



BACKGROUND INFORMATION

Crisis of Cancer Care in the United States

Summary

- It is documented that the United States has the best cancer care delivery system in the world, in which most patients receive high-quality care in their own communities.
- However, the cancer care delivery system is now in first-stage crisis because Medicare has substantially cut payment for cancer drugs and essential services.
- The crisis will deepen as demand for cancer care is now starting to exceed the supply of oncologists.
- Healthcare reform needs to fix the problems with cancer care, not worsen it with further cuts or by using Medicare as the basis for a “public” insurance option.

U.S. Cancer Care Delivery System and Community Oncology

Overall, the United States has the best cancer care in the world. Data show that cancer patients live longer in the United States than anywhere else on the planet.

- American women have a 63% chance of living at least five years after a cancer diagnosis compared to 56% for European women.
- American men have a five-year survival rate of 66% compared to only 47% for European men.
- Among European countries, only Sweden has an overall survival rate for men of more than 60%. For women, only three European countries (Sweden, Belgium, and Switzerland) have an overall survival rate of more than 60 percent.
- For men in the United Kingdom, the survival rate is only 45% and for women, 53%. [1]

The evolution of the cancer care delivery system is an American success story. Community oncologists have transitioned cancer care from large academic institutions to local community settings. This has allowed cancer care to be shifted from inpatient to outpatient care, resulting in significant savings, and enabling patients to receive quality treatment in their communities, close to family and friends. Now 84% of Americans with cancer receive high quality accessible cancer care from community oncologists. Additionally, earlier diagnosis, more targeted therapies, and accessibility to quality cancer care at the hands of academically trained providers in the community setting have caused the cancer mortality rate to decline.

Community cancer clinics have developed an extremely effective and efficient system of

delivering patient-centric medical care. This involves just-in-time inventorying, preparing, and administering an array of chemotherapy, biological, and supportive care drugs so that treatment changes, which are typical in cancer care, can be made immediately. Additionally, many practices provide their patients with other essential services on site, such as diagnostic imaging.

For cancer patients, the community oncologist and clinical support team become the care coordinators in a highly effective and efficient delivery system. Earlier diagnosis, more targeted therapies, and accessibility to quality cancer care at the hands of academically trained providers in the community setting have caused the cancer mortality rate to decline.

Cancer Care Delivery System in the United States in First-Stage Crisis

However, the U.S. cancer care delivery system is now in the first stage of crisis. The Medicare Modernization Act of 2003 (MMA) made substantial changes to the way that Medicare reimburses for cancer care. Prior to the MMA, Medicare drug reimbursement subsidized the non-payment and under-payment of a variety of essential cancer treatment services, such as treatment planning. The MMA lowered Medicare drug reimbursement to acquisition cost based on Average Sales Price (ASP). However, new payment mechanisms were promised, but ultimately not created, to cover unreimbursed services. Instead, the Centers for Medicare and Medicaid Services (CMS) provided stopgap funding by implementing cancer care demonstration projects for two years, in 2005 and 2006. This stopgap funding expired at the end of 2006.

As a result, in many cases community oncologists are not fully reimbursed by Medicare for the costs they pay out of pocket to treat their patients with cancer drugs. Payment for essential cancer care services, such as treatment planning, are not reimbursed and payment for cancer drug administration has been cut on average by over 25%.

PricewaterhouseCoopers calculated that the magnitude of the MMA cuts to cancer care is \$14.7 billion from 2004-2013. This far exceeds Congressional intent by \$10.5 billion — the original Congressional Budget Office (CBO) estimate for the MMA was \$4.2 billion in cuts. [2]

Medicare is the single biggest payer. On average, Medicare covers about 45% of cancer patients. Because of its size, Medicare has inordinate influence on private insurers, which generally use the Medicare system as their basis for payment.

Community oncology clinics are small businesses that cannot maintain highly trained staff and specialized facilities to deliver chemotherapy and overall cancer care without remaining financially viable by receiving appropriate payment for services provided. The cost of doing business for a community oncology clinic is enormous and carries inordinate risk.

The average oncologist accounts for the use of approximately \$2.1 million in cancer drugs annually. [3] Because Medicare and private insurers provide payment an average of 30-90 days after complex reimbursement claims for drugs and services are submitted, community oncology clinics have to make a major at-risk investment to treat cancer patients. Well in advance of payment being received, very expensive drugs have to be purchased, inventoried, prepared, and administered, with significant costs also incurred in staff, materials, and infrastructure.

