Disparities in Adjuvant Endocrine Therapy

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Multiple competing factors (economic, environmental, social, and personal) influence health outcomes. For many patients, the lack of adequate insurance coverage is an obstacle to timely and appropriate medical care. Cancer survivors may be particularly vulnerable to the ill effects of insufficient insurance benefits. In one recent study comparing cancer survivors with their unaffected siblings, cancer survivors were more likely to lack employer-sponsored coverage, have been denied coverage, have Medicaid, and have high out-of-pocket costs. They were also more likely than their siblings to borrow money for medical expenses, worry that they would not receive a medical procedure, and not fill a prescription.1 Uninsured survivors suffered even greater disparities when compared with insured survivors, and were less likely to have a primary care provider or fill a prescription, and more likely to postpone preventive care.1

Medicaid-Associated Disparities

Insufficient Medicaid benefits have frequently been implicated in the cancer-related medical disparities that are attributed to inadequate insurance. Although states are mandated to pay for certain aspects of care, such as inpatient hospital services, coverage for other needs (eg, prescription medications and colorectal cancer screening) varies by state.2 Consequently, patients who are uninsured or covered under Medicaid are more likely to be diagnosed with breast and colon cancer at later stages (stage III and IV),3 and those with melanoma who have Medicaid are also more likely to experience surgical delays.4 In addition, in one study of patients with breast, colorectal, lung, and prostate cancers and non-Hodgkin’s lymphoma, those who were uninsured and those insured by Medicaid had a significantly higher risk for death within 5 years of diagnosis than privately insured patients after adjusting for sex, age, race/ethnicity, marital status, socioeconomic status, and disease stage.5 Similarly, another large retrospective study of 976,178 women diagnosed with breast cancer showed that payer status was a statistically significant predictor of survival after adjusting for tumor stage, age, race, comorbidities, education, distance traveled for treatment, cancer program, diagnosing/treating facility, and treatment delay.6

Medicare-Associated Disparities

Although Medicare, as opposed to Medicaid, does require states to cover more comprehensive adult cancer screening, Part D prescription drug coverage still varies from state to state.2 Inadequate Medicare Part D coverage may cause patients to stop taking life-saving therapies. In one large study of prescription fill rates among 10,302 women diagnosed with early-stage breast cancer and who were prescribed hormonal therapy, 24% were “nonadherent,” meaning that they possessed <80% of the number of pills that would be required for continuous therapy between their first and last prescription (termed the “medication possession ratio”), and patients with Medicare were less likely to be adherent than those with commercial insurance (odds ratio, 0.58; 95% CI, 0.46–0.72).7

Results and Interpretation of the Newly Published Study

The article titled, “Geographic Variation of Adjuvant Breast Cancer Therapy Initiation in the United States: Lessons From Medicare Part D,” in this issue of JNCCN (page 1509) adds to the current literature on cancer care disparities in that it reveals how state-level variability in Medicare Part D benefits influence adjuvant therapy prescriptions. Specifi-
Cathcart-Rake and Ruddy

The finding that 70% of practice pattern variability was unrelated to Part D variability also deserves attention. The decision to prescribe a particular medication is subject to physician preference, which can be influenced by comfort with the medication and side effects. Charlson et al explain that both drug marketing efforts and the availability of treatments for a drug’s side effects (eg, bisphosphonates for AI-induced osteoporosis) may have played a role in the state-to-state variations they found.

Conclusions

In 2006 and 2007, when AIs were much more expensive than tamoxifen, adjuvant endocrine therapy prescribing patterns were partly driven by Medicare Part D coverage. As the insurance market, healthcare policies, and cancer treatment recommendations rapidly change, additional studies that investigate contemporary cancer care patterns will be needed (particularly regarding newer oral targeted therapies that cost multiple thousands of dollars per month). As more oral antineoplastic therapies are introduced, oncologists will need to advocate for affordable drug prices, help patients identify and access financial assistance programs, and keep up-to-date on guideline-recommended care to facilitate informed treatment decisions.
Adjuvant Endocrine Therapy

References


