

THE CANCER CARE REIMBURSEMENT CRISIS: RALLYING PUBLIC SUPPORT

by Lee E. Mortenson, MS, MPA

As the state lobbyist for a major insurance carrier and his companion corner a Senator in the Rotunda of the State Capitol, you experience a sinking feeling. Perhaps the insurance carrier is going to get its way after all. Perhaps you were not clever enough. The companion is a lawyer who used to serve in the State General Assembly, and they are both here every day.

You hear some laughter and there is some backslapping. The three come over to you—all smiles. Doctor, they say, we really need your help and input. You feel a warm glow of pride as they sell you down the river.

Do we really have to do this? Do we have to drag cancer patients, their families, and the public into the insurance reimbursement debate? Even when you win, you have the potential to lose.

Historically, physicians and other health care providers have been able to win the overwhelming majority of confrontations over whether a patient needs a specific treatment regimen. No where has this been more true than in oncology care, where the treatment regimens are highly variable and the state of the art is constantly changing.

But, the winds of change are blowing. Insurance companies are fighting for market share and they are looking for ways to cut costs. Some of their selections are rational; others are not. Insurance carriers are well aware that cancer care is expensive, and that it is likely to get more expensive with more and more new drugs and biologicals in development, many of which carry much higher price tags. The easiest way to cut costs is to challenge everything and to make the medical profession defend its every action. An article in this issue of *Oncology Issues* (see page 11) points out that medical oncologists are now spending half a day per week arguing with 22-year-old insurance company clerks about what constitutes proper care for their patients.

Do we really need to do this? Simply look at the number of meetings that are being held that deal with reimbursement issues. When we see the frequency of reported denials for standard therapies, combination therapies, and clinical trials, it is not hard to understand that action must be taken. Reimbursement policies are affecting the quality of care that cancer care providers can deliver. The problems are so pervasive that individual physicians, on a one-to-one basis, are losing the battle with insurers; they are being worn down by the need to defend every decision.

Who Are the Targets?

One of the most difficult aspects of the reimbursement problem is to figure out who needs to be convinced that something must change. Our first inclination is to focus on the insurance companies, but by now it should be clear that they are not about to change their coverage policies without outside pressure.

At the national level, we have had many discussions with insurance companies, and they have all led to expressions of concern and questions about how cancer care can be categorized and restricted. For instance, ACCC proposed to one carrier that it could identify some promising new therapies that could replace older, less useful approaches. The carrier proposed we tell them what doesn't work any more so they would stop paying for it, without any assurance that it would pay for some of the new, more effective therapies. At the local level, there is no longer any question that many insurers are trying to delay payments to enhance the next quarter's profits.

The question becomes, who can impact insurers' payment policies? There is no easy answer. Medicare and Medicaid are governed by federal and state legislation. Many commercial insurance companies are governed by state law. However, the largest growth segment in the insurance industry is in "self-insured" companies, which are exempt from both federal and state legislation. And, of

course, there are the large number of regulators who impact diagnostic coding policies at federal, state, and corporate levels. Faced with so many diverse players, it is not difficult to become disheartened.

Dancing in Washington, DC

Of the three targets, activities at the federal level need to be addressed by national oncology organizations. ACCC is meeting with the leadership of the American Society of Clinical Oncology (ASCO) in June to review specific reimbursement problems. To be effective, however, ACCC and other organizations must have the support of local health care professionals if we are to successfully lobby Congress on reimbursement issues. A key principle of political activity is that when a Congressman hears from more than a half dozen people on the same issue, it becomes a problem that requires his attention. A second key principle is that members of Congress are much more interested in hearing from constituents than lobbyists. ACCC and other cancer organizations will require the help of many individual oncologists before reimbursement issues can be resolved at the national level. But when all is said and done, influencing Federal legislation will only impact about 30 percent of all insured individuals, primarily Medicare beneficiaries and, perhaps, the beneficiaries of Federally-sponsored HMOs. While the Federal government is a big target, we simply can't rely on national organizations to save the day with Congressional legislation.

Working the State Rotunda

Changes on the state legislative level can impact insurers that control an additional 20 to 30 percent of all cancer care reimbursement. State legislatures can mandate that insurance companies based in their state follow certain rules and regulations. Thus, legislation that requires insurance carriers to include certain provisions and, at a minimum, to cover specific procedures is quite common. At the state

level, we are already seeing oncologists forming societies to address diagnostic coding issues and local regulatory problems, and that is where there is potential to impact another major segment of care.

The problem with targeting state legislatures is the frequent inexperience of the oncology team versus the professionalism of the opposition. Lack of coordination can also be a major problem. Recently, in Michigan, several individuals and associations attempted to counter an initiative by Blue Cross and Blue Shield to cut back payments to only those indications cited on FDA-approved drug labeling. As we know, this effectively denies payment for almost half of all current cancer chemotherapy.

Unfortunately, what occurred in Michigan is a textbook case in how easily too many cooks can spoil the broth. The initial legislation was prompted by a single, concerned oncologist contacting a single, concerned state legislator. The language of the bill was general, but the idea was good, and convincing enough to pass the House of Representatives by an overwhelming margin of 95 to 2.

Of course, the lobbyists from the Blues instantly appeared and began to strongly suggest changes in the legislation that "would make it acceptable" to the insurance industry. At the same time, representatives of three pharmaceutical companies, members of a newly-strengthened oncology society, and the society's lobbying staff, all became involved in the debate.