Community cancer clinics are increasingly cutting facilities, especially those serving rural areas. Many clinics have to cut staff or freeze hiring new staff to treat patients. Smaller clinics are struggling to operate and more are closing. Increasingly, Medicare seniors with no or inadequate secondary insurance cannot be treated in the oncology clinic and must be sent elsewhere.

This bifurcation of care results in inefficient, uncoordinated, poorer quality of care for distressed patients, and carries a greater risk of medical errors. With the financial crisis escalating, patients run the risk of falling through the cracks in not getting treatment. Thomson Reuters conducted a study earlier last year — *before the full impact of the financial crisis* — documenting that 12% of cancer patients were foregoing treatment (25% of patients with incomes \$40,000 or under were foregoing treatment). [4]

Second Stage of Crisis: Oncologist Shortage

The pool of oncologists is shrinking. Today, approximately 50% of the oncologists in the United States are over the age of 50. Moreover, the demand for cancer care is starting to outstrip the supply of oncologists. This will worsen each year so that by 2020 there will be an estimated deficit of up to 4,080 oncologists, which is a shortfall of one oncologist for every 1 in 3 cancer patients. [5]

It takes at least six additional years of training for a certified internist to become an entry-level oncologist. If we do not act now, we will have an oncology care crisis that will not be fixed over the short term.

Proposed Medicare Cuts Will Accelerate the Crisis

Now, the government wants to cut Medicare payment for cancer care even further — for example, the payment for the administration of chemotherapy will be cut by over 20%. Community oncology practices, which treat over 80% of Americans with cancer, need help — and certainly, cannot absorb any more cuts by Medicare.

Medicare and “Public” Insurance Option.

Certain health care reform proponents are proposing to create a “public” insurance option that is based on Medicare payment rates. Unfortunately, expansion of Medicare payment rates will force practices to cut staff and eventually close their doors. The influence of Medicare cannot be extended by using Medicare rates as the basis for payment under any “public” insurance option created by Congress. Medicare for cancer care first needs to be fixed.

Healthcare Reform Must Strengthen the Cancer Care Delivery System

Healthcare reform needs to fix the looming crisis in cancer care in the United States. Even with all our nation’s successes in diagnosis and treatment, cancer is still the second leading cause of death in America and is a large financial burden to the nation. On average, one American dies each minute from cancer. [6] As reported by the President’s Cancer Panel, “In effect, we are allowing a “bioterrorist within” to attack almost a million and a half Americans and kill more than 560,000 of us each year. With our population aging, these casualties will increase rapidly in the coming years, despite encouraging but small decreases in cancer mortality and longer survival for some patients.” [7]

We need to continue to improve our ability to fight cancer and fix the broken government payment system, to “*Fix Cancer Care; Don’t Break It Further.*” U.S. healthcare reform must not further accelerate the cancer care crisis by cutting Medicare payments to community oncology

clinics or using Medicare as the basis for a “public” insurance option. The costs in lives and medical costs will far outweigh any supposed short-term cost savings. As this country has unfortunately learned from the current financial crisis, trying to overcome the devastating impact of a full-blown crisis is substantially more expensive than averting it.

Solutions from Community Oncology Alliance

Community oncology has worked to provide specific solutions to evolving the payment system. House bill H.R. 3675 is a national demonstration project developed by oncologists and policy makers to transform the healthcare payment system. H.R. 1392 and Senate bill S. 1221 are identical bills that address problems related to drug reimbursement shortfalls.

- 1 US Cancer Care Is Number One, National Center for Policy Analysis, Brief Analysis No. 596, October 11, 2007.
- 2 Estimate of Savings to the Medicare Program from Payment Changes for Covered Oncology Outpatient Drugs and Biologicals Under the Medicare Modernization Act of 2003, PricewaterhouseCoopers, January 2007.
- 3 Data on file, Community Oncology Alliance.
- 4 The Cost of Cancer, Thomson Reuters, October 13, 2008.
- 5 Erikson et al: Future Supply and Demand for Oncologists: Challenges to Assuring Access to Oncology Services; Journal of Oncology Practice, 2:79-86, 2007.
- 6 Cancer Facts & Figures 2008, American Cancer Society.
- 7 Maximizing Our Nation's Investment in Cancer: Three Crucial Actions for America's Health, President's Cancer Panel, October 2008