The Future of Oncology Care—
One Physician Responds

by P. Gregory Rausch, MD, FACP

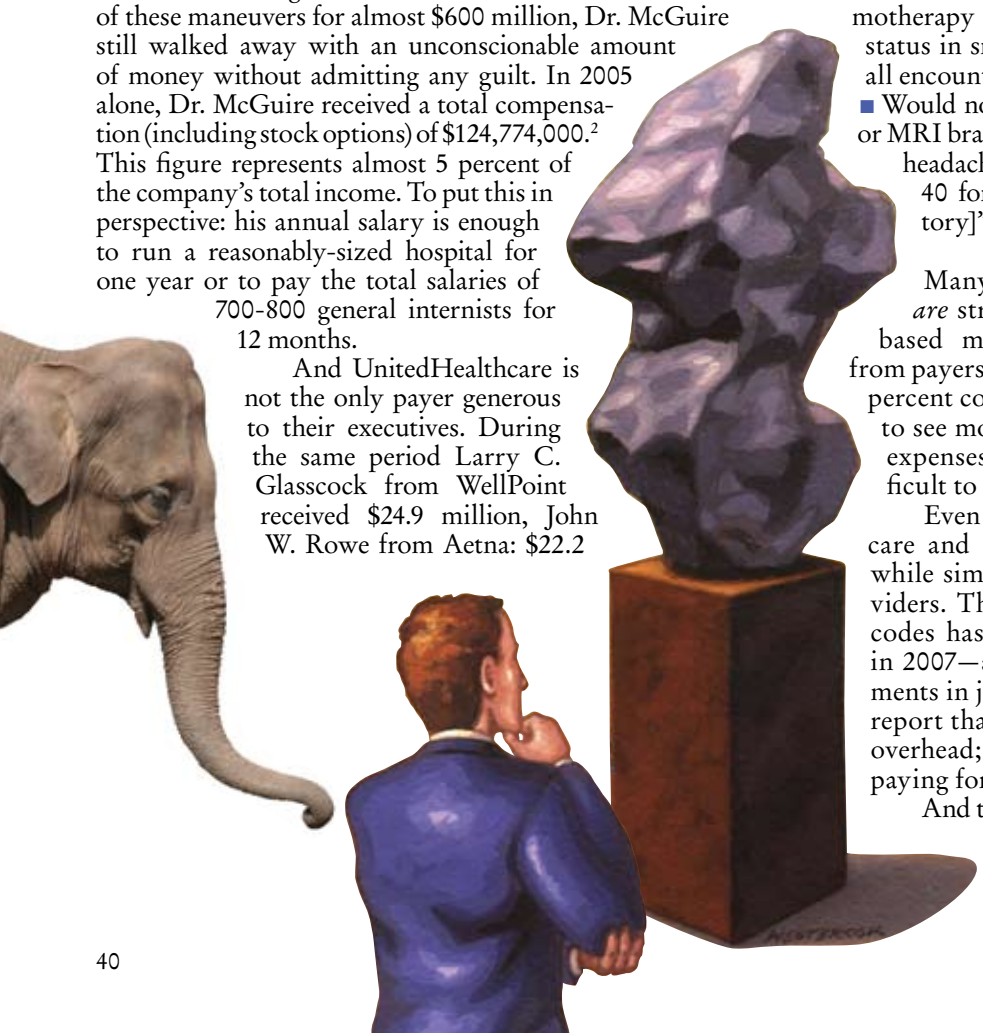
I read your series, "The Future of Oncology Care," in the Jan/Feb 2008 *Oncology Issues* with great interest. I thought the series was excellent—particularly Barbara McAneny's piece. In response, I would like to address three elephants left standing in the room:

1. Excessive profits and executive compensation in the insurance industry
2. Declining provider compensation
3. Increased cost-shifting.

Excessive Profits and Executive Compensation

One need look no further than UnitedHealthcare for an example of these egregious payer practices. In 2006, the *Wall Street Journal* revealed that executives from many firms had received generous stock options artificially backdated to times when the stock was at a low point.[1] As the CEO of UnitedHealthcare, Dr. William McGuire was the leader of the pack. Over a 12-year period, Dr. McGuire accrued nearly two billion dollars in stock options. While the Securities and Exchange Commission forced him to settle some of these maneuvers for almost $600 million, Dr. McGuire still walked away with an unconscionable amount of money without admitting any guilt. In 2005 alone, Dr. McGuire received a total compensation (including stock options) of $124,774,000.[2] This figure represents almost 5 percent of the company's total income. To put this in perspective: his annual salary is enough to run a reasonably-sized hospital for one year or to pay the total salaries of 700-800 general internists for 12 months.

