

Payers Must Create Defensible Oncology Management Strategies

By Kirk McConnell, Judy Wu, and Nicole Dautel

Larger private healthcare plans spend more than a billion dollars a year on cancer care, and those costs keep growing. According to an October 2009 Medco Health Solutions news alert, oncology drugs represented 5% of the total drug spend in the first half of '09. In addition, oncology specialty drug spending increased 15.1% last year alone. These growing costs do represent clinical progress. Certain cancers that were largely untreatable 10 years ago now have multiple treatment options, and, as innovative cancer therapies prolong survival, patients are being treated for longer periods of time.

These are positive developments for patients, but the associated costs are pushing payers to place more management attention on the oncology category. With more attention comes the threat of more aggressive management.

To understand what this more aggressive management will look like, the Managed Care Oncology Index, a semi-annual publication from The Zitter Group—a research and consulting firm—explores the oncology category through three distinct survey audiences: 104 medical and pharmacy directors from regional and national commercial managed care organizations; 103 clinical oncologists; and 104 oncology practice managers.

The winter 2010 report reveals that payers have two often opposing goals when managing the oncology category: 1) They must find ways to more aggressively control oncology spending, and 2) They must craft management policies that are politically and clinically defensible.

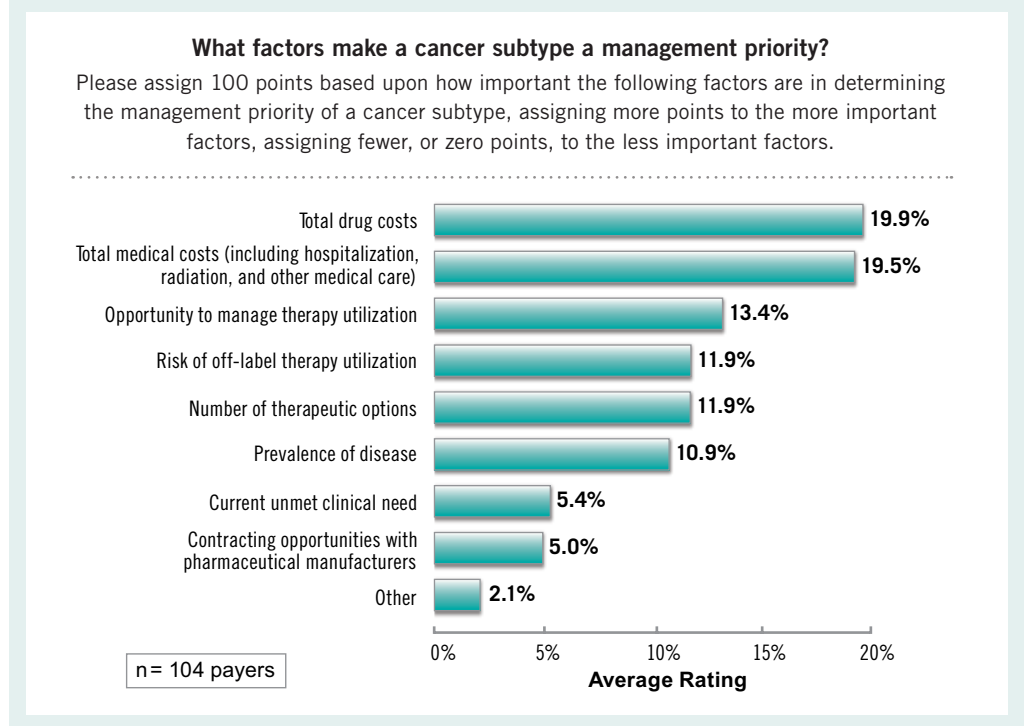
Historically, payers have had difficulty developing management tools that met each of these goals, but in the future of oncology management, opportunities may exist to do both.

Controlling Oncology Spending

To effectively reign in oncology drug spending, payers are current-

ly focusing management attention on specific segments of cancer care. As shown in Figure 1, when payers were asked “What factors make a cancer subtype a management priority?” the major driver of management attention is cost of care—both drug costs and total medical costs (i.e., hospitalization, radiation, and other medical care). As a result of the priority put on these combined costs, payers place the most management attention on higher cost cancer subtypes such as breast, colon, and lung cancers. By focusing their efforts on these high prevalence subtypes, payers are able to generate the largest return on their time and effort.

