PRESIDENT'S MESSAGE

Where Do We Go From Here?

BY GEORGE KOVACH, MD

As I write this column we are still several weeks away from Election Day, and by the time you read this, the election results will be old news. Still, I can safely make one prediction. Whether or not we have a change in administration in January, healthcare changes are coming and we, the practicing oncology community, need to be engaged. For too long healthcare policy has been crafted with a top-down rather than a bottom-up approach, which may help to explain many of the ACA's shortcomings. Rather than creating bold initiatives, the ACA continues along familiar paths, for example, accountable care organizations (ACOs), which are essentially the same as the managed care programs we saw in the 1980s. How did that work out?

Health insurance through employment continues to limit employee choice, and insurance competition remains regionalized, thus hindering competitive pricing. What if all insurance carriers participated in a national risk pool of more than 300 million covered lives rather than regionalized state exchanges?

The Centers for Medicare & Medicaid Services (CMS) continues to cover the older, higher-risk population and to underpay, thus shifting costs to the private sector. This scenario has not changed since "mandatory" insurance shifts costs to the younger populations by charging higher premiums than needed for this lower-risk population.

Reimbursement issues continue with the specter of the SGR "fix," bundled payments, and sequestration looming. Increased regulation and mandates, such as EMR requirements, increase the cost of compliance without adequate reimbursement. In a recent *Wall Street Journal* article, "A Major Glitch for Digitized Health-Care Records," the authors discuss EMR implementation and question the return on value due to the high cost and lack of a common data exchange, which is a significant barrier to realizing the major advantages of electronic records. An EMR should not only meet "meaningful use," but should also be meaningful and useful to the provider, which is not always the case.

Comparative effectiveness (CE) as a means of cost control may be used as the basis for selection of treatment on cost rather than value. This situation needs to be watched closely so innovation is not hampered.

Malpractice reform has yet to be addressed adequately due to the perception that the cost is "minimal" as compared to overall healthcare expenditures. At the same time, the cost of practicing "defensive" medicine remains underestimated (see my column in the July/August 2012 issue).

So what's the good news? I can make one additional prediction. As the healthcare debate continues, we have the opportunity to be at the forefront of the discussion by:

- Offering meaningful information on how current policies are adversely affecting our ability to provide appropriate care for our patients
- Supporting those policies that have merit
- Proposing alternative solutions to those that do not.

As part of the 39th Annual National Meeting, ACCC will host a Capitol Hill Day. But don't wait until March, become more involved now! ACCC has a long record of effective grassroots advocacy to carry our message to our elected officials at the state and national levels. Then plan to come to Washington in March and make the voice of community oncology heard on Capitol Hill.

Become engaged, our patients depend on it! OI

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