



Community Oncology Alliance Statement on Health Care Reform

Patient Protection and Affordable Health Care Act of 2009 (H.R. 3590)
as amended by the
Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

April 2010

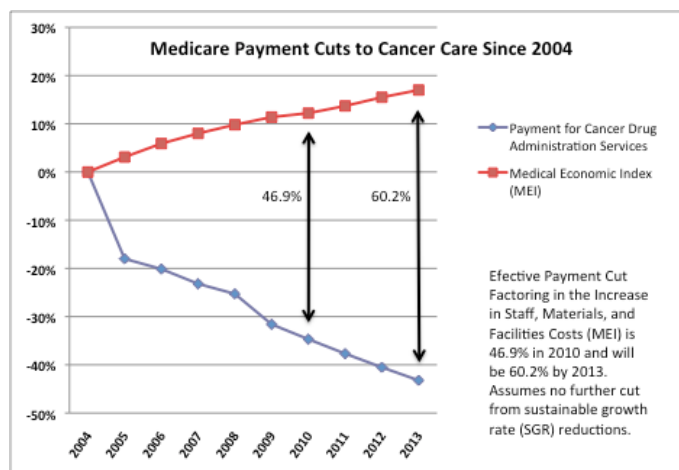
The Community Oncology Alliance (COA) believes that meaningful health care reform is essential for current and future generations of Americans, especially the increasing number of people with cancer. Health care reform legislation recently signed into law (“the law”) does contain important provisions that will help Americans. However, the law also includes provisions that will adversely affect the care of cancer patients — those Americans in active treatment, those surviving the disease, and those who will be diagnosed in the future. *On balance, COA is very concerned that health care reform has neglected to fix major problems that are eroding our nation’s cancer care delivery system.*

COA applauds measures to foster the prevention and early detection of cancer, especially by lowering barriers to affordable preventive health services. COA also supports the removal of lifetime caps on insurance coverage and insurer discrimination against pre-existing conditions. Lowering out-of-pocket costs of premiums and cost-sharing for individuals in need is an additional benefit of health care reform.

In terms of other positive aspects of the law, guaranteeing coverage for patients participating in clinical trials is critical to providing cancer patients access to the latest treatment advances. Clinical trials are vital in increasing our understanding of treating cancer and in fueling development of new therapies. We also note that the move to close the “donut hole,” as well as to provide Part D drug discounts, will be helpful to seniors covered by Medicare, especially those on oral cancer therapies.

On the surface, extending insurance coverage to an estimated 32 million Americans currently without coverage is an important aspect of the law. However, half of those newly covered individuals will be insured under Medicaid, which is a broken insurance system, especially relating to cancer care. Many states are now trying to rescue their Medicaid programs by drastically cutting provider reimbursement, in some cases significantly below rates paid by Medicare. Although the law will increase Medicaid reimbursement to primary care physicians, it neglected to do so for specialists. As a result, there will be access problems for all Medicaid patients seeking cancer care, especially those newly covered by the law.

Very significantly, the law totally neglected to fix an increasingly broken Medicare system. A mainstay treatment of cancer is drug therapy, which includes chemotherapy and related anti-cancer agents. Since 2004, Medicare reimbursement for drug administration services has been cut by 35%, which is an effective cut of 47% factoring in the increasing costs of operating a medical practice, as measured by the Medical Economic Index (MEI). The Centers for Medicare & Medicaid Services (CMS) will make additional payment reductions each year through 2013, when the cuts will total 43% or an effective cut of 60%. A recent study showed that in 2009 Medicare payment for drug administration services only covered 57% of costs. To put into perspective how



low Medicare reimbursement has fallen, the average payment for administering the second and any subsequent hour of infusible cancer drugs is only \$30.31. This payment is supposed to cover the costs of oncology nurse time, ancillary staff, materials, facility overhead, and billing. By 2013, CMS will cut reimbursement for this service to \$27.04.

The law also neglected to correct two important problems relating to coverage and payment for cancer drugs. First, it failed to address the problem of an excessive 20% Medicare copayment. This is an unrealistic burden for seniors with insufficient co-insurance and/or funds to cover out-of-pocket expenses. The Medicare 20% copayment requirement has a disparate impact on cancer care because of the extraordinary cost of cancer drugs. In addition to the patient burden, the increasing inability of patients to cover treatment costs creates an escalating bad debt expense for cancer clinics. This bad debt averages \$500,000 for a practice comprised of six oncologists. Second, the law did not correct a technical problem with Medicare drug payments that artificially reduces drug reimbursement by 2%, which results in many cancer drugs being reimbursed less than cost. The solution to this “prompt pay discount” problem is solidly backed by a wide variety of constituents and members of Congress who have sponsored legislation (H.R. 1392 and S. 1221) that corrects this problem. Although the solution was included in the Energy & Commerce health care reform bill, it was stripped from the final bill.

