Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Oncology's Future under Health Care Reform

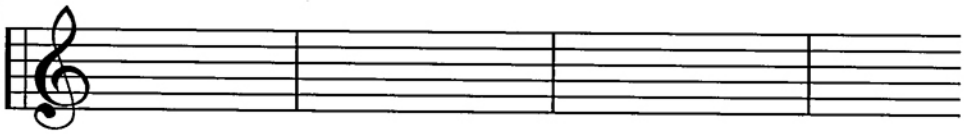
Lee E. Mortenson

To cite this article: Lee E. Mortenson (1993) Oncology's Future under Health Care Reform, Oncology Issues, 8:1, 9-12, DOI: 10.1080/10463356.1993.11904408

To link to this article: https://doi.org/10.1080/10463356.1993.11904408

Oncology's future under health care reform

Speculation and analysis by Lee E. Mortenson, D.P.A.



"...Now there's only one thing I'd like to know... where did the 20th century go? I'd swear it was here just a minute ago, all over this world. Has anybody seen my linoleum floors, petroleum jelly and two World Wars? ...The 20th century is almost over, almost over, almost over. The 20th century is almost over, all over this world."

Steve Goodman, folksong writer and singer and a high school classmate of Hillary Rodham Clinton

8:30 am January 29, 2000

Just seven short years from now. Life is quite different for you as a medical oncologist in the twenty-first century. Things have changed. Like always, there's good news and bad. You are working for a large physician group now. The salary is lower than your previous take home, but then again, you don't have to worry about overhead, malpractice, the nurses' salaries and the reimbursement hassles of private practice. No more drug inventory either.

This morning you and your team of nurses have a large number of patients to see. In fact, the number of cancer patients has doubled, and the number of practicing oncologists has declined. The patients who come to your office are primarily seen by nurses and PAs. Your job is strategy and monitoring. Of course, most of your patients have the basic benefits package, nothing fancy. No bone-marrow transplants. No extraordinary measures. There are some of those patients in this facility, but they're with another contract and handled by a different group of oncologists.

Lee E. Mortenson, D.P.A., *is ACCC Executive Director.*

On the other hand, the new gene therapy machine is getting installed within the next month or so. Here they are with all of the technologies that Rosenburg used to do in the early '90s so laboriously, and now it's a turnkey system. Plug and play... and relatively inexpensive. Moreover, the results are so promising that it is likely to be included as part of the standard benefits package for a number of indications. More will no doubt continue to be certified.

Looking over this morning's clinic load, you see that most of the patient diagnoses have already been made by your team of diagnostic nurses and recommendations on the chemotherapy regimens are attached. Most of them are by the guidelines book and are reasonable approaches. A few of the drugs continue to be expensive, but the results are important. Some of the multidrug-resistant biologicals appear to be having an impact these days. But then there are tax incentives for the pharmaceutical and biotechnology companies to develop these new agents and especially to develop and test some of the new man-made molecules.

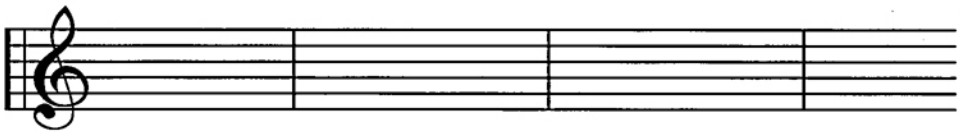
This morning you have a patient that will be beginning an NCI clinical trial, and two more that will continue on drug company trials. There are not a lot of "me-too" drugs in testing any more, so every patient on trial is important and many of the drugs have more than the usual low-key toxicity profile you used to see on most Phase III trials in the early '90s. One of the patients will certainly have to be hospitalized as part of his induction.

Telling patients that they are going to have to go into the hospital is always a little difficult. Hospitals are just another cost center here, and while they are cosmetically OK, there are real questions about the technical capabilities of a number of them. Everyone knows that only very sick individuals are admitted to the hospital and that the care is very intensive. This wouldn't be so bad if hospitals were not staffed at lower levels than a half dozen years ago and if the structures were not so stressed. Capital for improvements, expansion, and remodeling is pretty low on the list.