The outcome was mixed. The Blues were able to make it more difficult to prescribe drugs for indications that do not appear on FDA-approved labeling. They slipped in a phrase that requires physicians in Michigan to obtain an informed consent every time a drug is prescribed for an off-label indication. If one ignores the fact that someone is going to have to write a great many informed consents, there is also the problem that the Blues can still audit hospital charts and claim that every patient with an informed consent in the chart is on an "experimental" trial and disallow the admissions.

At one time, the Michigan legislation included references to the three compendia (the *U.S. Pharmacopeia Drug Information*, the *AMA's Drug Evaluations*, and the *American Hospital Formulary Service Drug Information*), but, because of a series of misunderstandings, the oncology society moved to have

Hints for Working in the State Legislature

1. **Get professional help.** It is not enough to be right. Professional lobbying power can assist you in reaching the right representatives or senators, and in translating your message into actual legislation.
2. **Check with ACCC and other national organizations first.** ACCC is developing model legislation and has dealt with many of the same questions that will emerge in your discussions with state legislators. The Association can provide you with specific hints and technical support.
3. **Don't move too fast.** When you suddenly feel crowded to make an immediate decision, that probably means that the opposition's lobbyists are trying to force you into an impossible position. Take a deep breath and say you'll think about it. Then, call in the reserves.
4. **Be wary of new provisions.** Stick with your own agenda. Watch out for provisions that will give you what you want but, at the same time, double your work impact.

the reference to the compendia taken out!

To arbitrate disputes, the Blues proposed the formation of a panel comprised of three physicians, but they were careful not to make it a specific part of the legislation. The legislation required that they pay only for drugs that are FDA approved, approved by an unspecified oncology society, and supported by the literature. Thus, even if the panel supports the use of a drug for a particular indication, the Blues can still deny coverage by indicating that it does not believe there is sufficient literature to support the panel's recommendation.

Moreover, because references to the three compendia were removed from the legislation, the three-man panel will now have to fight for every indication that is not on the label, which is quite a task even for three prominent Michigan oncologists.

There are several lessons to be learned here. First, there is a great deal of sympathy and public support for our posi-

tion that can translate into state legislative support for bills that address inadequate reimbursement policies. Second, it is important to involve a great many people in the development of any model legislation to ensure that the wording reflects the effect you want it to have. (ACCC is currently drafting model state legislation.)

Third, it is important to get professional help and to coordinate the involvement of concerned cancer organizations. Three different pharmaceutical company lobbyists, two different groups of oncologists, and representatives of national oncology societies, can easily trip over each other's feet.

It is also important to do your homework. What will be the impact of a specific provision proposed by an insurance carrier? What will be the cost of the provision that you propose? Knowing the answers to these questions are vital if you are to effectively state your case.

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Hints for Mobilizing Public Support

1. **Make certain you know what you want the public to do.** You have to be explicit and tell the public what specific actions need to be taken.
2. **Simplify the issues.** Reimbursement problems are complex and confusing. Make certain that you tell the public the impact on the bottom line and how the actions you are proposing can help.
3. **Put it in writing.** A simple one-pager is often what the public needs. ACCC is preparing a simple brochure that will provide model insurance language that ensures cancer patients access to standard therapies and to promising, new therapies.
4. **Mobilize other oncologists.** Every oncologist counts, but a cooperative initiative by multiple oncologists and hospitals in the region is likely to have a broader impact.

Rallying Support

(Continued from page 9)

Finally, countering the strategies of your opponents is an important part of developing your agenda. ACCC can help.

Mobilizing Public Support

Forty percent or more of insurance beneficiaries are employed by self-insured companies that are not bound by the usual state and federal regulations, because they are assuming some of the risk. Any legislation that is passed on the national or state level will not impact their coverage.

While public support and patient support is important in the legislative dance, it is vital if we are to change the insurance policies of self-insurance companies. Only public pressure will make a difference.

Public and patient support can be mobilized in several ways. At the outset, it is important to have a complete game plan. What do we want them to do? Is there a specific action that we are requesting? Are they on their own or will we help them?

How will we know if they are effective?

Oncologists have broad access to patients and their families. In order to mobilize patients, you need to ask for their support and to provide them with a brochure or set of instructions that tells them what specific actions need to be taken. A small percentage of patients and families will become involved if you just make the materials available to them; a significantly higher percentage will take action at the request of their physicians.

This is why a concerted effort by several oncologists and several hospitals in the same region can have a major impact. Company health care benefit plan specialists are likely to be responsive to multiple requests from employees and their spouses. However, they will want the same kinds of questions answered that we discussed before: How much is this going to cost the company? How will it help? What is the risk for the company?

ACCC is drafting model legislation, patient information brochures, and model insurance plan language. In some cases,

ACCC staff will be able to help you organize your local efforts or to work with local lobbyists. Contacting the Executive offices may be one of the first ways you can prepare to mobilize the public and to ensure that you achieve the legislative outcomes you really need. ■

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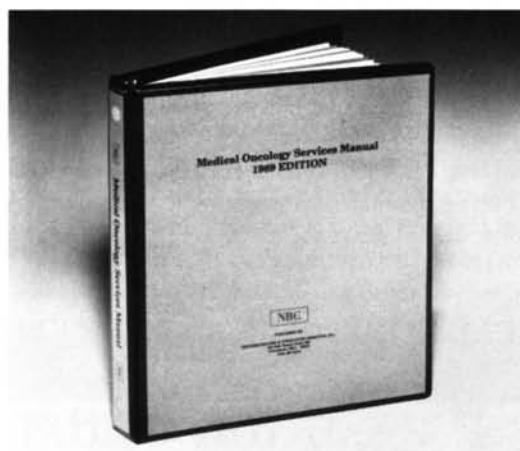
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