Oncologists: Cost-Effectiveness Policy Necessary Despite Quality of Care Warnings

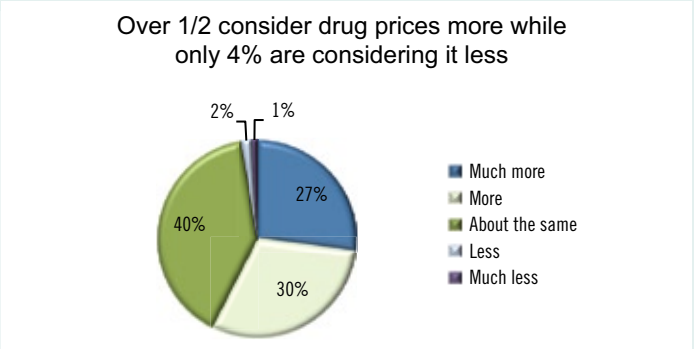
By Bryan Cote

To uncover new ideas, gauge support for current proposals, and collect opinions about how reimbursement and drug access changes may affect the cost and quality of cancer care in the US, we conducted a survey, in association with the Arcas Group, of which 118 community-based oncologists responded. About one-third of oncologists were from single-specialty groups with six or more physicians and about one-quarter of respondents were from academic medical centers and small practices with five or fewer doctors. The seven questions ranged from thoughts on drug pricing to cost-effectiveness policies.

Not surprisingly, the economic downturn has clearly forced many practices to consider drug cost in treatment decisions. This has exposed disparities in access to cancer care, particularly for those patients who have lost medical insurance benefits and, as a result, forgone treatment (Fig. 2).

However, before we get to that, Figure 1 shows that almost 6 in 10 of the respondents are considering the cost of cancer more this year, than they had at this time in 2008. According to some of the comments we received, this may be partly due for several reasons including, patients losing insurance benefits, getting approval from insurers, and Medicare payment reimbursement. One oncologist said, "Medicare pays less than my acquisition costs forcing me to send patients to long waits and delays to be treated at a local hospital at a much higher cost to insurers, including Medicare."

Figure 1. Drug price now more entrenched in therapeutic decision-making



Has your consideration of drug costs in clinical decision making changed from a year ago? (N=118)

Moreover, about one in every five surveyed reported that they use less effective, albeit, cheaper treatment modalities or chemotherapeutic regimens. For about half of respondents, generic scripts are more commonly written than in previous years (Fig. 2).

On the surface, the financial quagmire has inspired greater collaboration—44% said they are working more closely with insurers to address patient financial needs. According to a half-dozen comments by the respondents, manufacturer copay assistance is rising (as OBR reported in July). "[We] hired a part-time FTE, and have received $450,000 over 10 months in foundation assistance for patients," one oncologist said.

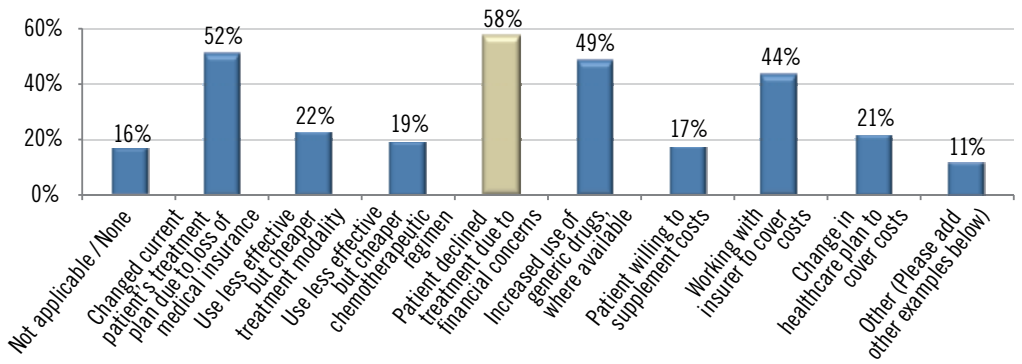
A total of 16 surveyed argued for better pay for cognitive services and uncompensated care that includes phone consultations, catastrophic care insurance after patients pay an up-front fee, better pay for academic centers, and—the most mentioned idea—salaried oncologists.

Despite the respondents' negative view of buy and bill, the payment option still garnered 16% of votes. Several smaller practices commented about their inability to negotiate a competitive ASP. One said, "I'd be happy if I really got ASP plus 6%, but in a solo practice it's generally not even ASP."