One of the hospitals in your city has devoted itself exclusively to those value-added contracts that the high price executives get as part of their benefits packages. This is really a big deal because the Clinton and the Gore administrations are taxing the heck out of these kinds of benefits. Still, companies are buying them.

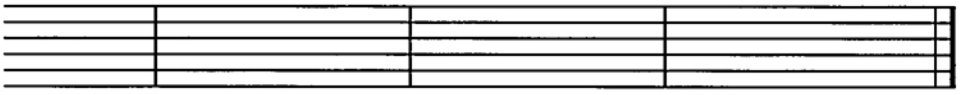
And while you are a little jealous, you are pleased to see that there are few patients who cannot get the basic services and reasonable care. You no longer have to ask about whether the patient is with the XYZ insurance plan before you can put them on a trial or give them appropriate drug therapy. That pre-existing conditions baloney is a thing of the past. Of course there are a few new drugs you are just going to have to do without for awhile... and some patients who cannot afford a BMT package or a gene therapy package. Fund raising for these patients is increasingly rare.

Your hospital and the physicians who are part of the same Physician-Hospital Organization (PHO) are likely to be consolidated again. A few years ago, there was just one hospital. Now there are a



"Nighttime on the City of New Orleans.... it's halfway home, and we'll be there by morning... the old steel rail hasn't heard the news... this railroad's got the disappearing railroad blues....Goodnight America, how are ya? Don't you know me, I'm your native son... I'll be gone a long, long time when day is done."

Steve Goodman



dozen in this region all under the same central management, along with hundreds and hundreds of physicians and nurses. They have bid very successfully for a number of the basic benefits packages, demonstrating reasonably good outcomes for the major types of care that are reviewed, reasonably nice facilities, good price and more and more attention to location and patient convenience features. The packages are all bid out by the statewide Health Insurance Purchasing Cooperative (HIPC) and the network allowed the group of facilities and physicians to compete effectively with other facilities in the region. The number of insurance companies in the area have decreased significantly and the basic plans are pretty reasonable.

The HIPC has some real economic clout and uses it. It pulls together employees from most of the small businesses of less than a thousand employees, all the part time employees and the unemployed in the region. Given the government requirement for community-wide rating by insurers and the clout, the insurance companies have from HIPC contracts, they can exert major influence on pricing and services.

Of course the health care tab for the nation continues to increase, frustrating Congress and the Administration. But then, a lot more people are coming into the system as the access programs come into full swing. And the population is getting older and the frail elderly are growing in numbers. Worse, the percentage of Medicare voters demanding services is increasing while the percentage of work-age adults needed to support these beneficiaries continues to decline. More money out of the pockets of fewer individuals, and something approaching intergenerational warfare over what is necessary and what we can afford. It never seems to end.

There was a lot of shake out in the early 90's and there was a swing in the pendulum toward more individualized care. In the beginning of managed competition, there was the phase-in. Actually, it was a shorter phase-in than we'd seen for previous systems, but then the Administration and the American people were desperate to see results.

At the outset, there was a rush to consolidate and pull together competitive networks of physicians and hospitals. Hospitals and physicians who were not on the cutting edge when it came to cost control were out in the snow during those days. In fact, just like the early days of HMOs, there were a number of places where large patient groups were shifted from one PHO to another. This meant that overutilized facilities and personnel were often sitting right next to underutilized ones. Shifts in physician loyalties and contracts when the work declined at the losing facilities. Sometimes the losing facilities were sold. And there were miscalculations and underbids.

There was also a lack of outcome data and a lack of interest in patient convenience in the first days. It was basically an all out rush to come in with the lowest bid.

As a result, there was a great deal of confusion, a good deal of consolidation, and only a modest amount of cost savings. Nonetheless the upward trend was slowed considerably.

As an oncologist, you had other problems. The cardiologists were doing an excellent job and saving more people for your attention. Still, the aging of the population is inexorable and, with it, comes more cancer cases. Without a doubt it was now the number one product line at your hospital and the subject of much attention.

Hospitals still want cancer patients. As cancer draws more national attention, there are more policies that include special provisions about cancer. This is not an "optional" disease. Too many headlines and too many of the quality control parameters deal with patient outcomes in cancer and patient quality of life.

