Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Health Insurance and Cancer Drug Reimbursement

Michael Kolodziej, M.D., FACP
National Medical Director, Oncology Solutions
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**

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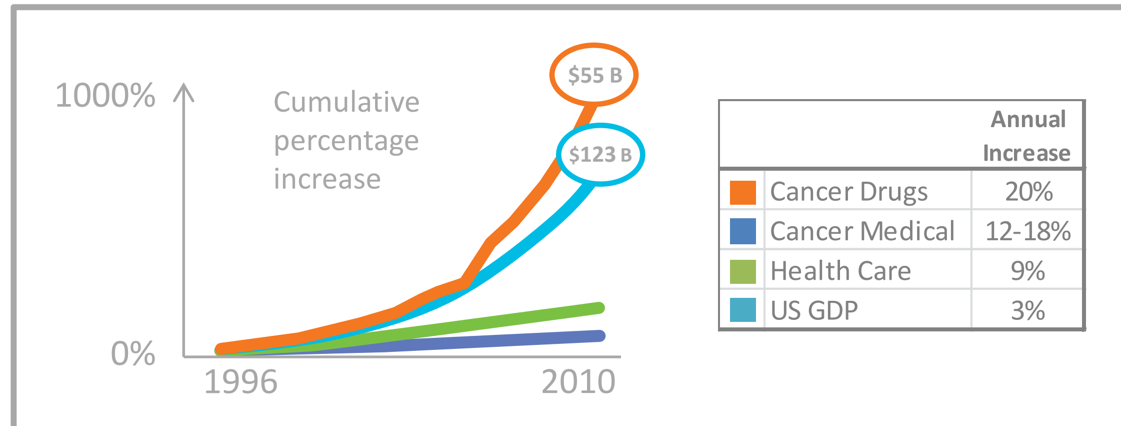
Cancer is the most costly medical item and increasing at 2-3x the rate of other costs

Cancer care is the leading edge of medical cost trend



	Annual Increase
Cancer Drugs	20%
Cancer Medical	12-18%
Health Care	9%
US GDP	3%

Aetna's top cost drivers in cancer care

Medical Rx	30.8%	$1.5B
Inpatient	23.3%	$1.1B
Radiology	22.4%	$1.1B
Specialist Physician	9.4%	$483M

