Key Factors Impacting the Delivery and Financing of Oncology Care in the United States

The American standard of health care may increasingly be determined by what is reimbursed or what individuals can afford. Accountability and responsibility for choosing health care benefits are evolving and will demand that consumers are actively engaged in defining and managing their care. Concurrently, insurers are implementing new products and networks based on “quality” and “efficiency” indicators that employers are using to select payor and sometimes provider contracts. These changes are being driven by different sets of conflicting metrics used by various stakeholders in the U.S. health care system.

One factor driving these changes is the aging population of “baby boomers” who, as they turn 60 this year while demanding the best health care, have been largely insulated from paying the associated costs. However, how “the best” health care is defined varies. Clearly, these metrics reflect the type of stakeholder the individual represents in the health care system (e.g., provider, employer, patient, insurer, government agency). The focus of all stakeholders in the foreseeable future is on data and information that will determine both the evolution of clinical oncology care and how it is delivered and financed.

Providers will need to learn how to distinguish themselves to a more educated and engaged consumer and a more demanding purchaser (e.g., employers, patients, insurers).

This summary article briefly explores developments in the following areas:

- Trends in the financing and management of oncology care
- Consumer-directed health care
- Public payer initiatives in the management and financing of oncology care
- Future challenges and future opportunities

Employer-based health insurance is rapidly transforming. From 2000 to 2005, the number of businesses offering employer-sponsored health insurance decreased 13.04%, with 20% of the employers who offer plans also offering a higher deductible plan. Of companies with 200 or more employees, 40% said they are “very likely” to shift more health care costs to workers in 2006, compared with 15% of smaller companies.¹ U.S. employers are estimated to pay an average of 8% more for employer-sponsored health insurance in 2006, with the average cost to employers approaching $8,424. In turn, workers will have to contribute an average of 10% more than they did in 2005 to participate in employer-sponsored health insurance.

Trends in the Financing and Management of Oncology Care

Sixteen percent of the gross national product is spent on health care in the United States, creating tremendous direct and indirect stressors on health care system financing. In 2004, spending for hospital care totaled $570.8 billion. Hospital spending by private insurers rose 9.5%, and Medicaid spending increased 9.9%. Spending for doctors’ services climbed to $399.9 billion in 2004. Medicare spending on doctors rose 11.1%, up from an increase of 8.8% in
2003. Doctors are performing more services and more complex services, for which they receive higher fees from Medicare. Overall, public spending on health care grew faster than private spending in 2004. In 2004, Medicare spending rose 8.9% to $309 billion for people aged 65 years and older or those who were disabled. According to Gabel et al., “The average cost of family coverage now exceeds the average yearly income of minimum-wage Americans.” Figure 1 outlines what these financial trends will mean to the United States in 2014.

Several factors keep cancer care in the forefront of the health care debate. Approximately 1.4 million new cases of cancer are diagnosed annually, with 60% of these in patients older than 65 years. In fact, 70% of all cancer deaths occur in patients in this age group. Although increasing incidence reflects the aging population, increasing prevalence reflects the success of early diagnosis and treatment intervention, which is transforming cancer. Many biologics now have better safety profiles, transforming some cancers to chronic diseases and allowing effective treatment throughout the course of disease progression. Although short-term research pipelines are replete with innovative and promising new agents, most will be as add-ons to existing regimens. Heuristic research in the clinical setting will continue to see extensive use beyond Food and Drug Administration (FDA)-approved labeling. However, most of these agents are expected to carry a substantial price tag, resulting in significant cost of care. In 2005, approximately $74 billion was spent on direct costs of cancer care, of which $118.4 billion and $17.5 billion were indirect costs for productivity losses caused by mortality and morbidity, respectively.

But what is the price tag on progress? Table 1 lists the estimated drug costs incurred for 8 weeks of treatment for metastatic colorectal cancer as reported by Schrag. Looking at second- and third-line treatments, the total cost of 1 year of drugs for a patient with colorectal cancer could be $161,000 for an average increased survival time of 1.7 months. Importantly, approximately 56,000 newly diagnosed cases of metastatic colorectal cancer occur annually.

What mechanisms are being considered to control these increasing costs? Restrictive coverage policies are increasing, with safety or effectiveness claimed as the basis for denial. Preauthorization and determination of medical necessity will therefore make a comeback if absolute coverage limitation becomes the predominate tool to control costs. Increasingly, discussions in both the public and private sectors have focused on requiring the additional analysis of cost versus cost-effectiveness. Much discussion has also centered on restricting use beyond FDA-approved labeling, possibly leading to coverage only with sufficiently developed clinical evidence.

This latter initiative is of particular concern because 50% to 75% of drugs and biologics are used beyond FDA approval for cancer care. Medicare pays for uses and indications approved by the FDA, but the Centers for Medicare & Medicaid Services (CMS) depend on drug compendia or demonstrable evidence (in medical literature) to support a specific use, and thus, reimbursement. Of particular importance is that very few national coverage decisions are made by CMS; in fact, final coverage decisions are left to the discretion of regional intermediaries (Part A) and carriers (Part B). In the CMS Decision Memo of January 28, 2005, coverage with evidence development was outlined to accommodate the diffusion and use of new technology (e.g., agents being studied in National Cancer Institute trials).