Actually your hospital is one of the smart ones. Your administrators stayed as far ahead of the curve as they could. They invested in a nice facility early on, bonded your group of medical oncologists, set up a transplant and stem cell operation and kept the radiation therapy equipment up to date. They are constantly recruiting new surgeons, one of those specialties that has been overwhelmed by the increasing demand for surgery, the increasing numbers of patients, and the inelasticity of the supply.

Of course there is a published list of those procedures and conditions that can and can not be actively treated. And there are guidelines now for the frequency of follow-up visits. For the most part, cancer patients are assured that they will, at least, get palliative care. But there were some hard fought battles at the beginning over what should and should not be on the list. Of greater concern is the fact that the list takes time to amend.

While your inpatient unit and outpatient facilities are in pretty good shape, you do wonder about the whole infrastructure of the hospital. A lot has been neglected. New facilities have not been built. And the new management is known for its cost cutting.....

9:00 am January 1993

Dave Kendall, the author of one of the managed competition bills, is sitting up in front of the huge round table. Around it are the Presidents of more oncology societies than have ever been in one place at the same time.

Kendall is at the Oncology Presidents' Retreat, an invitation-only meeting with official representatives of ASH, ONS, ASCO, ACCC, national ACS, MGMA, NCCS, and 30 state societies. Interspersed between the oncology

Good questions for Hillary's team

Ira Magaziner's January 1993 White House memo to the Health Care Task Force poses several questions to the team. Here are some of the issues not resolved as of that writing....

- What constitutes a reasonable guaranteed benefits package? If the chosen package is too thin, a multi-tier health care system will develop based on income; if it is too comprehensive, cost increases may be difficult to control.
- How should budgets and the associated premium caps be set? Who should set them? How should they differ by state? Should there be different capitations based on the health status of individuals and how should they be determined?
- How will quality of care be measured and improved? How will quality be ensured without micromanaging health care processes? How can the system move toward meaningful outcome measurements? How can "best practice" information be collected and disseminated efficiently? How can we be sure that cost control does not lead to lower quality care?
- Can doctors, hospitals, and nursing homes opt out of the system entirely and work on a fee-for-service or own insurance basis and be free of spending caps? If so, then might we be creating an elite system for those who can afford to pay more? If not, then are we denying people basic freedoms?
- How will administrative savings be realized? How do we create universal quality and reimbursement forms? How do we create an efficient patient information system? How do we reconcile the desire of different health care insurers to control costs and utilization in their own way with the need for simplification of provider paperwork?
- How will the malpractice system work? What review mechanisms will be built into health networks themselves? Under what circumstances will lawsuits be tolerated? Will there be caps on awards? How will malpractice insurance be sold?
- What restrictions, if any, will be placed on the type of relationship which can exist between insurer and provider? Will providers be free to affiliate with multiple insurers? Will hospitals be permitted to deny use rights to physicians not participating in affiliated plans of that hospital?
- How will drug price increases be controlled? Will this be done nationally? How can we ensure that innovation is not stifled?
- To what extent will insurers be permitted to offer packages which differ from the nationally guaranteed package? If they can, how can complexity and its extra costs be avoided?
- What will be the underlying ethical guidelines for the system? Will rationing be explicitly condoned or prohibited for certain tests and procedures?

Presidents are other representatives from HCFA, GAO, FDA, NCI, the Hill and the leadership of the biotechnology industry.

Kendall is saying that he hadn't heard from Hillary yet. But then, it's early. She'd just been appointed. She has yet to make her journeys up to the Hill or to work with the staff of 100 to 300 health care experts being assembled by Presidential friend Ira Magaziner.

Kendall has heard of a number of issues that concern oncologists and their patients.

"We are going to put something in the legislation about coverage for clinical trials," said Kendall, acknowledging the expressed concerns of ACCC and ASCO. He goes on to say that there was other good news for oncology: the end of pre-existing conditions and certain inclusion in the basic benefits package.

Dr. Mike Miller, the legislative aide for Congressman Sander Levin of Michigan is sitting next to Kendall. He's disagreeing with some of Kendall's views on managed competition within a global budget, and telling the group that he believes this Administration will be sympathetic to requiring Medicare carriers to use the three compendia for off-label determinations. The Levin-Rockefeller bill will be re-introduced just in case. Clearly there is a lot left to be resolved.

