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PODCAST

Supreme Court Affordable Care Act Decision: Implications for Practicing Oncologists

By Paul R. Helft, MD[1], David Eagle, MD[2] | July 19, 2012

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Interviewed by Anna Azvolinsky, PhD

CancerNetwork *discusses the recent Supreme Court ruling and its implications for oncology practices and cancer patients with two practicing oncologists—David Eagle, MD, a medical oncologist in North Carolina and president of the Community Oncology Alliance and Paul R. Helft, MD, director of the Fairbanks Center for Medical Ethics and associate professor at the Indiana University School of Medicine.*

In a 5-to-4 vote announced June 28, the Supreme Court upheld the Affordable Care Act, keeping the majority of the law intact and establishing the individual mandate as constitutional. The mandate requires Americans to purchase health insurance or incur a fine, or as the high court interpreted it, a tax. The ruling, however, restricted the law's expansion of Medicaid and now individual states, if they choose, will have the option not to expand their Medicaid program without suffering any penalties.

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AUDIO:

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CANCERNETWORK: *Now that the law is upheld, what are the next steps? When can we expect the majority of the changes to occur? Dr. Helft, let's begin with you.*

DR. HELFT: Well, the interesting thing about it, is that whether the law was upheld by the Supreme Court or not, the changes that were in a sense spurred on by healthcare reform in general had already begun to affect the healthcare system. My organization, like most large healthcare systems around the country have already begun the process of adapting to a new healthcare payment environment in which everybody expects that payments and reimbursements will go down, and a new model of healthcare financing will be put into effect whereby we will be responsible for the healthcare of populations of patients rather than being paid for each individual patient care interaction.

So, I would like to argue that a lot of the momentum has already carried changes into place, and in fact most large healthcare systems felt these changes were inevitable. The actual changes according to the law, from my understanding, those will happen in the next couple of years.

CANCERNETWORK: *So these changes you have described, is each individual state beginning to put these systems into place or is this happening on a more federal level?*

DR. HELFT: My impression is that this is happening at a national level and that there are some variations state by state, especially with respect to how to manage each state's Medicaid funding. But the idea of capitated payments, healthcare populations, accountable care organizations, quality incentives, and so forth—those are well underway—and I think that everyone is already in the process of preparing for those changes.

CANCERNETWORK: *Dr. Eagle, do you have anything to add?*

DR. EAGLE: To start with the initial question, I think the law is really implemented in phases. Some of the provisions have already been implemented such as allowing people to stay on their parents' policy until the age of 26—2014 is a critical year. That year the individual mandate becomes

enforced, Medicaid expansion was supposed to happen that year but that is no longer an issue since the Supreme Court has ruled on that. But a lot of administrative tasks have to be done too, which is getting the exchanges to operate, getting the rules and regulations for defining the private insurance market to function, and clarifying what are to be considered the essential health benefits. These are things we can expect to come.

I agree with Dr. Helft. I think people are preparing for a new payment model potentially, but in terms what exactly what that is going to be, I think it is still unclear. Massachusetts passed its healthcare law in 2006, which is similar to the Affordable Care Act, and is at its heart a coverage act. What it is struggling with right now is how to control the costs, and it is looking most strongly at fee-for-service and bundle payments, but that is taking 6 years just to get us started on that process. I think everybody expects something similar from the Affordable Care Act, but when and how that is going to happen is not clear. The Affordable Care Act lays groundwork for cost savings, bundle-payment initiatives, accountable care organizations, and the Independent Payment Advisory Board (IPAB), but exactly how that gets implemented remains to be seen.

DR. HELFT: Dr. Eagle's comment is really a great summary. What I am hearing from people in administration in large healthcare systems is that what they are struggling with now is, in a sense, living with one foot in a small boat and one foot on the dock, because healthcare financing changes are happening yet we are still operating, basically, under the old model. So management is very complicated as we are trying to live in two worlds at the same time.

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CANCERNETWORK: *In terms of oncology, specifically, what are the fundamental provisions for cancer patients and those at high risk for cancer? Will these now reach more patients under the new act? Dr. Eagle, let's start with you.*

DR. EAGLE: The law does a lot of great things for cancer patients. Those eliminations of lifetime benefit caps, prevents from rescinding coverage, and probably one of the most important things it does for cancer patients is eliminates pre-existing conditions as a reason to deny someone healthcare. We are seeing many more former cancer patients move into survivorship mode of care, so this is really important for them. Lower prices for preventive services, such as cancer screening as well as routine cost of clinical trials. In the next few years, the amount of the doughnut hole will be phased down as well, and that is very important as some of the oncology agents we are using are very expensive, and we do have patients that have a very hard time accessing these therapies because they have a payment responsibility. So I think these are the things that can be very helpful for cancer patients.