Few support episode-based payments as a viable cost-control solution, even as plans like UnitedHealthcare begin pilot programs to test the model (Fig. 4). Interestingly, about the same number who picked buy and bill say there is no compensation model that can control cost and sustain

Figure 2. Unintended consequences of drug cost-based treatment decisions

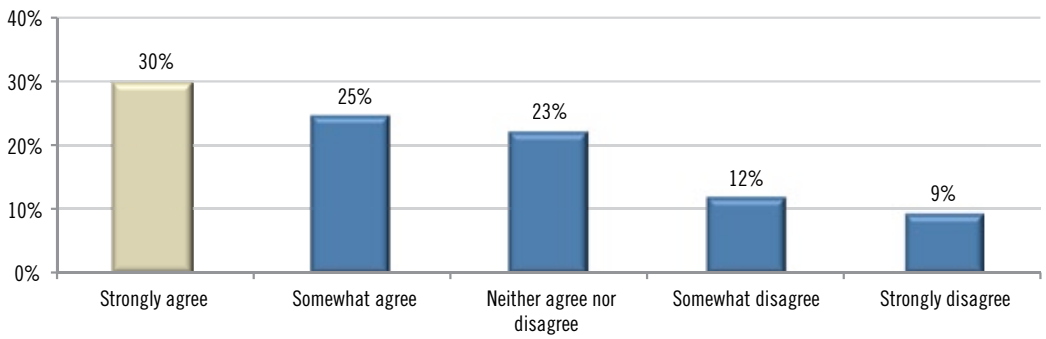
About half of the oncologists said that they have to modify treatment plans when patients lose medical insurance mid-stream, while 58% report that patients have out-right declined treatment for budget reasons.



How has the current cost of cancer treatment impacted your therapeutic decision making? (N=118)

Figure 3. Buy and bill places incentives in the wrong place

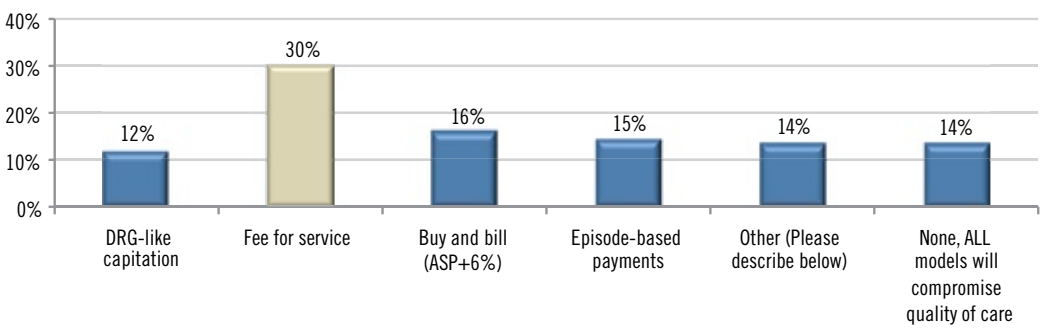
When it comes to buy and bill of the 89 oncologists who gave an opinion, 64 agreed that the buy and bill compensation model incentivizes doctors in the wrong way—by encouraging scripts for more expensive brands, not necessarily for the most effective ones.



Do you agree or disagree with the following statement: "The buy and bill model of compensation for oncology practices places incentives in the wrong place"? (N=118)

Figure 4. No clear physician compensation model

While it's no surprise that the fee for service model is the most popular payment approach to oncologists presently, the survey found no clear alternative consensus.



Which compensation/payment model do you think would BEST control the cost of cancer care without compromising quality of care? (N=118)

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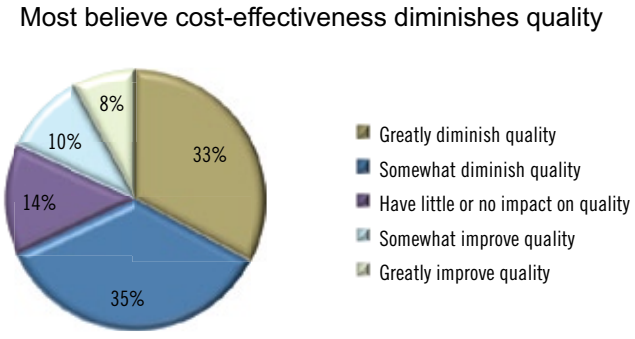
quality in cancer care. "The problem isn't that physicians are paid to provide a service," one oncologist said, it's that, "Patients demand that we make them live longer and we attempt to do that with therapy. If patients changed what they wanted, physicians would change their approach."

Of those resigned to accepting some form of cost-effective reform, many oncologists seem to be taking a pragmatic, societal mindset. One commented, "Given weeks to months of PFS with all these expensive cancer drugs, survival will not be affected by rationing marginally effective drugs."

Another thought, "Cost effectiveness like in the UK is probably the only real way to curb often inappropriate third [and] fourth lines of treatment, but it has the potential to slow uptake of new treatments as well."

