Journal of the National Comprehensive Cancer Network

Correspondence

To the Editor: Transparent debate that considers treatment costs is essential and long overdue. A corollary to Dr. Burstein's recent editorial, "If the choices are all the same, why not prefer the less-expensive option?,"[1] is "If the choices are all the same, why not prefer the most profitable option?" Although no one publicly acknowledges that profitability influences treatment decisions, it is self-evident that the current system of reimbursement rewards the use of more costly medications and should be changed. Using Dr. Burstein's example, at Medicare allowable rates, pamidronate costs $29 per month and the physician's office loses $7 on drug costs; zoledronic acid costs $904 per month and the physician's office makes approximately $40. The most costly bone-targeted agent, denosumab, costs $1727 and the treating office makes about $75. This inconvenient reality will not go away by itself, and starting a debate is the first step toward a solution. (The actual cost comparisons in this example would also need to account for drug infusion costs and variations in reimbursement formulas.)

In the United States, societal cost is seldom considered in patient treatment. Perhaps not coincidentally, health care cost has grown from 6% of the gross domestic product in 1965 to 17% in 2010. It is projected to reach 26% as early as 2035 (Congressional Budget Office, 2010). This trajectory threatens our entire economy and, if left unchecked, will surely undermine our ability to fund other national priorities.

We have a health utilization company that is dedicated to enhancing cancer care quality by reviewing and approving chemotherapy and supportive care regimens. In our day-to-day work, we face multifaceted challenges in ensuring the rational choice of both the most effective and cost-effective regimens. We believe that perverse incentives in the current reimbursement system are important barriers to physicians preferring "the less-expensive option," as expecting physicians to choose therapies that result in a lower income is not realistic.

The obvious mis-incentives in cancer treatment must be changed. For example, with the approval of the insurance carriers whose patients we help manage, we have altered reimbursement formulas of bone-targeted agents by making the physician's profit similar (or even higher in some situations) for pamidronate compared with zoledronic acid and denosumab. Essentially, the reimbursement for relatively inexpensive therapies is raised to compete with that of more expensive therapies. Because the large differences in cost are not matched by the relatively small differences in physician profitability, this strategy levels the field for oncologists while saving substantial resources at no risk to quality of care.

This approach does not, however, solve the problem of monumentally expensive drugs, with limited utility and no overall survival advantage; nor does it solve the serious problem of overuse of add-on drugs, such as pegfilgrastim, wherein the issue is not alternative choices but rather avoiding use of the drug with chemotherapy regimens with a low risk of febrile neutropenia.[2,3]

We agree with Dr. Burstein that a serious dialogue on cost-effective care is needed. Talk, however, is clearly not enough. We believe that it is time to act in a manner that will protect our patients, our citizens, and our national resources.

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References

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2. Fishman M, Meyer B, Fishman D, et al. Utilization of pegfilgrastim in the community setting: observation from 22 practices in south Florida and the effect of monitoring and education [abstract]. Presented at the 52nd ASH Annual Meeting and Exposition; December 4–7, 2010; Orlando, Florida. Abstract 1506.
3. Fishman M, Kumar A, Davis S, et al. Guidelines-based peer to peer consultation optimizes pegfilgrastim use with no adverse clinical consequences. J Oncol Pract 2012;8(Suppl 3):e14s–e17s.

Call for Correspondence

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