The US Oncology Network
Health Policy Report

Wednesday, November 28, 2012

Congress Begins Discussions on End-of-Year Fiscal Cliff

As previously reported, Congress has only four weeks to develop and agree upon a sweeping budget deal to avert a "fiscal cliff" of $7 trillion in tax increases and spending cuts over a decade set to take effect January 1. These 2013 funding cuts are attributed to expiring tax cuts and unemployment benefits, across-the-board spending cuts scheduled under the Budget Control Act and the 27 percent Medicare payment cut to physicians under the Sustainable Growth Rate.

While some members of Congress are pushing for a complete deficit-lowering plan by the end of the year, others are calling for a deficit-lowering "down payment" plan in the lame duck session that could serve as a foundation for a more comprehensive agreement next year. Recently, some liberal Democrats have even indicated that if Republicans are not willing to make concessions on increasing taxes on the wealthy and protecting benefits under entitlement programs, they are willing to "go over the cliff" and take up the matter again with new members and a greater opportunity for compromise in the 113th Congress. In this scenario, postponing action on a solution could lead to a second U.S. credit-rating downgrade in two years, according to credit-rating agencies.

According to a new report from the Congressional Budget Office (CBO), the nation's unemployment would rise from 7.9 percent to 9.1 percent by the end of next year if it goes over the cliff. Avoiding the cliff, on the other hand, would add 3.4 million full-time-equivalent jobs and add $503 billion to the federal deficit in 2013 and $682 billion in 2014.

Click here to read more about the CBO report.

GOP Doctors Caucus Pushes for One-Year SGR Fix

The GOP Doctors Caucus is pushing to pass legislation before the end of the year to delay for one year the scheduled January 1 Medicare physician payment cuts of 27 percent under the Sustainable Growth Rate (SGR).

Although Congress is expected to pass an SGR fix during the lame duck session, a shorter patch – such as one that lasts through the end of March – may be in order due to competing party interests and a limited window for action.

In terms of funding the $18 billion cost of a one-year fix, lawmakers have long argued over whether to use future troop drawdowns in Afghanistan as a payfor. While some Democrats, physicians associations and consumer advocate groups have urged the use of reductions in the Overseas Contingency Operations fund to pay for an SGR solution and avoid cutting Medicare benefits or payment to other providers, House Republican leadership has opposed the approach, saying that the war funding is budget gimmickry rather than real savings.

Congress' most recent SGR fix lasted less than a year, and both the House and Senate have held hearings this year to identify more lasting payment solutions to prevent steep cuts to physicians under the flawed SGR. Certain lawmakers have also introduced legislation on the topic, with Rep. Michael Burgess (R-TX) sponsoring a bill to keep payment rates intact for one year and Reps. Allyson Schwartz (D-PA) and Joe Heck (D-NV) creating legislation that would establish a five-year SGR transition period for testing new physician payment models, for example.

The US Oncology Network will continue to advocate for a permanent solution to the SGR cuts, and the development of legislation during the lame duck session to avert the looming cuts in January.

New York Times Article on Importance of Communication in Late-Stage Cancer Care Highlights Effective Approach of The US Oncology Network

In her November 20 article "When Treating Cancer is Not an Option," New York Times columnist Jane Brody explains how the majority of patients facing advanced and incurable lung or colon cancer incorrectly believe that chemotherapy drugs could render them cancer-free.

(Continued on page 2)

The US Oncology Network
Health Policy Report

Wednesday, November 28, 2012

New York Times Article on Importance of Communication in Late-Stage Cancer Care Highlights Effective Approach of The US Oncology Network *(cont'd)*

According to a new study of nearly 1,200 patients with stage 4 lung or colon cancer, 69 percent of patients with lung cancer and 81 percent with colon cancer did not understand "that chemotherapy was not at all likely to cure their cancer."

The study, conducted by researchers at the Dana-Farber Cancer Institute in Boston and published in The New England Journal of Medicine (NEJM), underscores how when patients do not understand the limitations of their treatment, their consent to receive it is not truly informed. Further, when patients pursue continued chemotherapy under the incorrect belief that they still have a chance for a cure, it can often delay their transition to hospice care and the physical, emotional and practical benefits it can offer.