*__2010__ CY Claims; Commercial & Medicare; All Funding; Excludes AGB/SH/SRC

www.cancer.gov/newscenter/pressreleases/2011/CostCancer2020

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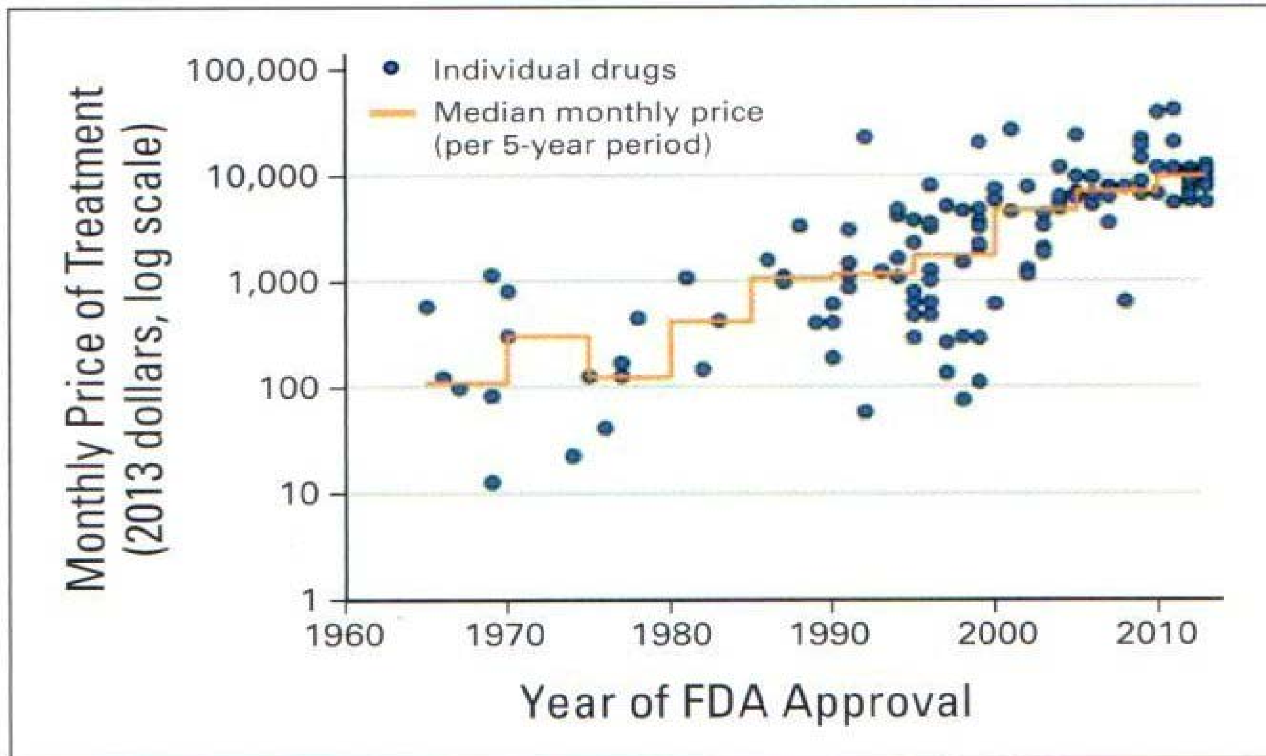
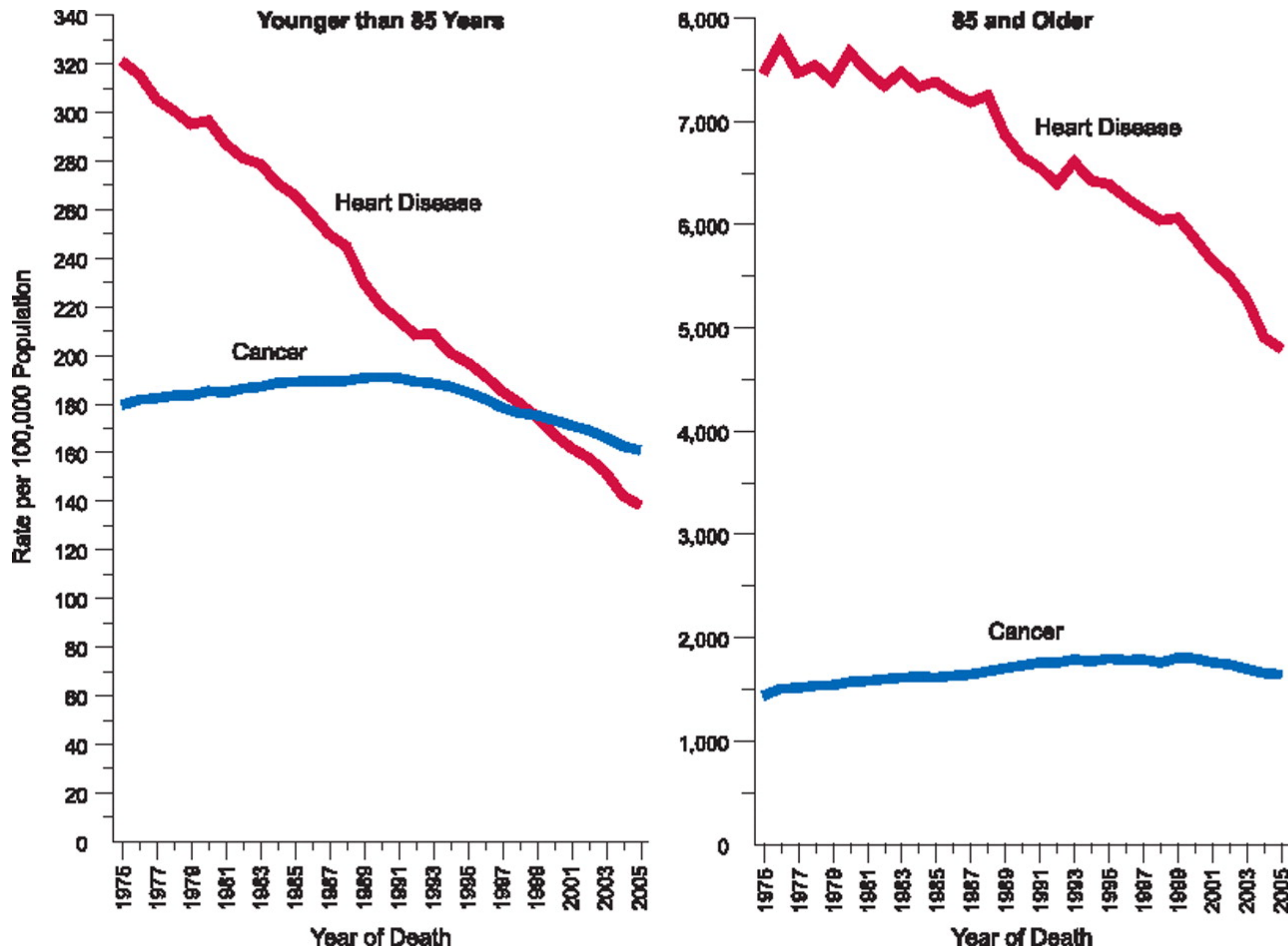


