

# NCCN 15th Annual Conference

## Panelists Discuss the Clinical and Economic Issues Impacting Cancer Care Delivery

### » Moderator:

**Clifford Goodman, PhD**, Sr. Vice President at The Lewin Group;

### » Participants:

**James Cross, MD**, Head of Medical Policy and Program Administration for Aetna, Inc.;

**Lee Newcomer, MD**, Senior Vice President of Oncology Services, UnitedHealth Group;

**Joseph Bailes, MD**, Chair of the ASCO Government Relations Council;

**Al Benson, MD**, Professor of Medicine at Robert H. Lurie Comprehensive Cancer Center at Northwestern University;

**Nancy Davenport-Ennis**, President and Chief Executive Officer of the National Patient Advocacy Foundation;

**Jayson Slotnik, Esq.** Attorney with Foley Hoag, LLP; and

**Douglas Lind, MD**, Managing Partner of GBP Capital

At the recently held annual National Comprehensive Cancer Network (NCCN) meeting in Hollywood, FL, a roundtable of experts gathered to discuss quality and cost of cancer care, costs and treatments associated with end of life care, aligning incentives, and other clinical and economic concerns associated with cancer care. Naturally, whenever there is a discussion about quality of cancer care, the topic of clinical guidelines and clinical pathways arises.

Dr. Goodman opened the session by asking the two insurers at the table about the scope of cancer care coverage at each plan. Aetna spends approximately \$1.5 billion per year on cancer care while United Health-



**Clifford Goodman, PhD**

care spends roughly \$3 billion per year, thus making cancer care a large budget item for these insurers. Both companies have adopted NCCN guidelines to assist in determining coverage decisions, especially in category 2B and above, and both insurers also said they rarely say “no” to coverage decisions concerning cancer care.

It is one thing to adopt guidelines, but it is another to use them, opined one of the panelists. To see how compliant physicians are with NCCN



**Lee Newcomer, MD**

guidelines for cancer care, Dr. Newcomer referred to a program that United Healthcare has implemented where they collect patient information such as stage, prognostic, and histology information, and combine that data with claims data to get a “mini electronic record” that can be ran through a computer algorithm jointly with NCCN. Together, these data can then be supplied back to participating oncologists as an informational tool on prescribing patterns—not, as some would infer, to make any judgments about the physicians regarding compliance with NCCN guidelines. According to Dr. Newcomer, the data is in fact not precise enough to make such judgments, but can be used to help define and implement quality cancer care.

Voicing his concern, Joseph Bailes, MD, pointed out that guidelines are just that, guidance, and reports such as these being generated shouldn't be



**Joseph Bailes, MD**

used to judge the treatment habits of participating oncologists. He noted that there are often disagreements between reviewers of guidelines and users of guidelines, and therefore input and feedback needs to be initiated in addition to pie charts and reports.

Bringing the discussion back to the patient, Nancy Davenport-Ennis reminded the panelists that the issue of access to quality care has not been resolved. According to Ms. Davenport-Ennis, her patient advocacy group



**Nancy Davenport-Ennis**

has seen a disturbing trend in the number of patient families proceeding to bankruptcy—a whopping 87% increase—because they could not get coverage or afford the out of pocket costs associated with care—93% of those patients were insured. Her group uses NCCN guidelines to fight appeals cases on a daily basis.

When asked about the role of guidelines, Al Benson, MD, responded that most physicians are very aware of the clinical evidence, and therefore don't practice evidence based medicine per se whereas the use of guidelines is permeating all aspects of cancer care.

He said he has recently seen “We Follow NCCN Guidelines” on the letter-



**Al Benson, MD**

head of practicing physicians demonstrating just how far the guidelines have permeated into practices and how accepted they are as part of quality cancer care. The reason for the popularity of the guidelines, he informed, is because they are a well structured system with a user friendly interface and broad access on the web.

