The Payer's Perspective: Where We Need to Go

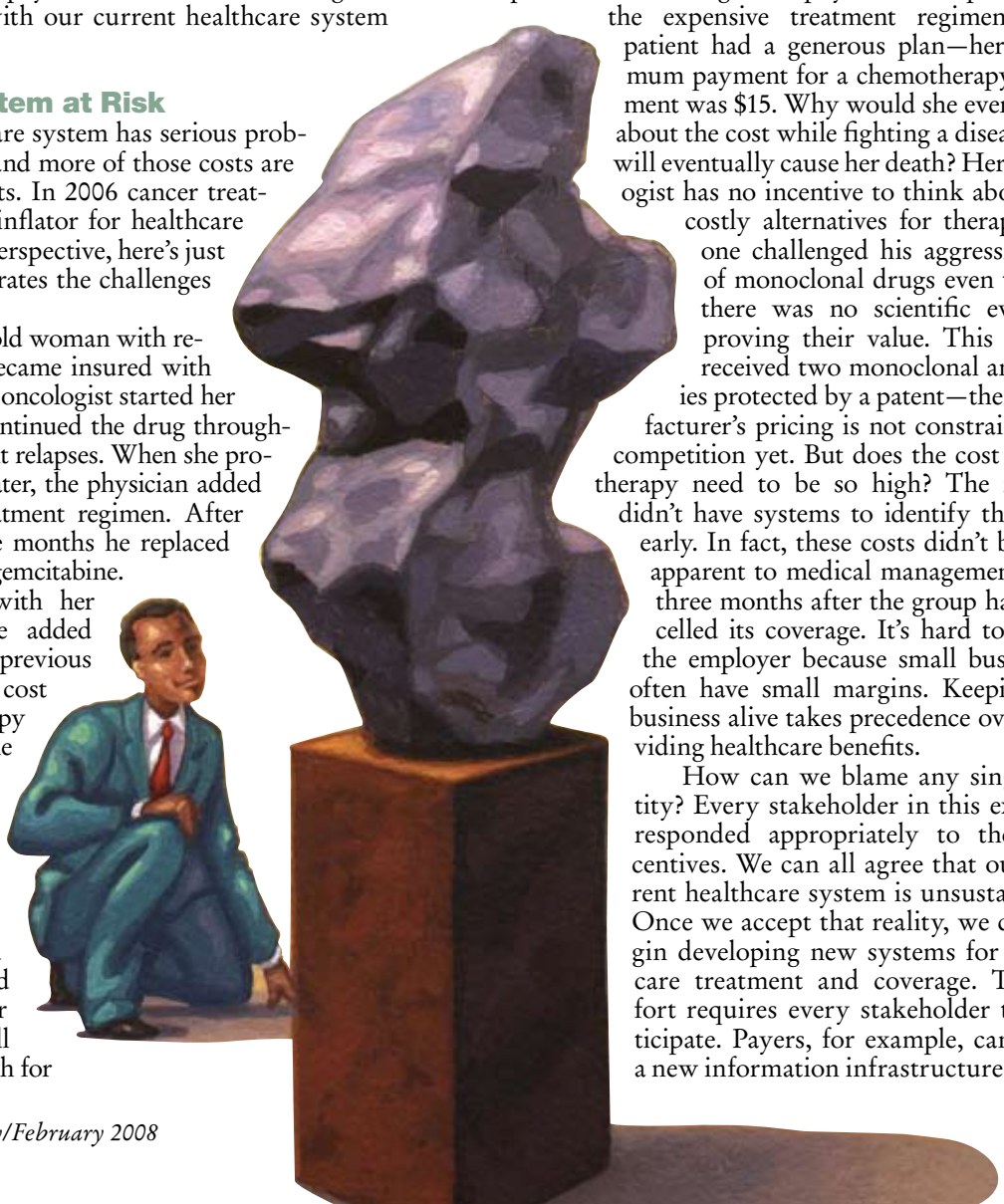
by Lee N. Newcomer, MD

All of us have the same goal for Americans with cancer—equitable access to skilled physicians and therapists, treatment with therapies proven by well-designed clinical trials, and benefit coverage to pay for the treatment. These goals can be met, but not with our current healthcare system and incentives.