Figure 1. Drivers of Cancer Subtype Management Priorities



While payers push to reign in oncology spending, both oncologists and payers report that management of the oncology category is becoming more aggressive. However, payers and oncologists see these management changes differently.

Figure 2 shows that 41% of oncologists rate current oncology management by payers as highly aggressive; while more than 80% of oncologists believe that payer management will be highly aggressive in the next 5 years.

Interestingly, while payers agree that the trend is moving toward more aggressive management, they also believe that oncologists are overestimating the aggression of current policies. As seen in Figure 3, only 9% of payers rate current oncology management as highly aggressive. Additionally, payers also believe that the rate of change will be slower over the next 5 years—only 49% believe oncology management will be highly aggressive at that time.

Different frames of context may explain the disconnect between oncologists and payers. Payers have traditionally used a “hands-off” approach in managing oncology. When compared with this historically weak management, payer policies have become significantly more aggressive over the last 5 years. From the oncologist point of view, this is a sea change that only promises to get worse.

Because payers manage a wide range of therapeutic categories, they have a broader view of the disease management landscape. They acknowledge that oncology management has become more robust over the years, but they also acknowledge how much more aggressive management could be in this category. Even

the most restrictive oncology management policies generally pale in comparison to highly managed specialty categories like rheumatoid arthritis or human growth hormone. Payers believe there is a significant delta between the aggression of current oncology policies and the high management aggressiveness found in other specialty categories.

Crafting Politically and Clinically Defensible Management Opportunities

The most predominant factors that influence how aggressively payers are willing to manage cancer care are Medicare’s (CMS) ability to adopt new policies and the release of new scientific information (Fig. 4).

If CMS initiates more aggressive oncology management, commercial

Figure 2. Aggression of Oncology Management: Oncologist Perspective

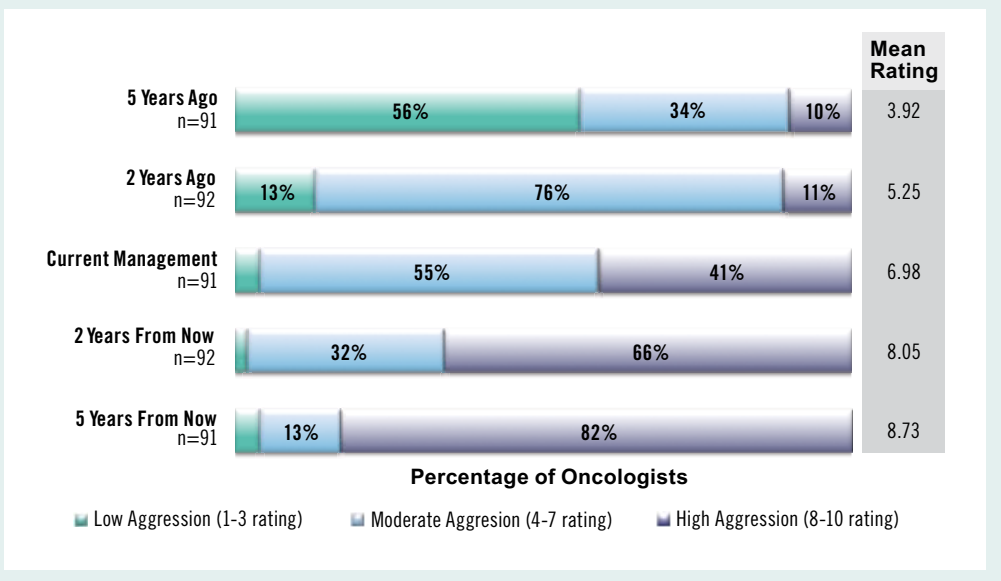
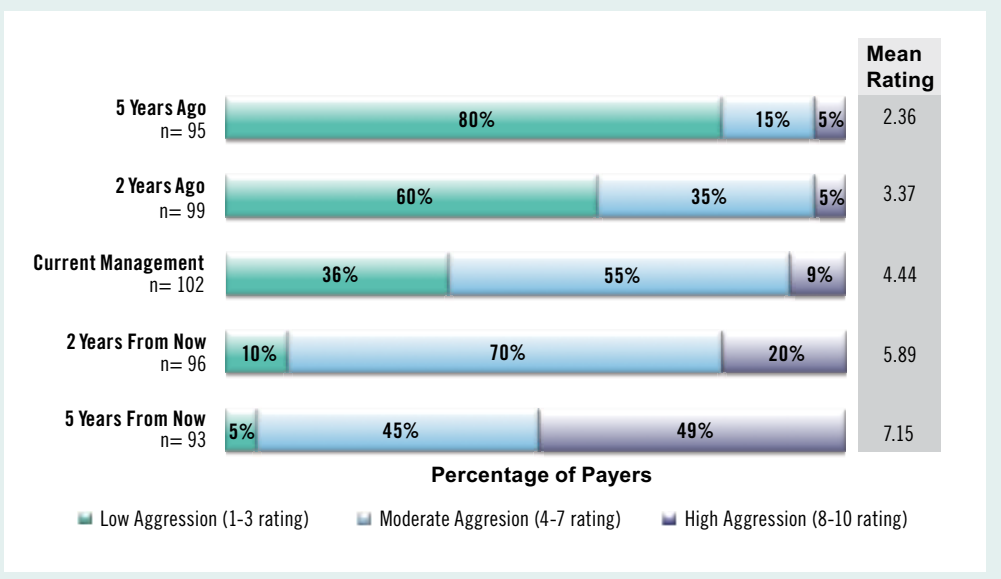