Figure 2. Monthly and median costs of cancer drugs at the time of US Food and Drug Administration (FDA) approval, 1965 to 2013. Adapted.[16]

J Oncol Prac 10: 119-42

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 CA Cancer J Clin 2009;59:225-249.

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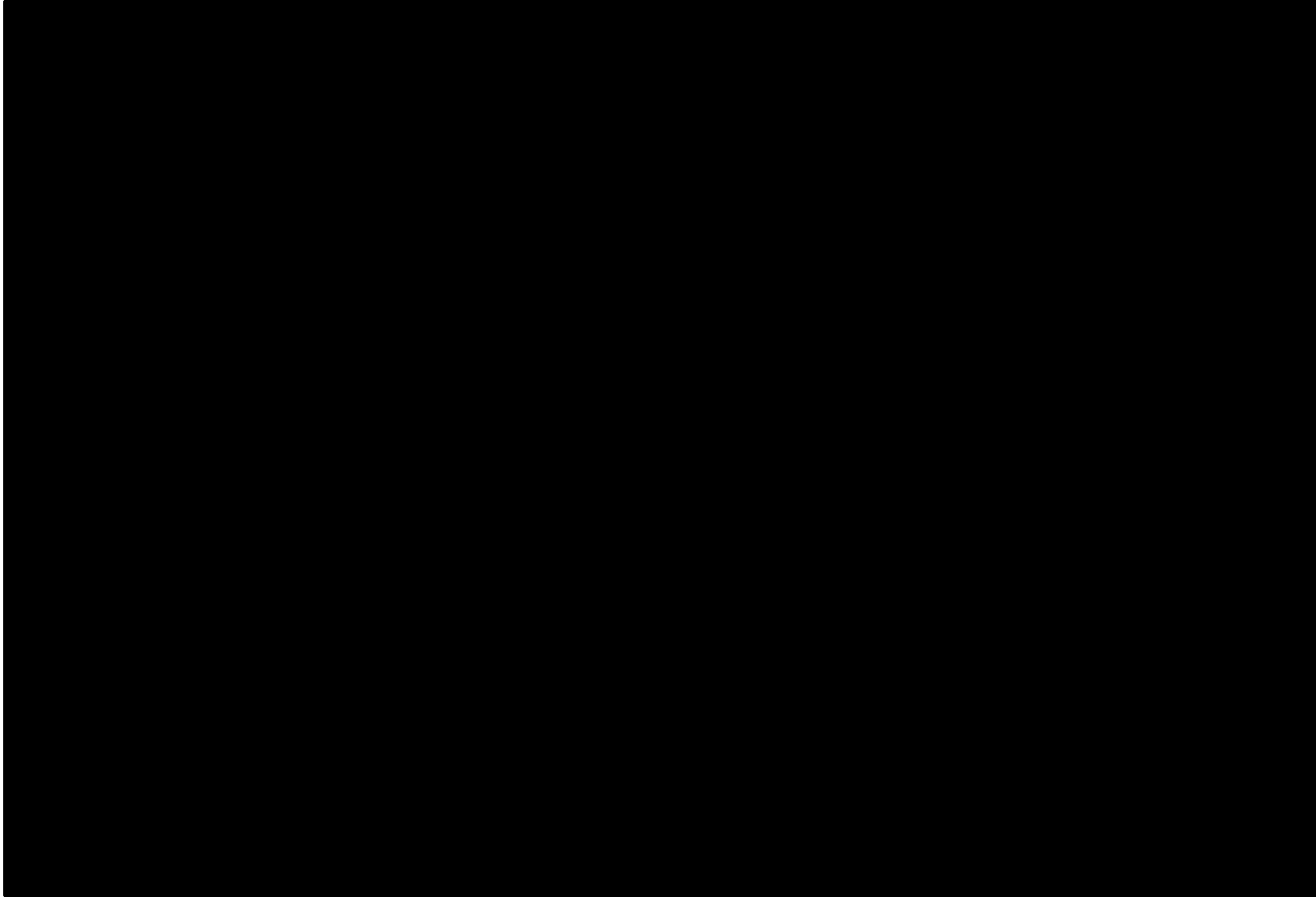