CANCERNETWORK: *Dr. Helft, do you have anything to add to that?*

DR. HELFT: No, that was just a terrific summary of the specific provisions that affect cancer patients. To state the obvious, we believe that more patients in general will receive care and therefore will have access to primary care, basic screening, surveillance and so forth—I think that can't be understated. It will have the effect it intended to.

CANCERNETWORK: *In terms of oncology patients, do either of you see major changes in terms of the patient? We have already touched upon this, but is there anything specific in terms of screening or care?*

DR. HELFT: This is already happening to a large degree, but the great focus on quality measures and outcomes will only be strengthened by the provisions of the act, by pay-for-performance measures, and I think that is already affecting oncology care and oncology practices.

DR. EAGLE: I agree with that. I am president of the Community Oncology Alliance, and we are taking a very active role in trying to define these quality measures. I think what you will probably see is the private sector taking the lead in trying to figure out the best way to operationalize quality metrics. We are working with payers in a multi-state initiative to do exactly what you propose, because I think there is an appetite within the Centers for Medicare and Medicaid Services (CMS) to look at pilot programs to figure out how to do that, but they will need the cooperation of the oncology community to do that.

DR. HELFT: Even prior to when it was popular to do so, we oncologists have always had a focus on end-of-life care because that is something that we deal with on a daily basis, but the way that the reform act changes the incentives I think will lead to an even greater focus on cost of care at the end of life. In particular, how cost effective many of the cancer therapies that we provide at the end of life in advanced cancer settings, how those are going to be utilized. So I think these will likely come under greater scrutiny.

CANCERNETWORK: *Most of the really expensive oncology drugs are those for metastatic disease at the end of life, and many of these treatments only incrementally benefit either progression-free survival or overall survival. So do you think there will be, like you said, more scrutiny in evaluating the value of these drugs?*

DR. HELFT: So that process has been taking place already for the past 10 to 12 years as new targeted and very expensive agents have come into general practice. There were questions raised even as very sensitive targeted therapies were brought online in the late 1990s and early 2000s about the overall cost-benefit ratio of these therapies. So that is going to receive more scrutiny.

There is a great deal of evidence that there is overtreatment of advanced cancer patients at the end of life. For example, chemotherapy given within 30 days and 2 weeks of death, and referral into hospice programs taking place with a median of about 20 days now, and those sorts of outcomes are clearly aligned with some patients' preferences, but there are data to suggest that they are not aligned with many patients' preferences. So one of the incentives, in a sense, lines up well with good medicine—that is, we should be treating patients at the end of life in ways that are consistent with their values and preferences. I certainly think that is going to receive a lot of scrutiny and focus in this context.

DR. EAGLE: I agree with Dr. Helft that those issues he pointed out need greater focus. The paradox of the law is, in a sense, it doesn't really do that directly. Under the current CMS system, drugs are approved based on efficacy, the cost of the therapy is not really included in the approval process and CMS is obligated to pay for any FDA label for its use. The independent payment advisory board is an important part of the cost-control measures of the law, but by statute it is really not allowed to address benefit design or what Medicare beneficiaries receive. It can only look at payment amounts for providers and therein lies the problem, because there is only so much you can achieve by looking at payment amounts of providers.

I think this is kind of the paradox of the law, that despite its being such a sweeping, comprehensive law, it is incomplete. At its heart it is a coverage act. The details in terms of how it is going to achieve cost control are really going to be decisions that are going to have to be made in the future and Massachusetts is struggling with this now. So I think that what Dr. Helft described is really going to be the hardest part of all of this. How do we actually do these things? The law doesn't really explicitly say how we are going to do these things, and I think those are going to be the difficult decisions that lay ahead.

