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EDITORIAL

Coils and Cash: What Coil Vendors Don't Want You to Know

My problem lies in reconciling my gross habits with my net income.

Errol Flynn

Until the introduction of coils by Micrus (San Jose, Calif) to the market in 2000, Boston Scientific (Natick, Mass) had a detachable coil monopoly. Since then, Cordis (Miami Lakes, Fla), MicroVention (Alisa Viejo, Calif), ev3 (Irvine, Calif), and Cook (Bloomington, Ind) have entered the market. Despite a large increase in competition in the marketplace, detachable coil prices have continued to rise. Perhaps the single largest contributor to coil cost escalation is that physicians are generally not sensitive to device pricing because their salary and resources have not been directly related to hospital costs. Physicians thus have tended to choose coils with little regard to cost. We now have coils on the market ranging in list price from \$500 to \$3000.

Many diseases can be treated with a single device, such as an arterial stenosis, which is treated with a single stent. However, cerebral aneurysms are unusual in that we generally need several expensive coils to treat a single aneurysm, and adding a stent for cerebral aneurysm treatment, which costs \$5200 to \$5300 each, makes the coils look cheap. In a recent study, it was shown that the hospital costs for coiling an aneurysm at a single center in the United States were *one-third higher* than the costs for clipping, largely because several coils cost much more than a single clip.¹ Stents under development to treat aneurysms by flow diversion are likely to take the costs even higher. This cost escalation is not sustainable in a new era of containment of medical care costs. In the current recession, many hospitals are suffering financially, with some even closing.² We physicians are going to be under increasing pressure to decrease costs. We need to help get control of device costs ourselves, because if we cannot regulate our own spending, health care administrators will probably ultimately step in and regulate it for us. Our salaries and resources may not remain disconnected from device expenses forever.

Physicians generally want what is best for the patient, which may in large part explain why we so willingly adopt new devices on the basis of only theoretic benefit and without regard to cost. Medicolegal paranoia also adds to the willingness of physicians to participate in this cost escalation. When “biologically active” coils were introduced to the market, many physicians were worried that they might be accused of malpractice for not using the “latest technology.” This medicolegal concern was widespread, even though there was no proof of benefit with these coils, and, in fact, these coils were brought to market as being “substantially equivalent” to platinum coils. Now that the “biologically active” coil hype cycle has run its course,³ we neurointerventionalists should face up to the fact that we spent millions of health care dollars and got no proved benefit in return.

Physicians will also buy new coils because they are afraid of being left behind if they do not embrace the latest technology. This is an understandable perspective, but rarely do any of the new coils represent a major technical advance. With time, there has been so much proliferation of subtle variations of coils that I no longer have time to listen to all of the hype and then try each one. With rare exception, my inclination now is to assume that each new coil is another “me too” product and then just wait to hear from an unbiased source if it actually seems to be of any particular added value.

Many neurointerventionalists are uninformed regarding the cost and reimbursement of medical devices. There seems to be a widespread misconception that when we use a coil, the hospital then charges for that coil and then the hospital gets reimbursed for that coil. In reality, that is not what happens for many, and perhaps most, of our patients. What often happens is that the third-party payers pay a limited amount for care of a patient with a specific problem. In 2008, the national average payment by Medicare for the entire hospitalization for the uncomplicated endovascular treatment of an unruptured aneurysm was \$12,599. Just the access materials (guide catheter, microcatheter, microguidewire, etc) cost at least \$1000. If you use 12 coils at \$1000 each or if you use a stent for \$5200 and 7 coils for \$1000 each, then you have spent more than the entire Medicare reimbursement on devices, and every other expense related to the hospitalization is a financial loss to the institution. It is easy to see that even more expensive coils would rapidly escalate the cost. Every time you coil an aneurysm, the vendor gets paid well for the devices used, but the physician and the hospital do not have any such guarantee of getting paid a fair price and may actually end up losing money after they have paid their bills.

Third-party payers have only so much money that they are willing to pay out for the treatment of each patient's cerebral aneurysm. This means that physicians and hospitals are directly competing with the medical-device industry for health care dollars that have been committed to treatment of these patients.

Neurointerventionalists and device-industry representatives love to talk about a partnership with each other. Occasionally, this partnership has something to do with research or device development. Much more often, the partnership translates into some arrangement in which the physician buys more coils. The typical neurointerventionalist spends much more time dining with and speaking with vendor representatives than with hospital representatives, and this works against the interest of hospitals. In the long run, it almost certainly works against the interest of physicians as well because we need constructive relationships with our hospitals if we are to prosper. If you are paying retail list prices for your coils, then I dare say that the only explanations that I can think of are that you are being played for a chump or you have a conflict of interest.

Physicians have not yet taken full advantage of the highly competitive market for endovascular devices, in which each vendor is struggling for market share. To a large extent, aneurysm coils are a commodity, and we physicians could let vendors know that we are paying attention to prices. Even if you are loyal to a particular vendor because you think the product is better, you should be able to use your loyalty in this com-

petitive market as a price negotiating advantage. I have started refocusing the discussion with vendors. I am telling each of them that I do not want to spend my valuable time talking about the theoretic advantages of introducing yet another \$1300+ coil to my practice, but instead I want to talk about *value*, which is a ratio of proven quality over cost. We can get proved quality from several vendors; so the question now is, which vendors can give us lower costs?

Partnering with our hospitals, we should be able to push vendors to give us the products that we want at competitive pricing. We need to make it clear to vendors that controlling device expenses is a priority and will be a central theme of our partnership with them in the future. If we do not, I suspect that

we will eventually find that hospitals can no longer afford to take care of our patients.

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