Cancer Health Disparities and the Cost of Cancer Care: Payment Model Issues

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Despite major advances in cancer research, screening, and treatment over the past few decades, not all Americans with cancer have benefited equally. Although the rate of cancer-related death has decreased 14% between 1991 and 2004, racial and ethnic minority patients continue to die disproportionately from cancer, even after adjusting for insurance status and income. Factors contributing to cancer health disparities include limited access to cancer care because of lack of insurance or underinsurance, lower quality of cancer care, lower socioeconomic status, and cultural and social factors.

In 2010, the Affordable Care Act (ACA) was signed into law, marking the most comprehensive health care reform since the creation of Medicare and Medicaid in 1965. The major provisions of the ACA serve to decrease the number of uninsured Americans, partly by expanding Medicaid coverage to an additional 20 million individuals. Other reforms set forth by the ACA are aimed at improving health care outcomes and streamlining health care delivery via several mechanisms: the creation of accountable care organizations (ACOs), a shift away from fee-for-service payment structures to payment bundling, and increased funding for comparative-effectiveness research.

Although the ACA provides several opportunities to reduce or eliminate cancer health disparities, very little in the law actually addresses the affordability of care. In fact, current political and economic climates have placed major aspects of health care reform in peril. National health expenditures as a percent of the US gross domestic product (GDP) totaled 5% in 1965 but are expected to total 20% by the middle of this decade. Although spending on cancer care constitutes only 5% of the overall health care budget, these costs continue to rise at a more rapid pace than any other area of health care. Debates over entitlement reform and sequestration cuts have brought health care costs to the forefront. In the current climate of cost-consciousness, how can health care reform simultaneously address health disparities and the cost of cancer care? With sequestration in place and looming cuts to entitlements, we focus on forthcoming changes to Medicaid, Medicare, and payment structures and how these will affect disparities in cancer care.

Medicaid Expansion

The cornerstone of the ACA is the expansion of Medicaid. Medicaid is often viewed as health care coverage for the nonelderly poor, and in fact, it currently covers about 50 million Americans, most of whom are in working families. Under the ACA, estimates of associated costs required to provide care in the face of increased demand are highly variable, but the Congressional Budget Office estimates that 16 to 20 million additional individuals will obtain care through Medicaid and the Children’s Health Insurance Program (CHIP) at federal costs reaching nearly $100 billion by 2019. About 160,000 of these Americans have a cancer diagnosis.

In June 2012, the US Supreme Court ruled it unconstitutional to mandate that states demonstrate full compliance with Medicaid expansion to receive any federal funding towards Medicaid. As a result, Medicaid expansion will move forward.
only in states that agree to participate. At the time of this writing, only 24 state governors have opted into Medicaid expansion. Even among those 24 states, many have state legislators who oppose expansion, which ultimately affects authorization and appropriation of Medicaid funds. Notably, several states opting out of Medicaid expansion have high percentages of uninsured, leaving their most vulnerable citizens without a pathway to coverage or a solution to reduce the financial burden of uncompensated care.

Moreover, in 2014, steep cuts in federal direct hospital funding will begin. In expansion states, the cuts will be more than offset by the federal funds for Medicaid. States that opt out will lose funding and gain nothing in return. That means that after the ACA, we can expect even worse health disparities among disadvantaged populations in these states than were seen before the ACA.

Compelling evidence suggests that Medicaid expansion improves survival. A study comparing states that expanded Medicaid with adjacent states that did not showed a decrease in county-level all-cause mortality by about 6% in the expansion states. Delays in care were significantly reduced in the expansion states, and self-reported health increased significantly. These are encouraging new data, but it is important to note that the benefits of Medicaid coverage for people with cancer have been controversial in previous studies. Although evidence suggests that patients who have Medicaid before a cancer diagnosis fare better than those who do not have insurance at diagnosis, several other studies have shown problematic issues with the quality of care that Medicaid patients receive throughout the cancer care continuum.

However, despite its shortcomings, Medicaid is a highly successful program considering the problems facing American health care with sharply rising costs and declining private-sector coverage. Medicaid provides solid coverage to millions of Americans and, according to the Congressional Budget Office (CBO), costs 50% less on average than private insurance.