An editorial accompanying the study in the NEJM speaks of the "optimistic bias" that prompts patients to believe treatment can cure them despite the odds. Dr. Thomas Smith, an oncologist and director of palliative care at Johns Hopkins Sidney Kimmel Comprehensive Cancer Center and one of the editorial authors, notes that even with repeated discussions approximately one-third of patients are unable to admit having a disease that will lead to their death within a year or so. "Our job is not to force them into acceptance but to encourage them to plan for the worst while hoping for the best. Such patients have better outcomes — less depression and less distress, and they're more likely to die comfortably at home," he said.

In the study, cultural and racial factors as well as religious beliefs were believed to influence patients' acceptance of the futility of continued treatment. However, patients' educational level, degree of disability and participation in their decision-making were not found to be associated with their inaccurate beliefs about chemotherapy as a cure. According to Dr. Smith, how doctors discuss patients' options with them and how they describe the potential of continued treatment can make an enormous difference in patients' decisions. He suggests that physicians ask patients what they want to know about their prognosis, tell them what they want to know, and then ask the patient, "What do you now understand about your situation?"

Other questions that Dr. Smith recommends for physicians are:

- How much do you want to know about your cancer?
- What do you know about your cancer?
- Who would you like to include in discussions about your care?
- Would you like me to write down the important points?
- What are you hoping for?
- Who are your other doctors so that I can communicate with them?

In addition, doctors should explain the patient's prognosis at the first visit, appoint someone in the office to discuss advance directives, schedule a hospice information visit and offer to discuss the patient's prognosis and coping at each transition point.

Brody's article highlights how using this collaborative approach, physicians within The US Oncology Network have doubled the time patients spend in hospice, lowered costs, lessened patients' symptoms, reduced stress on caregivers and have often lengthened survival – noting how various studies have indicated that cancer patients in hospice care live weeks to months longer than comparable patients not receiving hospice treatment.

Click here to read more about the NEJM study.

Bloomberg Article Highlights Higher Reimbursements for Hospitals Under Medicare

A November 19 Bloomberg article, "Hospital Medicare Cash Lures Doctors as Costs Increase," notes that hospitals receive higher reimbursements than individual doctors for the same specialty services – in some cases as much as three times more – forcing many physicians to either cut staff, lower salaries and defer investments to stay open or sell their practices to local hospitals. *(Continued on page 3)*

The US Oncology Network
Health Policy Report

Wednesday, November 28, 2012

Bloomberg Article Highlights Higher Reimbursements for Hospitals Under Medicare *(cont'd)*

Medicare rates for hospitals, according to the American College of Cardiology (ACC), are $400 for an echocardiogram, $180 for a cardiac stress test and more than $25 for an electrocardiogram. At a private physician's office, Medicare pays $150 for an echocardiogram, about $60 for a cardiac stress test and $10 for an electrocardiogram.

As noted in the article, in Wisconsin the number of cardiologists in private practice has declined to only 11 percent from 62 percent of cardiologists in 2007, according to the ACC. The larger national trend of hospitals buying private physician practices threatens to raise the price of health care, according to the report: Bigger hospitals' increased market share and elevated bargaining power allows them to negotiate higher reimbursements from insurers, thus adding to costs in the short term.

While physicians moving to hospitals are able to receive stable incomes, they experience less freedom over how they treat their patients and greater pressures to see more patients each day when employed by hospitals, according to the article. Patients could suffer from this consolidation in care by having to travel farther for care and not having access to the latest integrated, state-of-the-art care that many private practices offer.

Click here to read The US Oncology Network issue brief explaining the need for Medicare reimbursement equality in cancer care.

HHS Issues Draft Rules on ACA Requirements for Health Plans

On November 20, the Department of Health and Human Services (HHS) outlined how the Affordable Care Act (ACA) will regulate health insurance plans sold after 2014 with the agency's release of three new draft regulations related to the law's requirement that insurers cover sick or older applicants, what package of "essential benefits" must be included in health plans sold through state insurance exchanges and employers' provision of employee wellness programs.

These rules include:

A rule on health insurance market reforms detailing how the ACA will ban insurers from discriminating against consumers with pre-existing conditions and limit how much insurers can vary premium prices based upon age, tobacco use, family size and geography.

A rule on essential health benefits underscoring the ACA's requirement that all insurance products sold in state individual and small-group markets include a minimum package of benefits.

A rule providing employers with information on employee wellness programs, designed to offer companies financial incentives for keeping employees healthy without discriminating against sick.

Click here to read an HHS fact sheet on the proposed rules.