Figure 3. Aggression of Oncology Management: Payer Perspective



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payers will most likely try to follow suit. Following CMS's lead gives payers political cover; they can position themselves as 'replicating' not 'initiating' new policies. Similarly, payers watch for changes in scientific literature and/or cancer care guidelines that will allow them to tighten their definition of 'appropriate' cancer care without risking significant pushback.

Other key factors that influence how aggressively payers will approach the oncology category include the presence of numerous treatment options that give payers the opportunity to adopt new policies that leverage competitive dynamics, fear of negative publicity forcing payers to evaluate the public palatability of all new policies, and employers pushing to reduce healthcare budgets.

On balance, payers are looking for ways to increase oncology management aggression that are both polit-

ically and clinically defensible. They have become more interested in enforcing externally developed cancer policies than enforcing those created internally. According to our survey, by simply adopting decisions made by CMS and/or the scientific community, payers can leverage more aggressive policies while risking little clinical and political backlash. Payers also acknowledge the complexity and sensitivity of oncology, and believe it makes the most sense for them to use their energy and resources to enforce policies, not create them.

Aligning Oncology Management

Payers hope that more aggressive management and oversight will better align prescribing behavior with clinical care guidelines. This alignment has the potential to reduce costs by limiting therapy misuse and improve patient outcomes by ensuring that patients are treated in accor-

