

# 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.”

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).

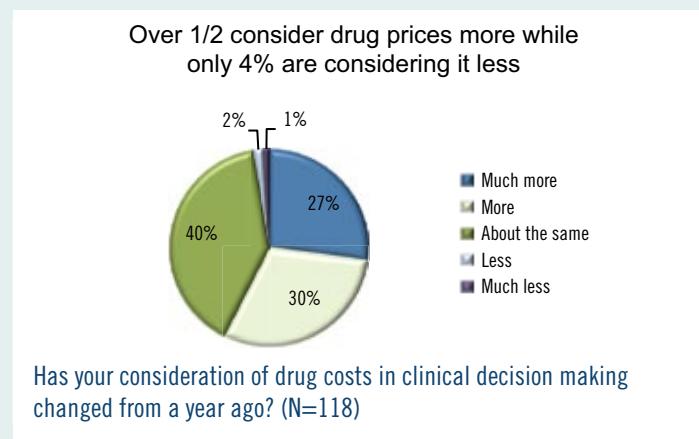
On the surface, the financial quagmire has inspired greater collaboration—44% said they are working more closely with insurers to address patient financial needs. According to a half-dozen comments by the respondents, manufacturer copay assistance is rising (as OBR reported in July). “[We] hired a part-time 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.”

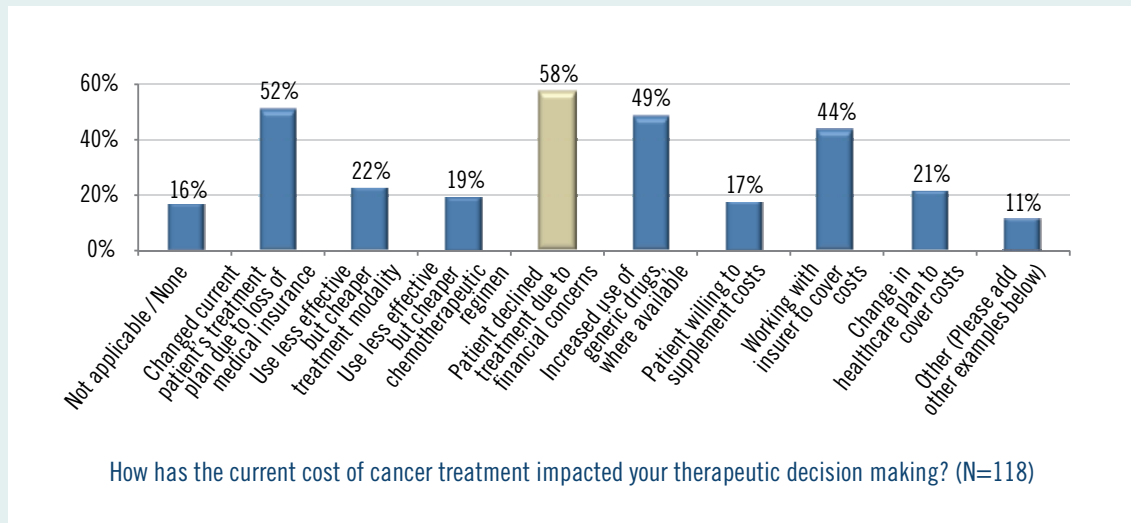
Few support episode-based payments as a viable cost-control solution, even as plans like UnitedHealthcare begin pilot programs to test the model (Fig. 4). Interestingly, about the same number who picked buy and bill say there is no compensation model that can control cost and sustain

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



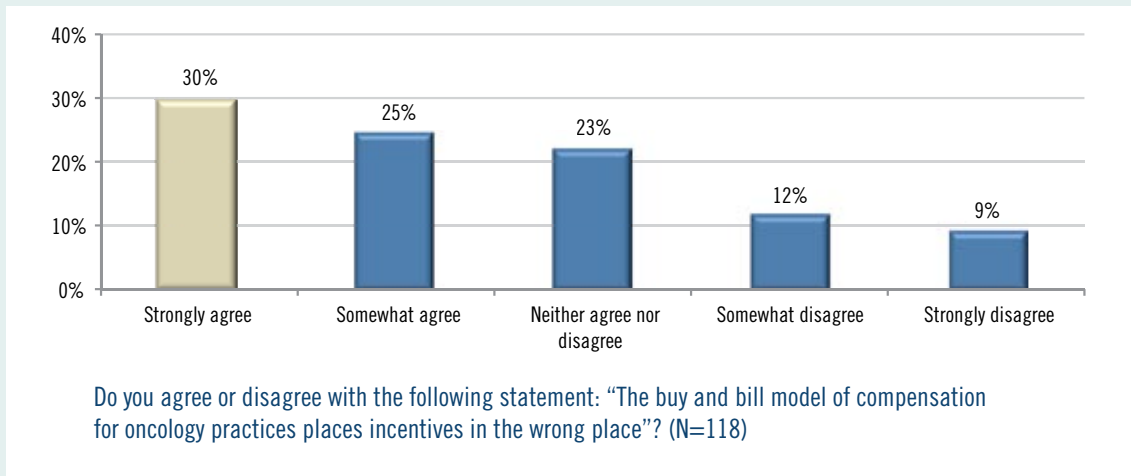
### Figure 2. Unintended consequences of drug cost-based treatment decisions

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.



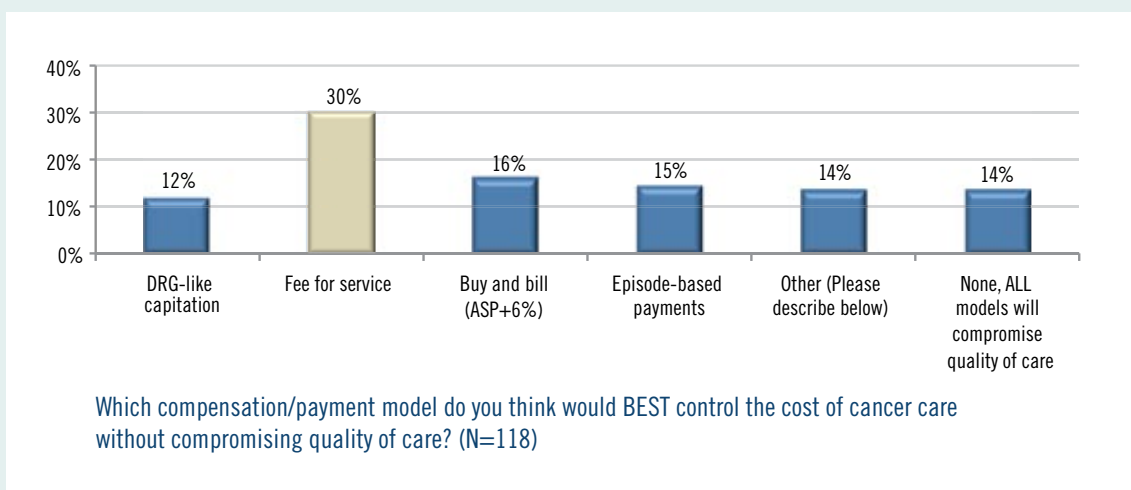
### Figure 3. Buy and bill places incentives in the wrong place

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.



### 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.



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