DR. HELFT: What a terrific point Dr. Eagle just made because this is the part—as both an oncologist and an ethicist I struggle with the most—and that is in a sense, the statute puts pressures on organizations to limit cost, but really, the limitation of cost will take place in the clinic office, right? When we sit down with patients or when we see them in the hospital. So doctors and nurses who deal with patients in these situations, I would argue, we are very unequipped to have these kinds of conversations about cost effectiveness, about the burdens and benefits of treatment. We do that to a large extent now but we leave out this whole dimension of cost. And certainly patients and families and the populous at large are not at all prepared

large extent now but we leave out this whole dimension of cost. And certainly patients and families and the populous at large are not at all prepared to have those discussions. So I totally agree with Dr. Eagle on that.

CANCERNETWORK: *Along the same lines, what do you think that this will mean for oncologists who serve a lot of low income or underinsured patients? Will this help ease some of the financial pressures for these practices?*

DR. EAGLE: I think that to an extent the answer is yes. The more patients that can become insured vs completely uninsured, that is a good thing. I think what we may see is a rising phenomenon of underinsurance, and Medicaid can sometimes be an example of that. For instance, in North Carolina, in 2009, they changed the fee schedule for drug reimbursement to where probably more than half of the chemotherapy drugs were reimbursed by Medicaid for a price of less than what I can purchase them for, and that just doesn't allow me to treat those patients in a lower-cost office setting. We figured out work-arounds for that, but it creates a new set of issues, so thorny issues will still be there. There is an underlying cost of providing care and even an insured patient, if the payment amounts are lower than the cost of the expenses of providing the care, you do get issues of figuring out how to manage those patients, so that is something that can happen with or without insurance.

DR. HELFT: I agree with every point that he made. There is also the sheer issue of the fact that as we bring more and more people into the healthcare system, which I am all in favor of. We practicing oncologists are about 11,000 in number across the United States. If you think about that up against the sheer number of cancer cases and those who will have greater access to care, I think there is a man and woman power issue that is going to be operative. That is operative now, by the way, but perhaps in new ways it will become operative.

CANCERNETWORK: *I wanted to follow up and ask whether this act will help flood the system and whether we will need many more community oncologists. Many of the baby boomers are also getting older, so the elderly population is also increasing quite a bit.*

DR. EAGLE: I think the demographic changes alone will drive that. The aging populations—if you just look at cancer incidence and prevalence, it is going up. Both because we have an aging population, but also because cancer patients are doing much better. A colon cancer patient with metastatic disease, 15 years ago, the median survival was 8 months, and now it is approximately 2 years. So there are just more patients that are receiving more intensive therapy for longer periods of time.

CANCERNETWORK: *As a final question, what do you see as the biggest questions that both oncologists and patients will be asking in the context of patient care and this new law? Dr. Helft let's start with you.*

DR. HELFT: I guess I would go back to the issue that is related to what we talked about and that is we have not really been asked as a society and as a medical care system to bring rationally driven treatment limitation decisions to bear. The few experiments that the United States has tried in those areas to limit treatment have actually not worked. So we have very limited experience at limiting treatments, especially on the basis of measures of cost and effectiveness together. The best example would be organ transplant patients where we do clearly allocate resources based on medical needs, but that is an example of an absolutely scarce resource. So we do not have enough donor livers to transplant into all of the patients who need a liver transplant, and so we have had to ration them. But we have not faced those kind of allocation decisions to any extent really, and I think we will be struggling with those for years to come.

CANCERNETWORK: *Dr. Eagle, do you have anything to add?*

DR. EAGLE: I completely agree. I think it is how we tackle this difficult issue of containing the cost. Anytime there is a renaissance of new and effective therapies, ready to come to market, I think that is going to be the central issue. And there are different ways to do that. Most other countries have health policies and agencies such as England's NICE that looks explicitly at these types of things and we do not do that. I think there is some appeal potentially, to have physicians do this at the bedside because oncology patients' circumstances can be very unique, and their wishes can be very unique, but at the same time not all oncologists see the value of treatment the same way.

In addition to that, we really don't have any authority over the pricing of the therapies either, so there is probably some disconnect between what we feel our obligations to our patients are, in terms of giving them what will help them. Provenge, for metastatic prostate cancer, might be an example of that, because we really don't have any authority over the pricing of therapies so it seems that perhaps we are not in the best position to withhold treatment if it looks like it would benefit our patients. I think those are some of the issues we are going to struggle with: what are the mechanisms to control costs and what is a fair way to do that at the societal level.

CANCERNETWORK: *Thank you both so much for joining us today!*

DR. EAGLE: Appreciate it, thank you!

DR. HELFT: Thank you!