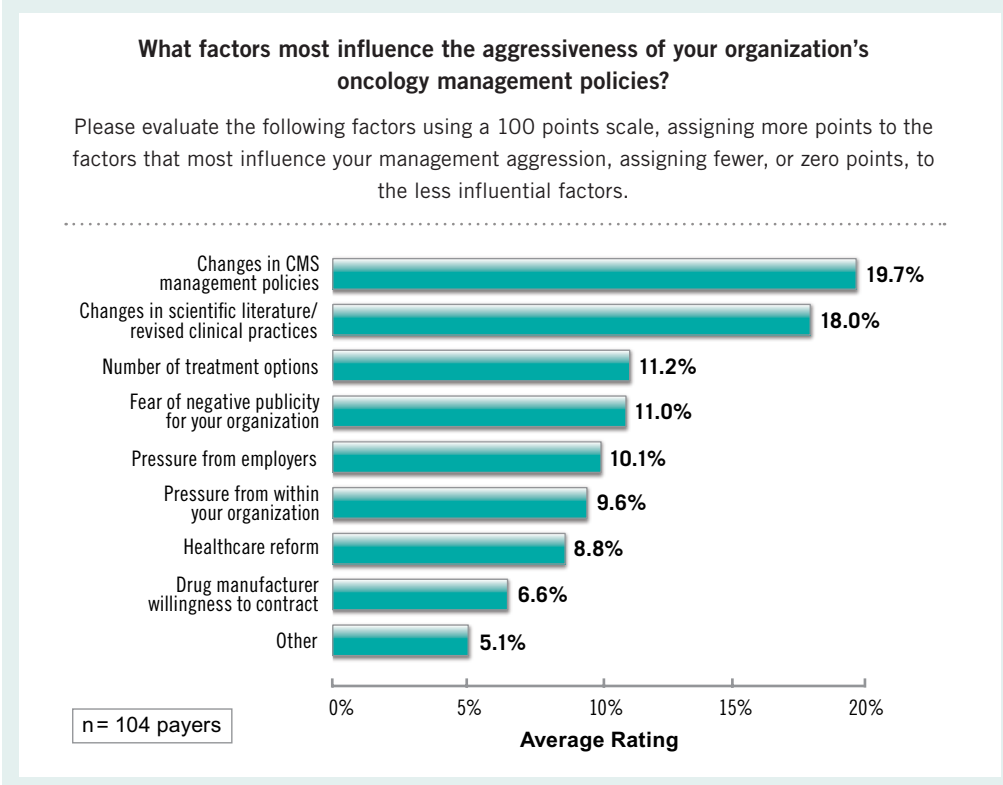
dance with clinical recommendations (Fig. 5). Oncologists are less optimistic. Figure 6 shows that oncologists believe the impact of payer policies will be much more negative than payers project it to be.

There are a few instances where oncologists believe that payer involvement may actually improve patient outcomes: widespread adoption of compendia listing requirements, tying drug approval to diagnostic tests/biomarkers, incorporating clinical treatment pathways. These interventions align oncologist decision making with clinical care guidelines, potentially improving quality of care.

However, oncologists believe that the vast majority of payer interventions will have a negative impact on patient health. Potentially detrimental interventions include: increased patient cost sharing, disease specific capitated rates, mandatory vendor requirements, and further adoption of ASP reimbursement. These types of interventions force oncologists to balance clinical and non-clinical factors, escalating concern that patient well-being is no longer the fundamental priority.

Prior authorizations (PAs) are one of the most aggressive forms of oncology management. While oncologists and practice managers report that PAs create incredible amounts of office hassle and are the management tool that most impacts their decision making, payers are unsure if PAs are actually effective. Only 27% of payers believe that PAs are fully achieving their intended management objectives. The question is: What must payers do to make oncology PAs more effective and how will that impact the already substantial practice burden?

Figure 4. Drivers of Management Aggression



It is interesting to note that, despite having clinical reservations, both payers and oncologists project that all 12 interventions (see Figs. 5, 6) will actually decrease oncology costs.

Conclusions

Payers need to control oncology spending and are looking for opportunities to increase the aggression of oncology management.

However, they must balance the push for cost savings with the reality that cancer care is sensitive and must be managed using clinically and politically defensible policies. This sensitivity is increasingly leading payers to enforce externally produced cancer care guidelines rather than create their own.

Stakeholders agree that there are sufficient opportunities to reduce oncology spending. The challenge is identifying which interventions will bring cost savings without having an overly negative impact on the quality of cancer care. **KM JW ND**

Key Points

- Growing cancer costs are forcing payers to increase oncology management.
- The sensitivity of cancer care pushes payers to only adopt policies that are politically and clinically defensible.
- Payers are increasingly looking to enforce externally produced cancer care guidelines rather than create their own.
- Oncologists and payers agree that there are sufficient opportunities to reduce oncology spending.
- The challenge is identifying which interventions will bring cost savings without having an overly negative impact on the quality of cancer care.