Up at the White House, Ira Magaziner, Senior Advisor for Policy Development, is putting the finishing touches on a memo to the 300-member, super-secluded health care task force. He's pointing out the basic structure of the White House plan, already laid out by the Jackson Hole group. There will be a "National Health Board...(to) set a standard comprehensive benefits package for all Americans," says the Magaziner memo. "All employers would be required to pay a percentage (perhaps 75-80 percent) of the cost of a standard plan for their employees and dependents....The federal government would assist small companies in the early years so that this requirement would not cause undue hardship."

"State-based Health Insurance Purchasing Cooperatives (HIPCs) would manage competition among private health care plans on behalf of at least small businesses and individuals who lack negotiating clout. Businesses not included in HIPCs would negotiate with providers to offer the basic package directly to their employees, much as they do today," Magaziner tells the Task Force.

He goes on to say that these Cooperatives will negotiate premiums, distribute information and marketing materials to consumers, and risk-adjust premiums to prevent adverse selection by consumers during open season. The unemployed and other non-workers will be entitled to buy a plan on a subsidized basis through the HIPCs.

Magaziner says "the plan (often described as managed competition with global budgets), would provide a new market structure within which competition could work to ensure efficient care delivery and control costs."

There are a number of benefits to the plan, says Magaziner:

> "Insurance reforms (standard benefits, no medical underwriting, community rates) would provide individuals freer choice of plans. HIPCs and large companies would drive tough bargains with insurers eager to sign up the consumers they represent:...The reforms would stimulate competition on price and quality among insurers....Consumers would be given incentives to choose efficient plans....Insurers would be held responsible for controlling costs. They would likely replace uncontrolled fee-for-service systems with new payment mechanisms (e.g., capitated payments, salaried doctors). These systems would likely hold providers accountable for managing the volume and quality of care."

12:30 pm
January 15, 2000

It's time to go down to the cancer control meeting. Screening clinics and prevention are a way of life now, and the contracts that your organization writes offer discounts for firms that insist that their employees go through regular prevention classes and reasonably frequent screenings. The early detection regimens have certainly moved the breast cancers and the colon cancers into the early stage category. Advanced ovarian cancers are a rarity even in poor rural minority areas of the country... thank goodness. It's good prevention and good cost effective care.

There will be rounds to do soon and there is a full house of very sick patients upstairs. You are not too worried about any of the care that you are giving. Most of it is by the guidelines and that is exempt from malpractice. You are pretty efficient in your care and with the nurses and the PAs and the social workers, your patients are sending back fairly high satisfaction ratings on the service. Your outcomes index is pretty good, survivals are where they should be...albeit that the sample is too small to be very meaningful.

Of course, it's not what you thought it was going to be when you went into medical school. And the kids that are following you are still under incredible pressure to go into primary care and stay away from specialized medicine. You can get the costs of your education covered and you have a good benefits package if you go into primary care. Teaching hospitals aren't doing very well, and their supplements from the Fed are based on primary care physician production. Pretty early on all of their extra supplements got cut out.

If you have a concern about the future, it is that the high technology stuff may dry up. The pressure on the pharmaceutical companies has been terrific the last few years, and they just aren't doing the kind of investment in R&D that they used to do.

Worse, the Feds are talking about reforming the system again. They are saying that health care costs are threatening the economy and the deficit is beginning to balloon once more. You are not certain how much more they can cut and still deliver quality care to the growing numbers of elderly cancer patients you have to see. Whatever happens, you hope that they will quit switching patients in and out of your practice every year, sending them this year to you and next year to the guy down the street.

Certainly your afternoon meetings should give you some clues. There's the session on guidelines for cancer care and ways that they can be updated more quickly. Then on to the strategic planning committee for the Springfield Accountable Health Plan (AHP) to determine what can be done to add value over the competition. Finally, there is tonight's medical and hospital society meeting. The topic should be interesting. Someone from Washington is coming in to talk about health care reform and the national budget.

Steve Goodman died of recurrent leukemia at Memorial Sloan Kettering in the late 1980s.