NCCN Roundtable Considers the Effect of Health Care Reform on Oncology Practice: Confronting Risk

The second roundtable of the NCCN 19th Annual Conference explored the Affordable Care Act (ACA) and the new-found risk that providers, payers, and patients are learning to navigate.

FORT WASHINGTON, PA—On Friday, March 14, 2014, the National Comprehensive Cancer Network® (NCCN®) hosted its second roundtable of the NCCN 19th Annual Conference: Advancing the Standard of Cancer Care™, titled, The Affordable Care Act: Where are We Now? Clifford Goodman, PhD, The Lewin Group, moderated the discussion, which explored the Affordable Care Act (ACA) and health care reform in the United States, its effect on the oncology landscape, and assessment of risk for providers, payers, and patients.

Dr. Goodman was joined by Christian G. Downs, JD, MHA, Association of Community Cancer Centers; Liz Fowler, PhD, JD, Johnson & Johnson; Michael Kolodziej, MD, Aetna; Lee H. Newcomer, MD, MHA, UnitedHealthcare; John C. Winkelmann, MD, Oncology Hematology Care, Inc., and Councillor, American Society of Hematology; Mohammed S. Ogaily, MD, Henry Ford Health System; and W. Thomas Purcell, MD, MBA, University of Colorado Cancer Center.
Dr. Goodman opened Friday’s roundtable discussion by asking Dr. Purcell how, since the implementation of the ACA, patients have been presenting differently than in previous years.

Dr. Purcell described how, at University of Colorado Cancer Center, two distinct groups have presented since the ACA: medically indigent adults and newly underinsured patients who, for the first time, are within a narrow network and do not have the same access to comprehensive care that was previously available through employer-sponsored programs. These groups, he said, now qualify for Medicaid or have purchased Bronze Packages; however, both are accompanied by large co-pays.

Due to the well-run state exchange and Medicaid expansion in Kentucky, said Dr. Winkelmann, adult patients are, for the first time in years, seeing their primary care physicians. In turn, he said, oncologists are experiencing an influx of newly insured patients because they have undergone overdue routine cancer screening.

Patients who recently acquired health care and who have been putting off treatment are now presenting with complex cases that require an immediate need, added Dr. Ogaily.

Dr. Fowler and Mr. Downs explained that this poses risk in oncology because, when the ACA was first implemented, young, healthy patients (less than 35 years old) were expected to sign up in multitudes. To the contrary, Mr. Downs added, a risk pool has emerged as the majority of new enrollees are around the age of 55, and this demographic is more likely to have cancer, require expensive treatment, and carry other comorbidities.

Dr. Goodman asked Dr. Kolodziej and Dr. Newcomer how, as payers, they are assessing their risk with more patients requiring more expensive care.
Drs. Kolodziej and Newcomer agreed that, given the fact that the market has been open for less than 90 days, the necessary claims data is not available to adjust premiums.

“We are trying to understand how the process works,” said Dr. Newcomer. “And, then we are ready to get fully committed and expand as soon as we understand how it’s going to work.”

“Given the uncertainty, you manage what you can manage,” said Dr. Kolodziej. “Many of the strategies to manage the risk of this unknown pool are the same strategies we use to manage the risk in the pool that we do know about.”

“If the risk pool stays risky, does it all fall apart?” Dr. Goodman asked Dr. Fowler.

“Congress and the public need to think about what adjustments they need to make,” said Dr. Fowler, who, prior to her employment at Johnson & Johnson, worked with the U.S. Senate and at the White House on the authoring and implementation of the legislature. Dr. Fowler explained that there are three mechanisms for self-correction—referred to as the premium stabilization programs—built into the law to make amends for enrolling sick people up front: the temporary reinsurance program, the temporary risk corridor program, and permanent risk adjustment.

According to the panel, risk is not only eminent for payers and providers, but also for patients. Quality of care is a major concern for patients with rare diseases, explained Dr. Purcell. Because patients with rare cancers require state-of-the-art treatment that is not always available in the community setting, they seek care at larger, academic centers that are not covered within their narrow markets, and these patients are forced to pay for their care out of pocket.
And, with more and more community oncology practices being purchased by larger hospitals, financial risk is eminent for patients, said Dr. Ogaily. Trying to work through a hospital is more difficult and more time consuming, therefore, raising administrative costs, he said, adding that those costs are transitioned to the patients.

Further, if a community practice is purchased by a hospital, said Dr. Newcomer, payers are seeing as much as a 10-fold rise in drug costs. Patients, then, make up for the rise in cost through co-pays and deductibles, and the provider pays the difference, he explained.

“We can all agree that there is a lack of transparency and this discussion degenerates into a qualitative versus a quantitative argument,” said Dr. Kolodziej. “The solution is shifting risk.”

“What we need to do, collaboratively, is work on reducing administrative expenses,” said Dr. Newcomer. “It’s going to take discussions, it’s going to take experiments, and it’s going to take a blank piece of paper.”

In closing, Dr. Goodman asked the panel to discuss what they believe the keys for successful implementation of the law will be. The answers: integrated care, payment reform, and an increased focus on value and quality.

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The National Comprehensive Cancer Network® (NCCN®), a not-for-profit alliance of 25 of the world’s leading cancer centers devoted to patient care, research, and education, is dedicated to improving the quality, effectiveness, and efficiency of cancer care so that patients can live better lives. Through the leadership and expertise of clinical professionals at NCCN Member Institutions, NCCN develops resources that present
valuable information to the numerous stakeholders in the health care delivery system. As the arbiter of high-quality cancer care, NCCN promotes the importance of continuous quality improvement and recognizes the significance of creating clinical practice guidelines appropriate for use by patients, clinicians, and other health care decision-makers.

The NCCN Member Institutions are: Fred and Pamela Buffett Cancer Center at The Nebraska Medical Center, Omaha, NE; City of Hope Comprehensive Cancer Center, Los Angeles, CA; Dana-Farber/Brigham and Women’s Cancer Center | Massachusetts General Hospital Cancer Center, Boston, MA; Duke Cancer Institute, Durham, NC; Fox Chase Cancer Center, Philadelphia, PA; Huntsman Cancer Institute at the University of Utah, Salt Lake City, UT; Fred Hutchinson Cancer Research Center/Seattle Cancer Care Alliance, Seattle, WA; The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD; Robert H. Lurie Comprehensive Cancer Center of Northwestern University, Chicago, IL; Mayo Clinic Cancer Center, Phoenix/Scottsdale, AZ, Jacksonville, FL, and Rochester, MN; Memorial Sloan-Kettering Cancer Center, New York, NY; Moffitt Cancer Center, Tampa, FL; The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute, Columbus, OH; Roswell Park Cancer Institute, Buffalo, NY; Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine, St. Louis, MO; St. Jude Children’s Research Hospital/The University of Tennessee Health Science Center, Memphis, TN; Stanford Cancer Institute, Stanford, CA; University of Alabama at Birmingham Comprehensive Cancer Center, Birmingham, AL; UC San Diego Moores Cancer Center, La Jolla, CA; UCSF Helen Diller Family Comprehensive Cancer Center, San Francisco, CA; University of Colorado Cancer Center, Aurora, CO; University of Michigan Comprehensive Cancer Center, Ann Arbor, MI; The University of Texas MD Anderson Cancer Center, Houston, TX; Vanderbilt-Ingram Cancer Center, Nashville, TN; and Yale Cancer Center/Smilow Cancer Hospital, New Haven, CT.

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