Figure 5. Relating Health Outcomes to Healthcare Costs: Payers

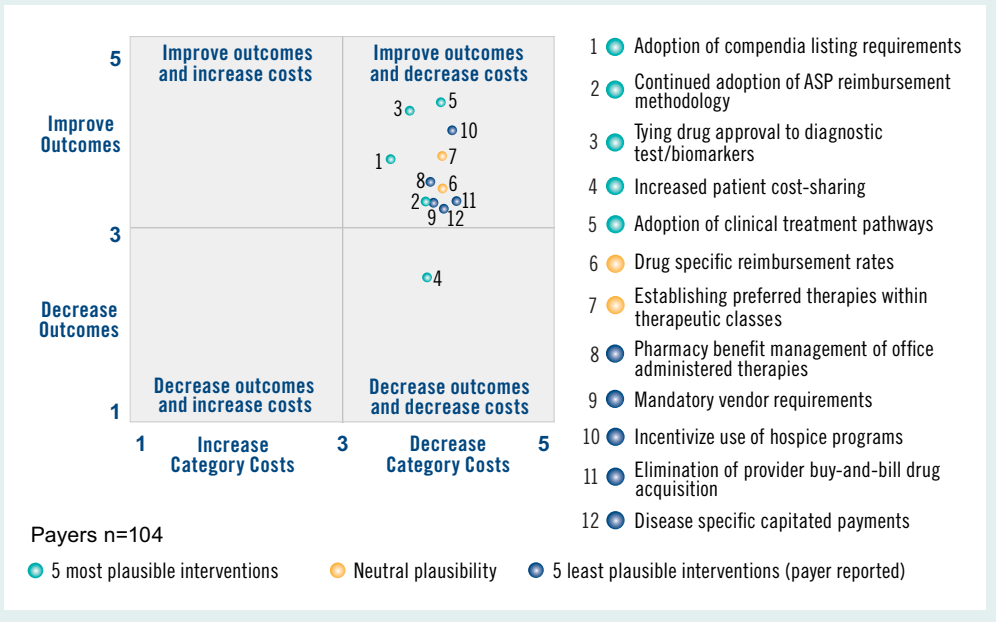
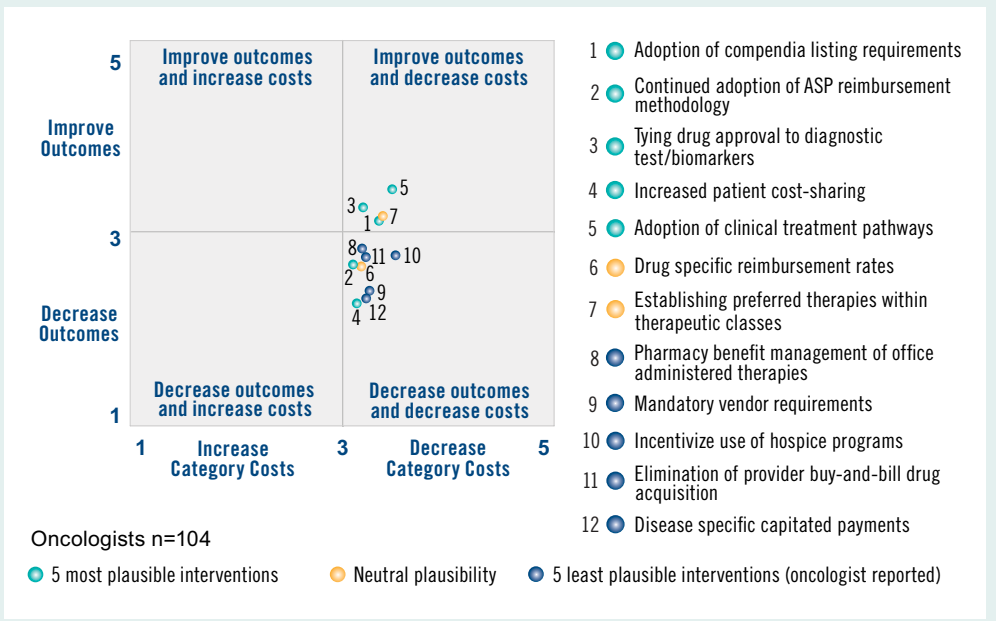


Figure 6. Relating Health Outcomes to Healthcare Costs: Oncologists



About the Contributor



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