EDITORIAL

What Healthcare Reform Means for Surgical Oncology

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On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act*. Seven days later, in true amendment style unique only to law-making, he signed the *Health Care and Education Affordability Reconciliation Act of 2010*. Every doctor in America will soon begin to notice the implications of these new laws in their daily practice. Several important provisions impact cancer care and surgical practices, including the creation of new agencies, increased research funding, and changes in the way that patients navigate the system and achieve access to surgical oncologists. In reviewing our new laws, we asked “What does health reform mean for surgical oncology?” We highlight key sections of the new laws that directly impact our field.

Funding for Cancer Treatment Research. Beginning this year, \$500 million will be appropriated to a new branch of the National Institutes of Health (NIH) called the Cures Accelerated Network. Grants of up to \$15 million annually per project will be awarded to perform basic science, translational, and clinical research. This new branch will collaborate with the Food and Drug Administration to expedite approval of new medications and devices.

Increased Cancer Screening. Key cancer screenings will now be covered without co-pays, deductibles, or other financial disincentives. Cancer screenings that will be covered will be determined according to highly endorsed Grade A and B recommendations from the U.S. Preventative Services Task Force. These screenings include colonoscopy and Papanicolaou smears. A notable override to these recommendations allows mammography to be covered for patients beginning at age 40 years. In addition, \$45 million will be allocated during the next 5 years to the

NIH and Centers for Disease Control and Prevention (CDC) for breast cancer research, including development and validation of new screening methods and ways to improve patient education. We anticipate that these changes will lead to an increased number of patients presenting with earlier stage cancers.

Funding for Cancer Care Delivery Research. A newly established Patient Centered Outcomes Research Institute will receive more than \$150 million annually in funds by 2012 to support research in delivery of care and outcomes. This Institute will function as a nonprofit corporation with a 19-person appointed board, which is neither an agency nor an establishment of the government. Grants will fund health care services research surrounding cancer care and programs that improve quality and safety for cancer care. A focus will be placed on multicenter trials, studies that can produce generalizable findings and collaborations that use electronic health data.

Keeping Coverage after a Cancer Diagnosis. The bill prevents a patient from being denied health insurance coverage because of cancer—a common preexisting condition. For children, this ban is immediately in effect; however, it does not take effect until 2014 for adults. In the interim, patients denied coverage because they had or have cancer as a preexisting condition can choose a short-term insurance plan from a government-subsidized, national, high-risk insurance pool. In addition, the bill prevents insurance companies from reducing a patient’s health insurance coverage when they acquire a new diagnosis.

Reimbursement of Advanced Imaging. Magnetic resonance imaging (MRI), positive emission tomography (PET), computed tomography, and other imaging machines with an acquisition cost of more than \$1 million will be reimbursed at a decreased amount under the assumption that their utilization has increased. To retain a profit, many imaging facilities will likely become more centralized to maintain high volumes with fewer machines.

Expanded Coverage. Approximately 32 million new Americans will now have access to insurance through a number of mechanisms. Those younger than aged 26 years will be able to remain on their parents' insurance, whereas those aged 55 to 64 years can enroll in a temporary reinsurance program. In addition, subsidies in the form of a sliding scale will be available for those with an income less than four times the federal poverty level. For an individual, that is approximately \$44,000. When all is in place, the Congressional Budget Office expects 1 in 20 Americans to remain uninsured, improving from 1 in 6 currently.

Physician Pay Fix. The bill fails to provide a permanent fix to the Medicare physician pay cut, which is currently tied to the Sustainable Growth Rate. This annual cut began with the passage of the 1997 Balanced Budget Act. Each year, in shocking unity, doctors' groups lobby Congress on the 11th hour to pass a hold to the cut, setting a higher projected cut for the following year. Meanwhile pay is not current with inflation and a permanent fix is not addressed. This issue, along with workforce reform, remains the leading issue among most physician groups.

Noticeably absent from the new law is malpractice reform and global payment reform. Direct costs to providers for malpractice liability, including insurance, settlements, and awards, totals nearly \$35 billion annually (an estimated 2% of total health care expenditures in the United States). Despite its small contribution to overall healthcare costs, tort reform is intensely popular among physicians and physician groups because it drives defensive and clinically unneeded practice patterns.

Whereas policy makers and physicians eagerly wait to see the bill's real-world impact, some argue that the reform is too costly, and still many more contend that more reform is needed to control our nation's soaring and unsustainable healthcare costs. These issues will continue to be studied in the coming years. One issue for which there is widespread agreement is that further legislation is needed to better address the issues still outstanding or partially addressed in the law. From an immediate and practical standpoint for millions of cancer patients, the reforms have significant benefits. In addition to the new funding for cancer research, cancer screening, and increased access to cancer care, insurers will no longer be allowed to limit or deny coverage *after* a cancer diagnosis is made. They also will not be able to cap total lifetime benefits provided to patients.

As surgical oncologists, we will likely soon witness the impact of the recent legislation in our practices. Work volumes will likely increase because more people will have access to medical care and cancer screening is now fully covered. At the same time, preexisting workforce deficits disproportionate to population growth and distribution continue to burden our healthcare system. Surgical oncology can benefit from the research funding, focus on cancer screening, improved patient access to care, and the development new model for efficient, high-quality care. Further legislation is needed to address the outstanding issues of payment reform and workforce planning.