The Cancer Program Administrator's Perspective: No Margin, No Mission!

by Matt Sherer, MBA, MHA

I agree with Dr. Newcomer's words that "all of us have the same goal for Americans with cancer—equitable access to skilled physicians and therapists, treatment with therapies proven by well-designed clinical trials, and benefit coverage to pay for the treatment." However, that statement is one of the only ones with which I can wholeheartedly agree. As you read this series of articles, keep in mind a few facts. First, Dr. Newcomer is an employee of UnitedHealthcare, and his comments are very much in favor of the payer's perspective. Second, all insurance companies are for-profit entities with stockholders who expect a positive return on their investment. Third, an overwhelming majority of healthcare providers are not-for-profit entities that provide care—regardless of a patient's ability to pay. It is easy now to see the "disconnect" that sometimes exists between this country's for-profit payers and its not-for-profit providers.

Our Healthcare System

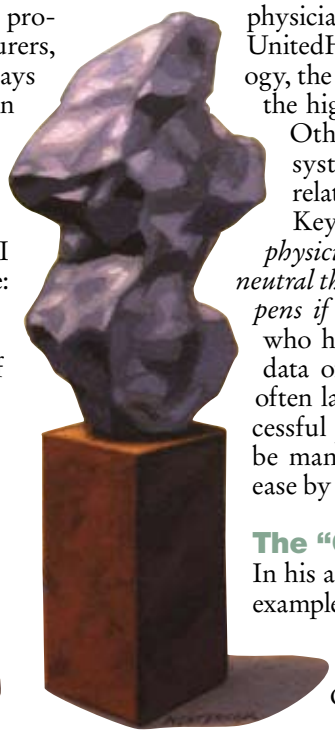
The United States' healthcare system is the only system in this country in which the end-user or consumer does not have much, if any, influence on the price of goods and services purchased. Instead, payers (public and private insurers) act as a "middle-man" who controls where and what the patient (consumer) pays for healthcare goods and services purchased. In turn, the patient pays a premium to these companies to hopefully help "control" these expenses. As our healthcare system evolves, the expenses keep going up and so do the amounts consumers are expected to pay. As Dr. Newcomer pointed out, it is not clear who is to blame for these increases—insurance companies, healthcare providers, drug companies, medical equipment manufacturers, and/or consumers. Most likely each of these entities plays a role in our escalating healthcare costs. The question then becomes: what can we do to help mitigate the situation?

Share and Share Alike

The other statement in Dr. Newcomer's article which I can wholeheartedly stand behind is an important one: insurers and healthcare providers must now come together to provide high-quality care, control costs, and keep access available to all Americans. This type of partnership can be forged, but it will take work and compromise from both parties. Insurers and providers will need to work together openly and share information about treatments, outcomes, payment rates, etc. But so far the "sharing" seems to be decidedly one-sided.

Providers have made it is easy for insurance companies to compile data on what treatments are being used, when they are being used, and by whom. Why? Because healthcare providers are *required* to provide this information in order to receive payment from insurers. The stumbling block: insurers are generally not willing to share this data with providers—despite the fact that this wealth of information could benefit both the end-user (the patient) and the healthcare provider. Even worse, insurers are generally reticent about identifying a dollar amount for what they will pay for any particular service.

Today, we are seeing a movement towards "transparency" related to healthcare costs. For example, in the oncology setting, the average sales price (ASP) methodology for drug reimbursement stemmed from an effort to identify the true cost of drugs for providers. Private payers have also jumped on this bandwagon in an effort to engage patients in cost-savings. Efforts include "ranking" providers in terms of what they charge (cost) and the quality of their services (outcome), and making this information available to consumers. Keep in mind, however, that in healthcare, these "charges" are not what consumers actually pay for their healthcare services. In other words, patients do not negotiate the price of their healthcare. Instead patients rely on their payer(s) to negotiate with healthcare providers to pay for services (i.e., fee for service, percentage of charges). Until consumers have more at stake and incentives, such as lower healthcare premiums or co-payments, many will continue to rely on their insurers to direct them to a provider.



Dr. Newcomer's article talks about the physician rating system being developed by UnitedHealthcare. Under their methodology, the higher the marks a physician receives, the higher his or her payment rates will be. Other payers are instituting similar rating systems and are already facing challenges related to management and data integrity. Key questions include: *Shouldn't these physician rating systems be managed by a neutral third party—not payers*? and *What happens if data are incorrect*? Some physicians who have been profiled have said that "the data often contain errors and that doctors often lack the ability to correct them."[1] Successful physician rating systems will need to be managed well and be "correctable" with ease by either party—payers and physicians.