A Healthcare System at Risk

This country's healthcare system has serious problems—costs are rising and more of those costs are being shifted to patients. In 2006 cancer treatment was the leading inflator for healthcare costs. From the payer perspective, here's just one example that illustrates the challenges we are facing.

In 2005 a 45-year-old woman with relapsing breast cancer became insured with UnitedHealthcare. Her oncologist started her on trastuzumab and continued the drug throughout all of her subsequent relapses. When she progressed three months later, the physician added vinorelbine to her treatment regimen. After another failure in three months he replaced the vinorelbine with gemcitabine. Three months later, with her fourth progression, he added bevacizumab to the previous combination. The total cost for that year of therapy exceeded $148,000. The patient was insured by a small business with six employees. Insurance regulations limit increases for small groups, but this group's premiums were raised to the maximum allowed by law. The employer sought other bids, but all of the bids were too high for the budget, and the employer dropped insurance coverage for his employees.



So who is to blame in this scenario? The insurer who raised the premium? The pharmaceutical companies that set the prices for these drugs? The physician who prescribed the expensive treatment regimen? The patient had a generous plan—her maximum payment for a chemotherapy treatment was $15. Why would she even think about the cost while fighting a disease that will eventually cause her death? Her oncologist has no incentive to think about less costly alternatives for therapy. No one challenged his aggressive use of monoclonal drugs even though there was no scientific evidence proving their value. This patient received two monoclonal antibodies protected by a patent—the manufacturer's pricing is not constrained by competition yet. But does the cost of this therapy need to be so high? The insurer didn't have systems to identify the costs early. In fact, these costs didn't become apparent to medical management until three months after the group had cancelled its coverage. It's hard to blame the employer because small businesses often have small margins. Keeping the business alive takes precedence over providing healthcare benefits.

How can we blame any single entity? Every stakeholder in this example responded appropriately to their incentives. We can all agree that our current healthcare system is unsustainable. Once we accept that reality, we can begin developing new systems for cancer care treatment and coverage. The effort requires every stakeholder to participate. Payers, for example, can build a new information infrastructure; create

incentives that are aligned with the goals of access, consistency, and affordability; and reward clinicians who meet those goals.

From the payer perspective, we need two major changes: adherence to evidence-based medicine and clinical guidelines and a consideration of the cost of treatment when making treatment recommendations.

Evidence-based Medicine

We can all agree that applying medical evidence in the treatment decision-making process makes good sense; however, it doesn't happen routinely in medical care. In 2003 the RAND group studied compliance with known medical evidence in 6,712 patients who had 98,649 opportunities for evidence-based medicine and found that patients received recommended care in only 54.9 percent of the visits. Equally alarming was the fact that 11 percent of patients received care that was dangerous. This study defined the state of the art for evidence-based medical care in the United States. The RAND study was not oncology specific and it raises the question—do we have the same problems in cancer care? Three recent case studies from UnitedHealthcare data would suggest the answer is "yes." All three of the case studies below are based on claims data.

Case Study 1. The scientific literature is clear that trastuzumab is only effective for patients with over-expression of the HER2/neu gene. In 2006 UnitedHealthcare sampled 187 patients from the entire population of women receiving trastuzumab for breast cancer. We asked physicians to provide the copy of the pathology report documenting HER2/neu over-expression. The test was not performed in 4 percent of the sample, and an additional 8 percent of the sample patients had under-expression based on the criteria of the original trastuzumab trial. This number is probably an underestimate—an additional 12 percent of physicians refused to submit the data.

Our study was not designed to determine the cause of the errors, but the anecdotes point to human error, including lab reports that are incorrectly labeled "positive," incorrect transcription, or chart errors. Based on these results, UnitedHealthcare began requiring a copy of the pathology report for each new trastuzumab patient starting in May 2006. There was an immediate drop in trastuzumab usage. More surprising—denials for under-expressed HER2/neu levels still persist one year later at the same rate. The errors are continuing.

