Health Insurance and Cancer Drug Reimbursement

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Aetna
Outline

1. Why is there a problem?
2. Employer funded health insurance and benefits design
3. Impact of the ACA
4. Patient contribution and compliance
5. New world challenges
6. Possible solutions from the payer perspective
Cancer is the most costly medical item and increasing at 2-3x the rate of other costs

Cancer care is the leading edge of medical cost trend

Aetna's top cost drivers in cancer care

<table>
<thead>
<tr>
<th>Cost Driver</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Rx</td>
<td>30.8%</td>
<td>$1.5B</td>
</tr>
<tr>
<td>Inpatient</td>
<td>23.3%</td>
<td>$1.1B</td>
</tr>
<tr>
<td>Radiology</td>
<td>22.4%</td>
<td>$1.1B</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>9.4%</td>
<td>$483M</td>
</tr>
</tbody>
</table>

*2010 CY Claims; Commercial & Medicare; All Funding; Excludes AGB/SH/SRC
Figure 2. Monthly and median costs of cancer drugs at the time of US Food and Drug Administration (FDA) approval, 1965 to 2013. Adapted.¹⁶
Death rates from cancer are decreasing but the decline is small compared to heart disease.

From Jemal, A. et al. Death Rates for Cancer and Heart Disease for Ages Younger than 85 Years and 85 Years and Older, 1975-2005
Basic insurance terms.....

1. Self insured and fully insured commercial population
2. Medical benefit and pharmacy benefit
3. Copayment and co-insurance
4. High deductible plan
EXHIBIT 1

Percentage Of Private-Sector Workers Receiving Offers Of Health Insurance, By Firm Size, 2000 And 2011

- Received an offer in 2000
- Received an offer in 2011

71.9 million
70.5 million
7.8 million
6.0 million
8.0 million
7.5 million
10.0 million
14.5 million
12.5 million

2-9 employees
10-24 employees
25-49 employees
50-99 employees
100+ employees

Source: Authors' analysis of data from the Medical Expenditure Panel Survey, Insurance Component.

Note: The size of the bubbles indicates the number of workers.

Buchmueller et al.
Health Affairs 32: 1522-30
Health Care Premiums are Growing at 3x the Rate of Inflation and Wages

Cumulative increases from 1999-2012

172% Health insurance premiums

47% Workers’ earnings

38% Overall inflation

Consumers are Paying for **Half** the Increase in Medical Premiums

**Consumer**

- **COST SHARE**
  - 48% (contributions + out of pocket)
  - **$2,989**

**Employer**

- **COST SHARE**
  - 52%
  - **$3,239**

**COST INCREASE**

2007 - 2012P

- $6,228

Why Cancer Is Important to Employers

• Almost 1.6 million new cancer cases will be diagnosed in 2013.¹
• 13.7 million Americans with a history of cancer were alive as of January 1, 2012.¹
• Cancer is the second most common cause of death in the US – one of every four deaths.¹
• Direct and indirect societal costs of cancer in the US exceeded $202 billion in 2008 – $77.4 billion in direct medical costs and $125.0 billion for loss of productivity due to premature death.¹
• Cancer is the leading cause of long-term disability (LTD) and the sixth leading cause of short-term disability (STD) for employers in the US.²,³
• Employers bear an estimated $7.5 billion in lost productivity costs each year.⁴
• Although only about 1.0% of the commercially insured population, cancer patients account for 10% (or more) of employers’ medical claim costs.⁵
• Caregiving: More than half of women and a third of men experience workday interruptions as a result of caregiving responsibilities.⁶

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3. UNUM, Cancer remains leading cause of Unum’s disability claims, April 30, 2013.
Evidence-driven benefits
Evidence-based, personalized care for beneficiaries
Built on evidence from NCCN Guidelines and other authoritative sources
Integration and coordination across the benefit continuum and cancer continuum
Standardization of benefits across health plans offered to employees
Vendor accountability
Employer’s Guide: Approach and Plan

Health Care Benefits Plan (2011)
General Medical, including behavioral health
Pharmacy
Care Management

Health and Productivity (2012)
Short-Term Disability (STD)
Family Medical Leave (FML)
Employee Assistance Programs (EAP)

Health Promotion/Wellness (2013)
Beneficiary Communications
Cancer Risk Reduction/Prevention
Wellness

Working group consists of staff from NBGH and NCCN, supported by an Advisory Committee that includes representatives from all stakeholder groups:
- Cancer centers (physicians)
- Employers/benefit managers
- Patient advocates
- Managed care plans
- PBMs
- Pharmaceutical industry
- American Cancer Society
- Benefit consultants
- Disability & EAP vendors

Advisory Committee approves all deliverables.

All resources developed through this collaboration are available free to all at: http://www.nccn.org/network/nbgh and at http://www.businessgrouphealth.org/cancer/resources
Reasonable out-of-pocket thresholds should be established so that cost is not a significant barrier for patients to obtain their medications. (Max of $100 per script and aggregate $200 per month)

Specialty Pharmacy programs should counsel individuals who are prescribed oral oncology drugs to reduce prescription abandonment and non-compliance.

Medical plans, pharmacy benefit plans and specialty pharmacy benefit plans should cover evidence-based cancer treatment, whether paid under the medical or pharmacy benefit. This includes coverage for off-label use of drugs and biologics when supported by evidence, as indicated in NCCN Guidelines.