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Basic insurance terms.....

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

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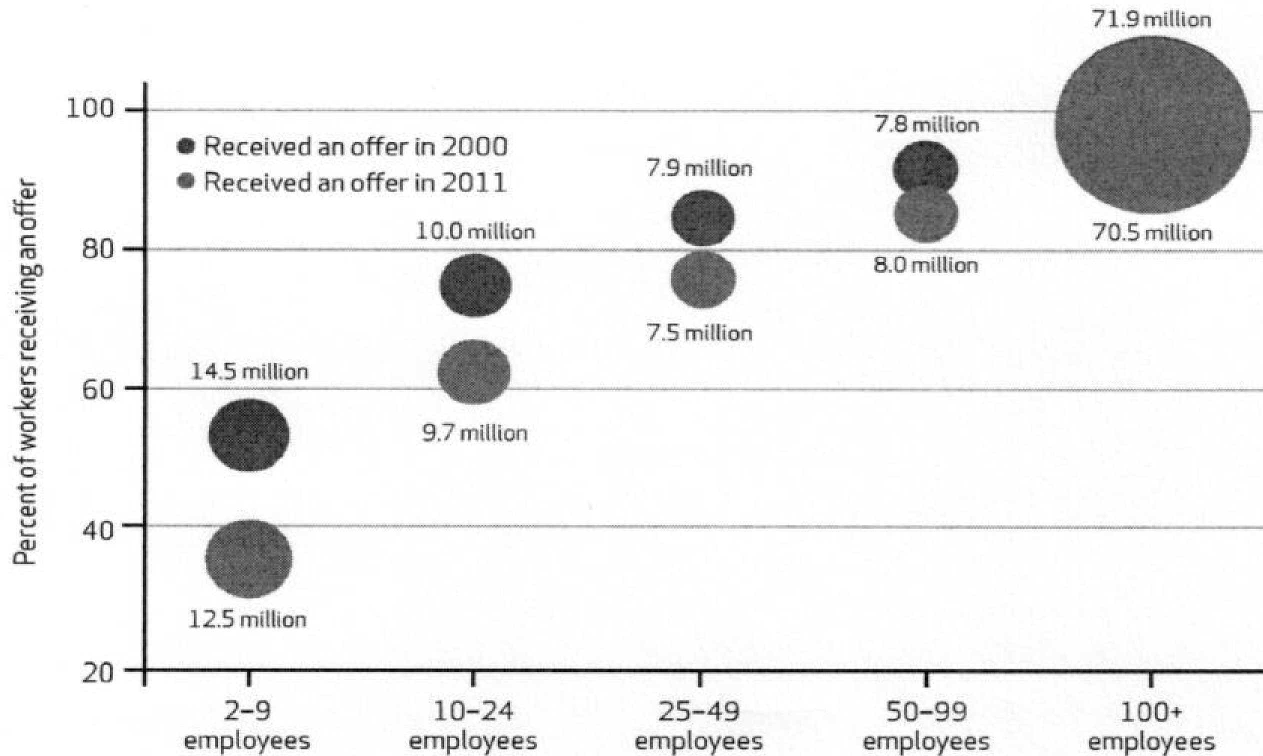