And UnitedHealthcare is not the only payer generous to their executives. During the same period Larry C. Glasscock from WellPoint received $24.9 million, John W. Rowe from Aetna: $22.2 million, Edward Hanway from Cigna: $13.3 million, and Howard Phanstiel from PacifiCare: $3.38 million.[2]



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Declining Provider Compensation

No one would argue that physicians can do a better job of practicing evidence-based medicine, and the RAND study referenced in Dr. Newcomer's article and published in the *New England Journal of Medicine* does indicate areas for improvement.[3] However, analysis of the care criteria used (developed by the RAND Institute) also revealed that many of the criteria used were either:

- Highly patient dependent (e.g., "treatment referral for alcohol dependence, choice of surgical treatment for Stage I or II breast cancer, lifestyle changes for patients with hypertension, or breast, colorectal and cervical cancer, and HIV screening");
- Not always medically appropriate or were impossible to fulfill (e.g., "advise binge drinkers to stop drinking at *every* encounter, all hospitalized asthma patients will receive systemic corticosteroids, all women with high-risk breast cancer should be treated with systemic chemotherapy and/or tamoxifen, document smoking status in smoking patients in at least 50 percent of all encounters); *or*
- Would not be covered by many insurers (e.g. "CT or MRI brain scans for all patients with new or severe headaches, colon cancer screening starting at age 40 for high-risk patients [positive family history]").

Many practices and healthcare organizations *are* striving to improve their use of evidence-based medicine—with no financial assistance from payers. Nevertheless, we can never achieve 100 percent compliance. And, as physicians are forced to see more and more patients to cover overhead expenses, this goal becomes more and more difficult to attain.

Even worse, payers are calling for improved care and adherence to evidence-based medicine while simultaneously reducing payments to providers. The average reimbursement for all E&M codes has fallen from $102.69 in 2004 to $73.48 in 2007—a 28 percent decrease in physician payments in just three years.[4] Many physicians today report that Medicare payments barely cover their overhead; nationally, commercial payers are now paying for services below Medicare rates.[5]

And the predatory practices of payers continue:

- More and more "bundling" or packaging of services
- Down-coding of claims

- Paying the same amount for different levels of complexity
- Delaying payments with excessive requests of "additional information" to increase the float time
- Denying necessary services that result in hospitals and practices having to make multiple appeals
- Refusing to negotiate with physicians to solve some of these challenges.

Increasingly, physicians are forced to practice medicine in a strictly "take it or leave it" climate. This challenge is only compounded by the fact that four insurance companies, UnitedHealthcare, WellPoint, Aetna, and Healthcare Service Corporation, control more than a third of the national market—36.5 percent.[4]

But perhaps the most unsettling payer practice is the refusal to pay for critical screening tests and interventions, such as stool occult blood testing, digital rectal examinations, stop smoking counseling, flu shots, lifestyle counseling, telephone interventions, and a host of other important services. Instead, most payers simply bundle these separate services into office visit codes. Many payers, including UnitedHealthcare, routinely refuse to pay for a screening mammogram if the study is performed even one day before a full year from the previous examination, and I have even been denied payment for providing a flu shot to an elderly cancer patient on chemotherapy.

Cost Shifting

The final elephant in the room is the tremendous additional overhead costs that physician practices incur because of ever increasing payer demands. One estimate found that we spent over $320 *billion* in administrative and overhead costs for healthcare in 1999.[6] This dollar figure includes insurance companies' overhead and profit, as well as costs related to employers' management of their health plans; hospital, nursing home, and home healthcare administration; and administrative costs of practitioners. One can only guess what these administrative expenses are in 2008.

My oncology practice consists of three physicians and one nurse practitioner. We have a total of 11 employees, two of whom (a medical assistant and a billing clerk) do nothing but pre-authorize prescriptions, laboratory work, and radiology tests, and appeal denials of care by third-party payers. Their combined salary is 21 percent of our total payroll. Of course these costs are never compensated by any of the payers. So in essence, our practice pays two FTEs to reduce insurance companies' expenses.

In a particularly egregious example of these unnecessary expenses, UnitedHealthcare requires us to telephone a central office to "register" every patient for whom we order a CT scan or MRI. This process is not a pre-authorization, but a simple registration—the studies are never denied. Nevertheless, we order between 10 and 20 such studies every day and each call takes an average 12.5 minutes—a tremendous and unnecessary expense. Since this insurer has never been able to explain the reason for this requirement, one must conclude that it is intended only to increase the hassle factor and discourage physicians from ordering necessary and indicated studies for their patients.

Dr. Newcomer concluded his article with these words: "We have the opportunity to experiment with changes now. It will require collaboration, a willingness to examine the data, and the spirit to change. Most importantly we have the opportunity to improve patient care, as well as make it more accessible and more affordable. It's worth the effort."[7]

These are lofty ideals, but I fear they will remain only words. Until insurers and providers come together, I fear there is no hope of improvement. So let's open a dispassionate dialogue and start by talking about some of the elephants left in this room.

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