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HIGHLIGHTS OF THE 16TH ACCC ANNUAL MEETING

Bylaws Amendment Spurs Approval of First ACCC Chapters

The House of Delegates passed a proposed amendment to the Association's bylaws to allow the formation of ACCC Chapters by professional organizations. Any professional, oncologic organization of 25 or more general ACCC members can apply for status as a chapter of ACCC, according to the amended bylaws. Each approved chapter of the ACCC will have one vote in the House of Delegates. All organizations applying for membership as a chapter must have bylaws that conform with the national organization's bylaws.

In answer to questions raised during the House of Delegate's meeting, the Board has clarified the intent of ACCC Chapters. It is not the Association's intent to exclude any appropriate professional organization from applying for status as an ACCC Chapter, regardless of geographic location. In other words, there may be more than one ACCC Chapter in the same state or region. Each ACCC Chapter is free to determine its own membership, which may be multidisciplinary in nature or limited to one or more oncologic specialties.

Following the approval of the bylaws amendment, the Board of Trustees unanimously accepted two professional organizations as ACCC chapters: The Illinois Medical Oncology Society and the Indiana Medical Oncology Society. The two chapters currently have memberships of 37 and 53 state-based medical oncologists, respectively.

Reimbursement in Spotlight at Annual Meeting

A special forum on reimbursement at the recent Annual Meeting focused on national, state, and public concerns. The high attendance for these sessions, and the wide array of concerns expressed by speakers, make it clear that reimbursement is an issue of great concern across the nation.

National Issues

Peter Barton Hutt, Partner, Covington & Burling, Washington, DC, and a member of the Lasagna Committee of the President's Cancer Panel, predicted a "flood of law suits" if third-party payors continue to deny coverage for "reasonable and necessary" medical treatment. Hutt said that the "use of an unapproved drug in a clinical situation for the desperately ill" is "clearly in the best interest of the patient." He also advocated the use of unapproved drugs for patients who are unable to get into phase III clinical trials; payment for all investigational drugs under an IND/NDA and Group "C," including associated patient costs; and payment for any off-label drug use approved in one of the three compendia.

Hutt attacked insurance coverage policies that he said "vary from public to private carriers, from contract to contract, from region to region, and from region to region within the same contract." Such a system, he said, is a "model for all time of utter chaos. There is no consistency and, thus, no fairness [in the system]."

Dr. McGivney

Mr. Hutt

He maintained that "reimbursement should not be dependent upon approval, but on the medical legitimacy of the use," pointing out that this view was confirmed by a U.S. Court of Appeals in a recent Medicaid case involving an AIDS patient who was denied payment for AZT. Hutt said that the "court reinforced the 'medical and necessary' statute," stating that "where the doctor certified that AZT was medically necessary, it must be reimbursed."

William McGivney, M.D., Ph.D., Director, Division of Health Care Technology, the American Medical Association, warned that proposed rules by HCFA define "reasonable and necessary to mean that a service is safe, not investigational," and also add a cost-effectiveness criterium, which is "the first suggestion by a third-party payor that cost be incorporated in third-party coverage decisions."

"We need to get away from adherence to labels and rely on the clinical literature and available medical evidence in making health policy and coverage decisions," McGivney maintained. He also pointed out the need to "identify promising, new technologies and to push for their appropriate utilization, but also to identify old technologies that pale as new ones come on board, and to identify unproven and fraudulent activities." To that end, McGivney said that "one idea whose time may have come is to involve the practicing medical community, payors, patient advocacy groups, and others to expand the ongoing dialogue about technologies and to integrate their activities. I think we'd be surprised at the extent to which we would agree on the issues."

Robert Refowitz, M.D., Ph.D., Vice President, Medical Services, The Prudential Insurance Company of America, pointed to the public's perception that "it is not getting value for its money in health care." He said that this year, it is costing employers $2,900 per person for health care coverage, excluding out-of-pocket contributions by employees, and that figure is likely to rise to $3,200 per person next year. He promoted the importance of dialogue to help bring "reason to reimbursement and care, and to ensure that America gets value for its health care dollars. We want new technologies to be identified and followed, and meaningful research to be well funded. And we, collectively, as an insurance industry, want to have the most effective medical care and treatments."

