize that when they don't have to submit a claim and wait for reimbursement or put out any of their own cash, they don't lose revenue. We haven't had any complaints about the program since a few months after it started, and we've never had complaints about our service."

As for the federal government, *Oncology Issues* called six offices in the Food and Drug Administration. No one contacted had heard of brown bagging, and all said they could not comment.

ACCC WANTS TO HELP

If brown bagging is allowed to take hold in the U.S. medical system, it will leave a string of preventable tragedies in its wake. Firm stands by oncologists, assistance from the government and the media, and united efforts on the part of local and regional medical organizations will help eliminate the practice.

The Association of Community Cancer Centers (ACCC) has joined oncologists in opposing brown bagging attempts in several states, and continues to question the merits of a system that puts profit before quality patient care. ACCC will be happy to help private oncologists form coalitions to fight this practice in the future.