Benefit plan should establish parity of patient cost-sharing between the medical and pharmacy benefits.
ACA impact on oral cancer drugs

1. Pharmacy is an essential health benefit
2. Strict regulations on formulary management
3. Max out of pocket for individuals and families
Pre ACA

1. No max out of pocket
2. Variable deductible
3. Variable member responsibility
Post ACA

1. Family/personal max out of pocket
2. High deductible
3. Variable member responsibility
Post ACA, expensive oral cancer drug

1. Max out of pocket reached with first prescription
2. Deductible and coinsurance irrelevant
3. Member responsibility capped at max out of pocket
4. Cost of treatment is health plan responsibility as long as premium is paid
Cost Sharing and Adherence to Tyrosine Kinase Inhibitors for Patients With Chronic Myeloid Leukemia

Dusetzina SB, Winn AN, Abel GA, Huskamp HA, Keating NL
J Clin Oncol 2014; 32: 306-311
Study Goals and Methods

1. Examine trends in patient out-of-pocket and health plan expenditures for imatinib from 2002-2011
2. Estimate association between copayments for imatinib and TKI discontinuation and non-adherence for patients newly initiating imatinib

Used Truven Marketscan data on 1541 privately-insured individuals with CML initiating imatinib (mean age 49, 45% women)

Adjusted for patient characteristics using propensity score analysis

Dusetzina et al, JCO, 2014; 32: 301-311
Mean and Median Patient Copayments

Dusetzina et al, JCO, 2014; 32: 301-311
Mean and Median Total Expenditures

Dusetzina et al, JCO, 2014; 32: 301-311
## Association between Copayments and Discontinuation & Adherence

<table>
<thead>
<tr>
<th></th>
<th>Lower copayments*</th>
<th>Higher copayments*</th>
<th>Risk Ratio Higher to Lower (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discontinue within 180 days</td>
<td>10%</td>
<td>17%</td>
<td>1.70 (1.30-2.22)</td>
</tr>
<tr>
<td>&lt;80% adherent in first 180 days</td>
<td>21%</td>
<td>30%</td>
<td>1.42 (1.19-1.69)</td>
</tr>
</tbody>
</table>

*Lower copayments – bottom quartile; higher copayments—top quartile
Adjusted for patient characteristics using propensity scores

Dusetzina et al, JCO, 2014; 32: 301-311
Summary/Implications

TKIs are costly to patients and insurance plans. Even relatively small out of pocket expenses have a large effect on discontinuation in the first 6 months. Given the importance of adherence to prevent resistant clones, higher-cost sharing will likely lead to poor outcomes.

Dusetzina et al, JCO, 2014; 32: 301-311
Upcoming challenges

1. Unit consumption: personalized medicine
2. Unit cost: sequence of therapy
3. Cost of innovation
## Monthly cost of oral agents used to treat renal cell carcinoma

<table>
<thead>
<tr>
<th>Agent</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunitinib</td>
<td>$11,900</td>
</tr>
<tr>
<td>Sorafenib</td>
<td>$10,500</td>
</tr>
<tr>
<td>Pazopanib</td>
<td>$7,800</td>
</tr>
<tr>
<td>Everolimus</td>
<td>$9,400</td>
</tr>
<tr>
<td>Axitinib</td>
<td>$11,000</td>
</tr>
</tbody>
</table>
Cost Effectiveness of EML4-ALK Fusion Testing and First-Line Crizotinib Treatment for Patients With Advanced ALK-Positive Non–Small-Cell Lung Cancer

Sandjar Djalalov, Jaclyn Beca, Jeffrey S. Hoch, Murray Krahm, Ming-Sound Tsao, Jean-Claude Cutz, and Natasha B. Leigh
Fig 4. Two-way sensitivity analysis of crizotinib cost versus ALK prevalence. ICER, incremental cost-effectiveness ratio; QALY, quality-adjusted life-year.
Cancer Drugs in the United States: *Justum Pretium*—The Just Price

*Hagop M. Kantarjian, Tito Fojo, Michael Mathisen, and Leonard A. Zwelling*
CML: Background

1. CML is rare (5000 cases per year, prevalence 80,000).
2. Imatinib is AMAZING
3. 2\textsuperscript{nd} and 3\textsuperscript{rd} generation TKI’s out-perform imatinib in many surrogate endpoints but NOT survival
4. There are clinical subsets of patients that do better with 2\textsuperscript{nd} and 3\textsuperscript{rd} generation TKI’s.
5. Initial cost of imatinib in 2001 = $30,000/year.
6. Current cost of imatinib = $80,000/year
7. Current cost of 2\textsuperscript{nd} and 3\textsuperscript{rd} generation TKI’s = $115,000-$138,000/year

Kantarjian et al. JCO 31:3600-4
Imatinib will be available in a generic formulation in 2015
Post ACA, CML therapy

1. Max out of pocket reached with first prescription
2. Deductible and coinsurance irrelevant
3. Member responsibility capped at max out of pocket
4. Cost of treatment is health plan responsibility as long as premium is paid
CML paradigm, generic Imatinib

1. Cost of generic drops substantially
2. Generic drug not on specialty tier
3. Deductible not met by first fill
4. Small member responsibility for generic option
CML paradigm
2\textsuperscript{nd} and 3\textsuperscript{rd} generation TKI

1. Max out of pocket reached with first prescription
2. Deductible and coinsurance irrelevant
3. Member responsibility capped at max out of pocket
4. Not applicable if medical necessity met
Value-Based Pricing Agreements