The result of these problems is that community cancer clinics, which treat 4 out of 5 Americans with cancer, are increasingly struggling to treat Medicare patients. For example, just recently, the cancer clinic in Selma, Alabama was forced to close after serving the community for 25 years. Clinics have been forced to cut staff, close facilities, and send patients to the hospital for drug infusions. Shifting treatment location results in inefficient, bifurcated care, higher costs in the hospital setting, and impediments to clinical research, which drives access to new life-saving cancer drugs.

Further compounding the Medicare payment cuts specific to cancer care, the law neglected to correct the flawed sustainable growth rate (SGR) formula, which is the basis for Medicare physician-related reimbursement. Instead, the law effectively removes oversight of Medicare from the Congress and empowers a non-elected, 15-member Independent Advisory Payment Board to make Medicare cuts simply based on expenditure targets, which is the basic flaw of the SGR-based system.

The law weakens access to advanced imaging, which is an essential component of cancer care, in terms of diagnosing cancer and managing the progress and effectiveness of treatment. Appropriate use of imaging in monitoring the results of drug therapy can lead to cost savings and avoidance of toxicity when the therapy is proven ineffective. Arbitrarily cutting payments for imaging based on insufficient data not specific to cancer care is potentially harmful policy.

Finally, COA is disturbed that there is an underlying theme in the health care reform legislation that physicians should be focused on cost control. A physician’s professional responsibility is in the delivery of appropriate, quality care. COA is concerned that “gain sharing” arrangements, whereby provider payment is primarily based on cost savings, will force less medical care rather than ensuring appropriate, quality care. Additionally, “bundling” of services shifts the financial risk of patient care to providers — effectively, and inappropriately, making them insurers — and typically has been an excuse to cut reimbursement by hiding the cost of essential components of care.

The reality is that private insurance subsidizes the shortfalls in Medicare/Medicaid reimbursement for cancer. Because the law expands the influence and scope of government payment for health care, it is essential that the costs of cancer care be adequately covered in order to preserve the delivery system.

COA believes that ensuring the delivery of quality health care is critical in treating cancer patients. We also recognize the responsibility of making cancer care effective and cost-efficient as possible. As a result, a COA task force of oncologists spent close to a year developing a system of principles ensuring

quality and efficiency associated with treatment planning and follow-up cancer planning. COA worked with the Congress in crafting this into a demonstration project that was used as the basis for legislation (H.R. 3675) and was included in the health care reform law under the CMS Innovation Center. We applaud the inclusion of this project in the law; however, we are concerned that it potentially will take years to implement and will be insufficiently funded.

Despite problems in other areas of health care, we have the world's best cancer care delivery system as documented by survival rates; however, that system is now in crisis. In addition to the crisis relating to patient care, there is a research crisis. According to the Institute of Medicine (IOM) in a just-released report¹, *“The system for conducting cancer clinical trials in the United States is approaching a state of crisis. Changes are urgently needed if we are to continue to make progress against the second leading cause of death in this country. If the clinical trials system does not improve its efficiency and effectiveness, the introduction of new treatments for cancer will be delayed and patient lives will be lost unnecessarily.”* The shortfall in Medicare reimbursement is strangling clinical research in the community setting, where 4 out of 5 cancer patients are treated, because research participation places even greater demands on providers already struggling with inadequate payments.

President Obama's guiding principle of health care reform was *“Fix what is broken and build on what works.”* Unfortunately, this was not followed in health care reform legislation when it comes to cancer care and research. COA is ready to work with the President and the Congress in building on the strengths of the world's best cancer care and ensuring that all Americans have access to quality treatment in the years to come. This is witnessed by recommendations COA has already made on evolving the payment system to ensure future viability of care. We also have recommendations on how to address the crisis impacting research and the development of life-saving cancer therapies. *However, immediate relief is needed to stabilize the system of care that Americans fighting cancer are dependent on or it will be too late.*

¹ A National Cancer Clinical Trials System for the 21st Century: Reinvigorating the NCI Cooperative Group Program