Since 2003, CMS has focused on restructuring the oncology drug concession that exists in the community setting. Through a continuing series of regulations (e.g., MMA 2003 Action Plan) and adjustments, CMS has endeavored to restrict reimbursement for pharmaceuticals purchased and delivered to patients in private clinics and community hospital outpatient settings. Reimbursement for drugs

---

**Health Care Costs could be 19% of Economy by 2014**

- Nation's tab for health care — already the highest per person in the industrial world — could hit $3.6 trillion by 2014.
- Nearly 19% of the entire U.S. economy — up from 15.4% now.
- Growth in healthcare will outpace economic growth through the next decade with the government picking up an increasing share of the tab.
- The United States, by 2014, will spend the equivalent of $11,045 per resident on health care annually, compared with $6,423 in 2004.

Source: USA Today

---

**Figure 1** Estimated health care costs by the year 2014. Source: USA Today.
Table 1 Estimated Drug Costs Incurred for 8 Weeks of Treatment for Metastatic Colorectal Cancer

<table>
<thead>
<tr>
<th>Drug Treatment</th>
<th>Cost Estimate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly bolus of 5 FU + leucovorin</td>
<td>$63</td>
</tr>
<tr>
<td>Weekly bolus of 5 FU + leucovorin (8–12 mo survival)</td>
<td>$304</td>
</tr>
<tr>
<td>Biweekly 5 FU + leucovorin in 48-h infusion</td>
<td>$263</td>
</tr>
<tr>
<td>5 FU + leucovorin + oxaliplatin (FolFox) (21 mo)</td>
<td>$11,889</td>
</tr>
<tr>
<td>FolFox + Avastin</td>
<td>$21,033</td>
</tr>
<tr>
<td>Folfiri + Erbitux</td>
<td>$30,675</td>
</tr>
</tbody>
</table>

*Source: Schrag5.

significant percentage of revenues were previously derived from this pharmaceutical offset, will a radical shift occur in the venue of chemotherapy treatment for 80% of cancer patients in the United States?

Will unintentional restructuring of the medical oncology subspecialty result in increased fragmentation and reduced access to appropriate care? Can evaluation of the quality of care (ostensibly through increased data reporting) appropriately drive payment based on quality of performance? Will rationalizing cost-effectiveness in determining coverage improve cancer care or cause it to stagnate, if not deteriorate?

Consumer-Directed Health Care

In theory, providing consumer/patient information should lead to better decisions on setting, provider, and type (e.g., treatment) of care. Evidence indicates that data and information can accurately reflect the surgical mortality rate for individual surgeons and the success rate of health care technologies. However, for drugs, information centers on legal definitions of the prescription, coverage limitations, and financial exposure to the patient. Is quality of care (i.e., access) more limited by a patient's copay (copay, deductibles, and coinsurance) than it is by the availability of providers or continuity of therapies? If so, then consumer-directing health plans could evolve into consumer-restricting health plans based purely on patient affordability. Such plans offer higher deductibles and limited or tiered drug coverage in exchange for lower premiums. For example, a sample plan might offer a $7,500 family deductible, a $2,000 maximum benefit after a $500 per-person deductible for drugs, and a drug copayment of $25 plus 50% of the cost of the drugs.

delivered under Medicare are based on average sales price (ASP) (strict reporting rules) plus 6% rather than average wholesale price (AWP) – 5%, –15%, or –18%. Many oral cancer therapeutic agents are extended general coverage and reimbursement under Medicare Part D. With minimized margins, acquisition of some drugs with a zero or positive margin become impossible. This is exacerbated by an insufficient reimbursement for professional (medical and clinical) services such as nursing, infusion, pharmacy, and office costs. As a very signif-
Furthermore, does a role exist for pay-for-performance to improve concordance with guideline recommendations?

Conclusions

Experts are again attempting to implement the transition of health care beyond its one baby step into the era of accountability. Innovative drugs and biologics entering the marketplace bring great promise for patients but will raise a series of issues and barriers before they can be broadly used in clinical practice. Coverage and reimbursement processes are being retooled based on some modicum of learning from the 1990s, but clearly the battles loom again! Consumer-directed health care presents a double-edged sword driven by a new era of functions such as quality evaluation, public reporting of performance data, and benchmarking pay for performance.

The American standard of health care may increasingly be determined by what is reimbursed or what individuals can afford rather than by providers or even society. Accountability and responsibility for health care is evolving and will actively, if not forcefully, engage the consumer. Concurrently, insurers are implementing new products and networks based on “quality” and “efficiency” indicators. This is all exacerbated by an aging population of “baby boomers” who will demand the best health care but who will not want to or can not pay the associated cost. Decision-making by all health care stakeholders will eventually be driven by common or standardized data sets. As such, information will be the key differentiator in the future of oncology care. Oncologists will need to learn how to distinguish themselves to a more educated and engaged consumer and purchaser or they will be passed by, much to the detriment of the patients they serve. This must not be allowed to happen.

References