The "Cost" of Treatment

In his article, Dr. Newcomer provides several examples of studies and/or patients that support his point of view. But you know

what they say about data: it's all in the way you look at it. First, let's take a look at the 45-year-old breast cancer patient. Dr. Newcomer writes, "Her oncologist has no incentive to think about less costly alternatives for therapy." I must disagree with his statement. All physicians—regardless of whether they practice in an office or hospital setting—work to control their costs. If they do not, they will eventually be out of business.

In another example, Dr. Newcomer writes, "The preferred regimen costs $12,000 more per month than cisplatin/vinorelbine." We should first clarify the word "cost." The "cost" Dr. Newcomer is referring to may be better termed the "charge amount." Most important: these two terms are not synonymous. For some treatment regimens, the charge may be more than the actual cost, and the provider makes a profit. Other times, providers are forced to take a loss when the charge of a particular treatment regimen is actually less than its cost. In oncology today, a number of "under-water" drugs fall into this category. For still other treatment regimens, providers may break-even with regards to cost and charge. So, in our example above, the $12,000 "cost" per month is actually a dollar amount that has been negotiated between providers and insurers. The challenge is now to identify the true cost of this treatment regimen. Unfortunately, healthcare providers do not do a good job of justifying what their true costs are in relation to any particular treatment. And until we get better at gathering that data, it makes it hard to justify $12,000—and sometimes much higher—treatment costs.

A Matter of Margins

Dr. Newcomer writes, "Small businesses often have small margins." I would go one step further and state that healthcare as a business has small margins. The average hospital in America has a profit margin of only two percent.[2] In fact, one third of all hospitals in this country are in the red.[3] One can't help but contrast these figures to financials reported by Weiss Ratings: "The life and health insurers showed their profits increased 212.5 percent in the first three months of 2004"[4] and "HMOs reported a $3.6 billion profit for the first three months of 2005, representing a 21.4 percent increase."[5]

Much attention has been paid to drug reimbursement. The payer perspective seems to be that cancer providers are making too much of a profit margin on drugs. Less attention is focused on the "under-water" drugs, which will only increase in 2008 when drug reimbursement falls from ASP+6 percent to ASP+5 percent. Dr. Newcomer alludes to this problem when he states, "The profit margins on generic cisplatin and vinorelbine are so small they will not cover the actual costs of maintaining an infusion room." The question begs an answer: *Who then should cover these costs*?

Drug costs are only a portion—granted a significant portion—of the total cost of cancer treatment. Similar to any other business, healthcare providers have overhead (employees, benefits, rent, utilities, etc.) that must be included in their true "costs." These business expenses must be accounted for when calculating and establishing what providers will "charge" for their services. While this business practice is not new or unusual, many in this country seem to have trouble reconciling its use by healthcare providers. And no one in the healthcare community seems to want to address the big elephant in the room: *How much of a margin is enough for our physicians and hospitals*?

Change is Possible

Today's providers cannot help but be concerned with the cost of cancer treatment. Outside of the ER, most cancer patients are not seen until coverage or assistance has been addressed and verified. In my role as administrator, I expect our physicians to be aware of the "bigger" picture and cognizant of the fact that cost containment is in the best interest of everyone—provider, payer, and patient. On the other hand, I am not willing to limit a physician to a different standard of care simply due to the cost of the treatment. Physicians should have the knowledge and ability to choose the regimen or treatment option they think is best for each cancer patient.

No one in the oncology community can argue with Dr. Newcomer's statement that, "There needs to be an aligning of incentives with healthcare providers and payers." One can, however, disagree with his argument for *why* this alignment has not already happened—i.e., because it would potentially lower the income of physicians. Although they seem to make easy "targets," providers are only one of the many players that have helped to create this country's current healthcare system. If payers and providers are able to come up with strategies to lower healthcare costs and keep quality high, then *all* parties should benefit from this alignment.

Before such an alignment takes place, however, payers need to answer some tough questions, such as *Would payers be willing to cut premiums if these incentives work*? and *Would payers be willing to lower patient deductibles or co-payments based on potential savings*?

I agree with Dr. Newcomer that changes to our healthcare system are possible—even necessary. A shift of this magnitude will require patients, payers, and providers, working together to share information about *all* aspects of care. And in my opinion, the first step needs to come from the payers that have all of the data and hold the purse strings. If payers would share their wealth of information with providers, physicians would potentially be able to make better informed decisions. It will not be an easy road, but it can be done.

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