Case Study 2. The use of erythropoietins provides another example of non-adherence with clinical-based evidence. ASCO and NCCN guidelines both recommend treatment for cancer therapy induced anemia to a hemoglobin level of 12 grams per deciliter (g/dL). In a pilot study conducted in the Northeast, UnitedHealthcare required preauthorization of these drugs using these coverage guidelines. Over the next six months, the usage of erythropoietins dropped by 30 percent. The result: we established a policy that requires hematocrit levels on *all* claims for erythropoietin, and we now deny claims for patients with hematocrit levels greater than 36. The claims policy was based on evidence of overuse.

The reason for the over utilization of these drugs vary. For example, many clinicians write a routine order for erythropoietin at the initial visit for chemotherapy, and the hematocrit level is often overlooked during the subsequent chemotherapy infusions. Prior to the FDA warning, the drug was considered to be relatively harmless and there was less concern about treatment at higher hemoglobin levels.

Case Study 3. UnitedHealthcare studied 248 patients treated in 2005 for pancreatic cancer. Those patients received 188 combinations of chemotherapy for a disease with only seven drugs recommended in the NCCN guidelines—5FU, gemcitabine, bevacizumab, capecitabine, cisplatin, oxaliplatin, and cetuximab. The data suggest that oncologists are treating with drugs that have no efficacy.

The payer perspective: prescribing therapies that do not have valid scientific evidence wastes resources that could be used on other patients. Insurers can use the claims payment system as a quality check on compliance with guidelines, but the process is cumbersome and inefficient A better option would be evidence-based compliance systems established and followed by clinicians in their own clinics.

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The Cost of Treatment

Another issue that is crippling our healthcare system is the cost of treatment and therapies. From the payer perspective, clinicians should take into account the cost of the treatment when making treatment decisions. In other words, if multiple therapies are available and of equal efficacy, clinicians should strongly consider using the less expensive therapy.

For example, let's look at the SWOG and ECOG lung cancer study, which compared five chemotherapy couplets. The study could not demonstrate a survival advantage for any of the couplets. However, both groups chose carboplatin and paclitaxel as their new standard for lung cancer therapy based on the observation of slightly less nausea and vomiting compared to patients treated with cisplatin and vinorelbine. The preferred regimen costs $12,000 more per month than cisplatin/vinorelbine. A separate economic analysis showed no significant downstream savings in other areas to offset the increased costs.

No insurer would make the argument for sacrificing a better response rate to lower-costs; however, this study failed to use the lower cost alternative when multiple equivalent options were available. From the payer perspective, our reimbursement system should reward usage of low-cost alternatives. Unfortunately the current incentives do exactly the opposite—the profit margins on generic cisplatin and vinorelbine are so small they will not cover the actual costs of maintaining an infusion room.

Collecting the Necessary Data

If we are to improve the way we deliver and reimburse cancer care in this country, data are essential. And payers and providers must work together to obtain this data. Insurer

claim data sets contain information about the drugs given, the procedures ordered, and therapies provided by other specialists. The oncology medical record holds the patient's stage, the patient's current clinical status, laboratory reports, and the exact dosages of the chemotherapy medications. When combined, these two data sets allow comparisons of medical groups for complications, costs, and outcomes. Those comparisons are the basis for critical conversations about changes that could improve the cost *and* the quality of patient care.

UnitedHealthcare is testing several approaches to combine its claims data with clinical information. We cannot use claims data to infer a patient's clinical status; comparisons without that vital information would be misleading. So, every six months we are asking oncologists to update the patient status with a tool that is similar to the Medicare Demonstration Project of 2006. After submitting the clinical stage at diagnosis, the follow-up form asks if the patient is free of disease, on adjuvant therapy, or has relapsed. This information allows us to "cluster" patients with similar clinical characteristics. The addition of these few clinical elements allow comparison of highly specific categories, for example, pre-menopausal, hormone receptor negative, HER2/neu over-expressed, and metastatic disease breast cancer. All patients in UnitedHealthcare's database will be updated regularly much like the tumor registry at hospitals.