Figure 5. Cost effectiveness policies will diminish quality

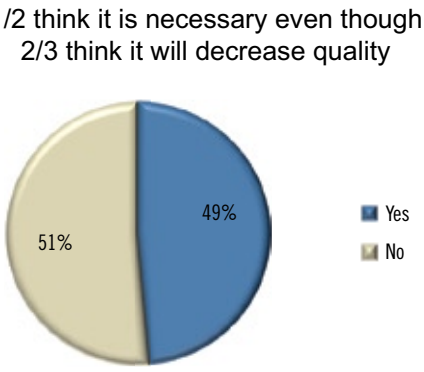
In a startling comparison, two-thirds said cost effectiveness policies such as those instrumental in the United Kingdom would not improve quality of cancer care here in the US, and yet approximately half think it is necessary to reform the US healthcare system (Figs. 5 and 6). Put this in context with the nine oncologists who say the UK model would improve quality of care. On what do they base their views, and even though they are in the minority, could they be right? We don't know from the results, but if these disconnects tell us anything it's that aligning oncology payment and quality of care is as much impossible as it is inevitable.



The UK's National Institute of Health and Clinical Excellence (NICE) uses a cost-effectiveness model to determine which cancer therapies are made available to patients and oncologists in the UK. How would such a cost-effectiveness model impact the quality of cancer care for US patients? (N=118)

Figure 6. Despite reservations, cost-effectiveness considered necessary

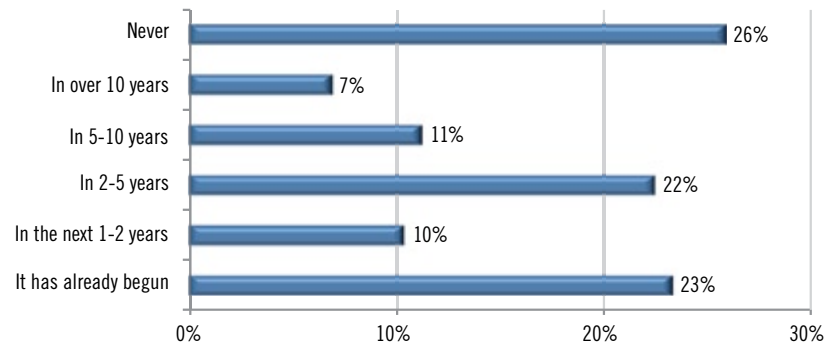
Of the 51% against the NICE model, several found flaws in its approach. "It is inconsistent with genomic, genetic and molecular advances in personalized treatment options," one oncologist said, while another opined about how the UK system limits the availability of effective and valuable therapy. "It is often impossible or very slow to conduct the kind of comparative effectiveness research that establishes the cost effectiveness of a new therapy. Even with such research, there is often insufficient information on important subgroups of patients to establish cost/benefit that may apply to that group."



In your opinion, is a UK-like cost-effectiveness model necessary as part of the US's attempt to reform healthcare? Please provide any comments why or why not. (N=118)

Figure 7. Doubts about comparative effectiveness

About one in four doubt comparative effectiveness (CE) studies can ever improve quality of cancer care and control costs, and another 18% aren't sure CE will improve quality for at least 5 to 10 years or longer, compared with about one in five who say they have already begun to see CE's benefits—though unfortunately no one surveyed could say how. Perhaps many still consider comparative effectiveness as a mere euphemism for cost-control.



When do you think Comparative Effectiveness policy (comparing efficacy and cost of cancer therapies) will have a POSITIVE impact on controlling costs while maintaining quality of cancer care? [Please select 'Never' if you believe it will only have NEGATIVE impacts.] (N=118)

Conclusion

Closing disparities and realigning incentives can still be achieved, but it seems from this survey that there is more we can learn and share about the true value of comparative effectiveness studies, episode-based payments and other ideas like salaried MDs. The sheer number of comments to this survey (more than half of the sample) suggests oncologists are eager to have a voice in healthcare reform legislation even at this late stage, but the results suggest that they believe their warnings about cost controls may not ultimately be heard, and will likely hurt their businesses, compromise cancer care quality, and hinder progress made in personalized treatment. BC

About the Contributors of this Survey

The Arcas Group is a strategic life sciences marketing organization with a singular focus: supporting our clients' commercial success through enhanced connectivity with Thought-Leaders and Clinicians.

Our disease intelligence platform, MDoutlook, offers a real-time, oncologist-driven view of the oncology landscape. MDoutlook collaborates with more than 43,000 global cancer care providers to ascertain comprehensive views of clinical decision patterns and treatment choices. **www.thearcasgroup.com**

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Asking nurses to reach out to people who have advanced cancer—even if only by phone—can improve patients' mood and quality of life, a study in today's Journal of the American Medical Association reports. *(USA Today, Aug, 19, 2009)*

A national survey on cancer recently conducted by the Community Oncology Alliance (COA) found that Americans are almost as equally concerned about paying for the disease if they developed it (69%) as they are of dying from it (68%). *(COA, 7/8/09)*

Around 35% of colorectal cancer patients are estimated to have KRAS mutations, making them likely ineligible to benefit from the use of the anti-EGFR antibody, Vectibix®, based on recent data from the pivotal PRIME trial, the first to test the drug in patients screened for KRAS type. *(Reuters, 8/7/09)*

Payments for radiation cancer therapy services could be cut nearly 20%, according to the radiology group ASTRO, if proposed Medicare reductions take effect in January 2010. *(American Medical News Online, 8/11/09)*