To take the discussion to the next level, Dr. Benson was asked “What happens when an oncologist has used up everything in the guidelines?” He responded that the most appropriate thing to do at that point is to refer the patient to clinical trials, but this in itself is an ongoing challenge since there aren’t enough clinical trials accruing for every patient. Even the guidelines state that best supportive care may be the most appropriate choice of therapy for patients when the guidelines run out of options.

Dr. Newcomer also suggested that when the guidelines run out of options, it means that we don’t have any other active agents. The rule in that case, he said, should be “first, do no harm”. When a patient reaches that point, it will take much more work for society to grasp that there are limitations as to what the current health-care system can do. He also pointed out that high end of life costs are mostly caused from hospitalizations

due to complications associated with the disease.

Thus, the discussion turned to coverage of clinical trials, and Dr. Cross iterated that if the therapy is truly experimental, meaning outside of guidelines, and the patient is facing a life-threatening situation and the therapy is being used as part of a well-

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controlled clinical trial, then Aetna will cover the costs associated with



**James Cross, MD**

the trial. So while it is not easy, often times the patient may have to go to a different site for treatment, research protocols are the answer when guidelines run out of options. Dr. Bailes said that he is in agreement with patient participation in clinical trials and explained that Congress is taking steps to make coverage of clinical trials part of health-care reform.

When the discussion turned to reimbursement, Jayson Slotnik brought



**Jayson Slotnik**

up that there seems to be an appetite for change and that there is movement away from a buy and bill model or any type of drug revenue model, and a move toward a combination of episode of care type payments or quality payments.

Clifford Goodman, the moderator, pointed out that changing incentives and disincentives changes the very model that is being worked from, which made Douglas Lind, MD, remind the panelists that there was a time when there wasn’t a concern about cost



**Douglas Lind, MD**

in the early stages of development. Now the first question venture capitalists ask is not whether the clinical trial works, not will the product get approved by the FDA, but will the product be reimbursed? In his case, GBP Capital looks at the intellectual property and innovation behind a new product, and if they can’t conceptually understand what the product does to reduce costs for patients, then he rhetorically asks, “Why would anyone bother investing in that product?” Dr. Lind went on to say that it isn’t only venture capitalists grasping this concept, pharmaceutical R&D is asking the same ques-

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tions. He thinks this is a good concept to grasp because it helps direct innovation, not stifle it.

The panelists generally agreed that it is not a good idea for scientific progress if reimbursement is driving capital investments. Cancer in particular is a frustrating disease because of its high morbidity rate and due to its complex nature is in need of innovative thinkers and a good dose of serendipity. Dr. Benson emphasized that a shift toward applied science would not be good for the country. The private insurers on the panel reassured that if new products are approved by the FDA, they would be covered so there is not, in effect, a “new hurdle” out there that is stifling investment and innovation.

As reimbursement came to the forefront of the discussion, Dr. Goodman directed the conversation toward the cantankerous topic of quality adjusted life year: How much is a day, month, or year of life worth? To set the tone for this, Dr. Newcomer brought up the case of metastatic lung cancer. Speaking in very general estimates, he said that over the last 2 years United looked at 900 or so patients that elected not to continue therapy and compared them with about 1,200 patients that received chemotherapy. The difference in duration of life between the groups was about 10 days and the cost of care difference between each patient was roughly \$60,000—approximately \$40,000 for those that did not receive treatment and \$100,000 for those that did.

With figures like this, it is surmised that the cost of health care will continue to be a topic that has to be addressed. According to the panelists, the way our current healthcare system works in conjunction with the norms of society, a price can never be placed on the value of a patient’s life. For example, when the topic of evidence based medicine is discussed, physicians are accused of not necessarily following protocol; when comparative effectiveness research is brought up, it is labeled as rationing of care, and the recent headlines surrounding the new mammography recommendations, or the end of life discussions between physicians and patients are referred to by some as “death panels”.

Perhaps Dr. Bailes summed it all up best when he said in closing, “the most expensive patient to treat is the one that is not treated correctly.” That was the one comment that seemed to resonate strongly with the audience. **OBR**

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