A pilot program is also underway to combine claims data with a statewide tumor registry. This strategy would allow the accurate and specific staging found in hospital-based registries to be strengthened by much richer data, including testing, therapy, and follow-up. The information will be shared with the hospitals on a confidential basis.

Not every approach has been successful. In 2006 UnitedHealthcare offered a technology to oncology offices that extracted digital information from multiple sources in the office, including dictation tapes, printed or faxed lab reports, and hospital transcriptions. This data populated an electronic data registry for each practice. Only three practices accepted the invitation to participate, and the program was abandoned for oncology. (The program has been successfully deployed for primary care offices by another payer in Iowa.)

Data allow us to compile information about treatment variations, and any data we collect will be shared openly with providers for discussions about those variations. Yes, the comparisons will be imperfect—a fact we cannot emphasize enough. Claims data are designed for financial reporting and that causes some flaws for clinical analysis. For example, an adjustment may be reported on a single claim line, creating a false report that a simple test may cost thousands of dollars. The wrong diagnosis is often submitted on claims—for example, patients with metastatic breast cancer to bone are coded as primary bone cancers. UnitedHealthcare data analysts are aware of these issues and are making further adjustments in the reports, but every new analysis exposes new data idiosyncrasies. Although imperfect, the data will be significantly better than any other resource available today that does not require chart reviews. The new process will be automated. It will be relatively current. It will be infinitely better than working with the limited studies and the anecdotes that dominate our thinking today.

Aligning Incentives

The other critical element for changing our healthcare systems and infrastructures is the creation of new incentives. In an ideal world, oncology practices that measure compliance with evidence-based medicine and that use the low-cost alternative when many equally efficacious options are available would be practicing the best quality oncology care possible. Unfortunately, employing those two strategies will almost certainly lower physician incomes as well. It should come as no surprise that these strategies have not been implemented broadly.

UnitedHealthcare is currently conducting a study with a large integrated oncology group that has employed both strategies. The practice's patients are being compared for complications, costs, and quality measures against randomly selected patients with the same clinical characteristics treated in other practices. The study will document the differences and the anticipated savings from this approach. It is the intention of both the clinic and UnitedHealthcare to use this data to create a new payment system. For example, a retainer (an initial payment on the first visit) could be used to help offset the differences in profits from the new approach. Or perhaps a monthly disease management fee would be appropriate. Without data we are only guessing, but the study will give us the information to create a win/win solution for both providers and insurers.

UnitedHealthcare has already started rewarding high-quality and cost-effective physicians in 18 other specialties. These physicians are selected based on their compliance with evidence-based standards as measured in claims analysis. Providers who pass the minimum compliance earn a star for quality. Those physicians are then compared for costs in risk-adjusted diagnostic groups. The top half of this group earns an additional star rating for cost effectiveness.

Physicians with two stars are given top priority in the physician directories, and they are granted higher fee increases than non-rated physicians. Additionally, many benefit plans are offering lower co-payments to patients who use these physicians. The program has been enthusiastically embraced by patients and employers. Oncology was omitted from this program because we could not build the patient comparison categories without clinical status information.

Change is Possible and Imperative

Two quotes summarize the next few years for oncology. Frederick Douglass said, "If there is no struggle, there is no progress." None of these changes will be easy; errors will be made; and adjustments will be mandatory. Soichiro Honda helps with perspective, "To me success can only be achieved through repeated failure and introspection. In fact, success represents the one percent of your work which results only from the 99 percent that is called failure."

To continue with our current healthcare system is simply unsustainable. We have the opportunity to experiment with changes *now*. It will require collaboration, a willingness to examine the data, and the spirit to change. Most importantly we have the opportunity to improve patient care, as well as make it more accessible and more affordable. It's worth the effort.

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