**Medicare Cuts**

In August 2011, Congress passed the Budget Control Act (BCA), mandating a $1.2 trillion reduction in the federal deficit over 10 years. On March 1, 2013, the failure of Congress and President Obama to reach an agreement on how to achieve this mandated deficit reduction triggered $85 billion in across-the-board cuts in many federal programs and agencies for the remainder of 2013 and subsequent cuts over the next 9 years, known as sequestration. Over the next decade, several health care agencies will see steep reductions in funding, including NIH, NCI, CDC, and FDA. These cuts will have a significant impact on cancer research, delivery of oncology care, and drug approvals.

Importantly, Medicare will face a 2% reduction in funding starting April 1, whereas Medicaid and funding for private insurance subsidies will remain exempt. This preserves the ability of the ACA to fund Medicaid expansion and to continue extending insurance coverage through the creation of health insurance exchanges, which will be implemented in 2014.

The cuts in Medicare will primarily come from reductions in payments to physicians, hospitals, and insurers providing coverage through Medicare Advantage. For now, Medicare Parts B and D will remain untouched. This 2% decrease in funding amounts to $11 billion in payment reductions to physicians, hospitals, and other health care providers. This will place enormous strain on oncologists, who have seen Medicare payments increase by a mere 4% over the past 12 years, while the cost of caring for patients with cancer has increased by 20% over the same time. The Sustainable Growth Rate (SGR) formula is the method by which annual updates for physician
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payments are determined by Medicare. In recent years, the SGR has actually resulted in a reduction for physician payments, although Congress has typically "patched" the cut every year. The cumulative effect of repeated patching would mandate a 30% cut this year, which would surely force physicians to restrict their Medicare patient base. Although most agree that the SGR has been ineffective, no alternate solution has bipartisan support. In 2012, the CBO estimated that the amount required to replace the SGR was nearly $250 billion; however, they recently revised that figure to $138 billion, putting a solution to the SGR problem within reach.

Despite renewed optimism and energy for SGR and Medicare payment reform, we can expect that the budget cuts will continue to force oncology practices to choose between increasingly thin profit margins or reducing the number of Medicare patients they treat. We can also expect that these cuts will shift the cost burden toward patients. More than half of patients with cancer, many of whom are elderly or disabled, receive insurance coverage through Medicare. Medicare beneficiaries, therefore, represent one of the most vulnerable groups in cancer care, and their numbers are growing rapidly due to population aging. These cuts to Medicare may well reduce access to care and ability to pay for minimum standards of care, thereby potentially worsening existing disparities.

Payment Bundling

One of the most direct measures the ACA will implement to curb rising costs is to institute a payment-bundling model for reimbursement. Under this scheme, each diagnosis will receive a flat-rate payment for inpatient and outpatient care, in contrast to the current fee-for-service system. This structure will provide financial incentives to minimize or eliminate unnecessary testing and to consolidate care plans. Additionally, the ACA provides for the creation of ACOs, the goals of which are to consolidate and streamline medical resource use through a multidisciplinary approach. The overarching goal of ACOs is to encourage enhanced communication between multiple care providers to make health care delivery both effective and efficient.

That payment bundling alone will solve the skyrocketing costs of health care seems overly optimistic. Oncology providers will need to acquire expertise in fiscal responsibility and resource allocation. Even among all available evidence-based FDA-approved treatment options, we can anticipate being increasingly forced to prioritize the use of expensive interventions, potentially depriving access to approved medications or procedures to some patients. Unfortunately, the patients most likely to lose access to these therapies are the most vulnerable patient populations, such as racial or ethnic minorities and the poor.

Conclusions

Health disparities and the costs of cancer care are issues of paramount importance to the entire oncology community. Given our current cost crisis and the stalemate within Congress, oncology providers must be engaged in this issue. Crucial decisions made now will determine how cancer care will be delivered to all of our patients, but particularly the most vulnerable ones. As Medicaid expansion, Medicare cuts, and payment models evolve in the post-ACA era, the entire oncology community must be united in the goal of providing access to high-quality cancer care for all individuals, regardless of race, ethnicity, or socioeconomic status.
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References