State Issues

After waging two intense campaigns to defeat pending legislation in Illinois that would affect the ability of oncologists to

Meeting Highlights

(Continued from page 21)

deliver state-of-the-art cancer therapy (see "Coalition Defeats IL Legislation," Winter 1990 Issue), James Wade, M.D., President Pro Tem of the Illinois Medical Oncology Society, reviewed the lessons the Society has learned from those lobbying efforts:

First, he said, the "issues are so complex, we found you can only trust oncologists;" physicians who are not on the frontlines of new technology and laypersons "don't pick up on subtleties of new technology, the meaning of experimental," and other important points. Second, Wade pointed out the "need to collaborate with other groups, such as the state medical society, that have knowledge of legislation that will be introduced. Third, he stressed the need to network with other states. "If this bill in Illinois had passed," Wade said he believes that insurance companies would have proposed "similar legislation in other states."

Finally, he said that "one-on-one input to legislators is more effective than having a paid lobbyist, but cancer care providers still need help." Because the Society thinks the same bill will come up again this June, it has been working with the ACCC and an attorney to "either neutralize the bill or change the definition of experimental," and it plans to continue to closely monitor legislative activities.

Lee Mortenson, M.S., M.P.A., Executive Director of the ACCC, predicted that we will see "a flurry of bills" on the part of legislators and insurers that will require activity on the state level, because of the threat they are likely to present to adequate and fair reimbursement for cancer care. He urged the ACCC membership to "look closely at bills emerging in their states over the next few years."

"We can attack such an attitude at the state level," Mortenson said, noting that about 40 percent of all insurance is regulated at the state level. However, "it's important to get legal counsel, external monetary help for lobbying efforts, and it's helpful to devise sample letters for individuals to send to their legislators." (See the news story on page 7 for a look at two pieces of legislation pending in New York and California that would greatly improve reimbursement for state-of-the-art cancer and AIDS treatment in those states.)

Public Issues

The more than 1,000 members of the National Coalition for Cancer Survivorship are "becoming increasingly concerned with playing an advocacy role," according to spokesperson Natalie Davis Spingarn. "We see the need to speak up for ourselves and to bring issues to the attention of national policy-makers, particularly in terms of insurance coverage and job discrimination." She urged greater communication between the two organizations to identify similar concerns and to come up with potential solutions. "We are particularly concerned about the denial of off-label drug uses, clinical trial participation, the disproportionate incidence and mortality rate in minority populations, and in enhancing cancer survivor research. These are the areas in which we are beginning to work, and we welcome your input and support."

New ACCC President Outlines Goals

Under the leadership of the new ACCC President, Jennifer Guy, members can expect that the Association will continue to focus on the political, social, and economic issues affecting their ability to delivery quality cancer care at the community level.

At the House of Delegates meeting, Guy asked the membership to make a "collective effort, to evaluate its actions carefully, and to continue to target such important issues as payment and the recognition that clinical trials constitute state-of-the-art care. The ACCC was founded because of the "need for technology transfer and system transfer to take the best possible care of patients in the community, and to enable all disciplines to work together to that end."

Guy also urged members to become more active in the organization, especially younger members. "You have things to teach us, and new strategies for dealing with this evolving health care environment." ■

NSABP's Fisher Honored for Advances in Community Research

Bernard Fisher, M.D., Project Chairman for the National Surgical Adjuvant Breast and Bowel Project (NSABP) since 1967, was honored for his contributions to the advancement of community-based clinical research. In his keynote address, Fisher said that when he spoke at an ACCC meeting in 1982, he raised several concerns about CCOPs "that have not materialized. Today, he said, "CCOPs are well-established as members of the clinical research community." In fact, CCOPs now enroll 25 percent of all NSABP patients, according to Fisher.

However, Fisher did express some concerns about the present and future of clinical trials and cancer research. He pointed out the need to "establish markers in trials and to institute a large markers program;" to combat the "overwhelming negativism about clinical trials," which has evolved because of the incremental nature of cancer research; and the need to segregate cancer control trials from other clinical trials, noting that "cancer control requires its own expertise."

Fisher also maintained that the findings of previous trials are not being adequately disseminated or acted upon. For instance, a trial of lumpectomy vs. total mastectomy with or without radiation therapy showed that, after 10 years, only 9 to 10 percent of patients had a recurrence and distant disease survival was exactly the same, yet "lumpectomy is not used as often as it should be in the United States," Fisher contended. "We must get across the findings of these trials."