Buchmueller et al.
Health Affairs 32: 1522-30

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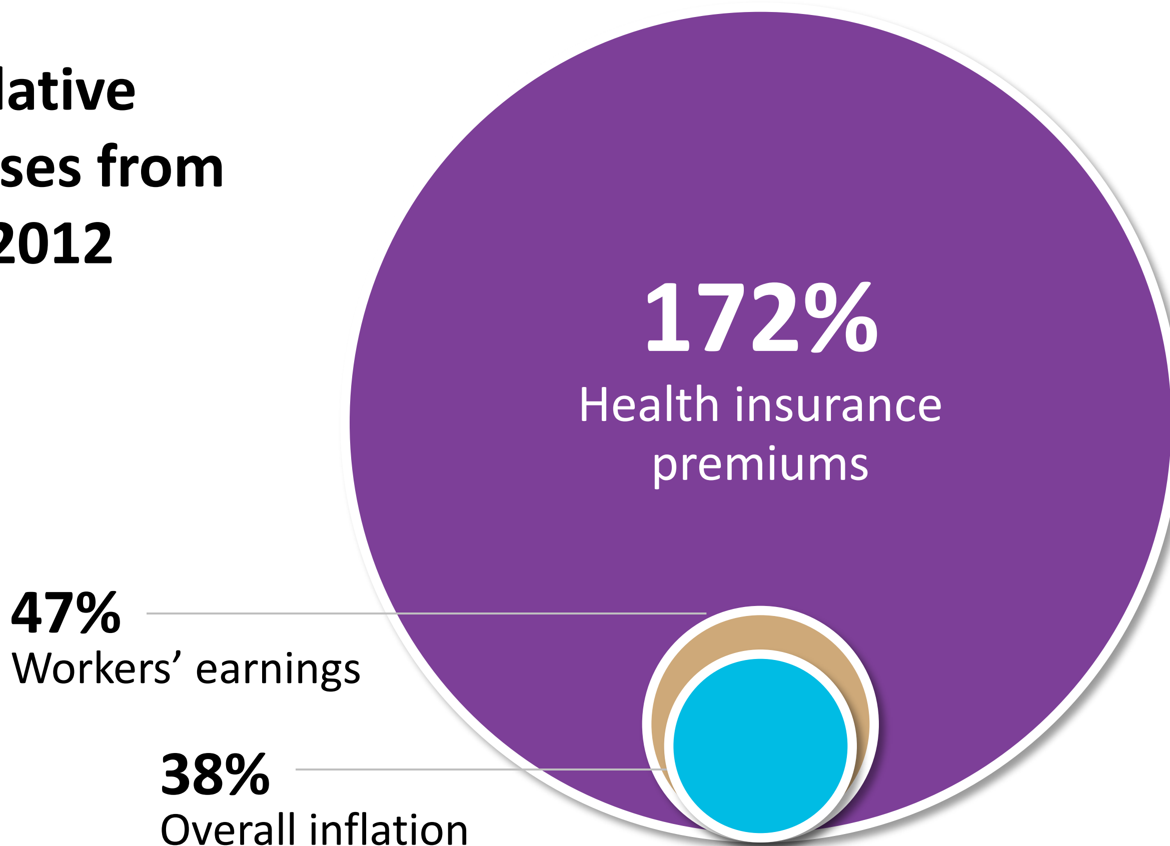
Health Care Premiums are Growing at 3x the Rate of Inflation and Wages

Cumulative increases from 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index and Employment Statistics Survey

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Consumers are Paying for Half the Increase in Medical Premiums

	Consumer	Employer
COST SHARE	48% (contributions + out of pocket)	52%
2007 - 2012P COST INCREASE **$6,228**	$2,989	$3,239

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index and Employment Statistics Survey

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NCCN National Comprehensive Cancer Network®

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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1. American Cancer Society, *Cancer Facts and Figures 2013* [http://www.cancer.org/research; accessed May 2013].
2. Leopold RS. *A Year in the Life of a Million American Workers.* New York, NY; Moore Wallace, Met Life Group Disability: 2003.
3. UNUM, Cancer remains leading cause of Unum's disability claims, April 30, 2013.
4. Powell, AC. Health care expenditures, hospitalizations and productivity associated with cancer in US employer settings.*" JOEM*, December 2012.
5. Pyenson B. Cost of Cancer to Employers. Milliman, American Cancer Society, C-Change. 2007.
6. MetLife Mature Market Institute, 2006.

What Employers Want

Evidence-driven benefits

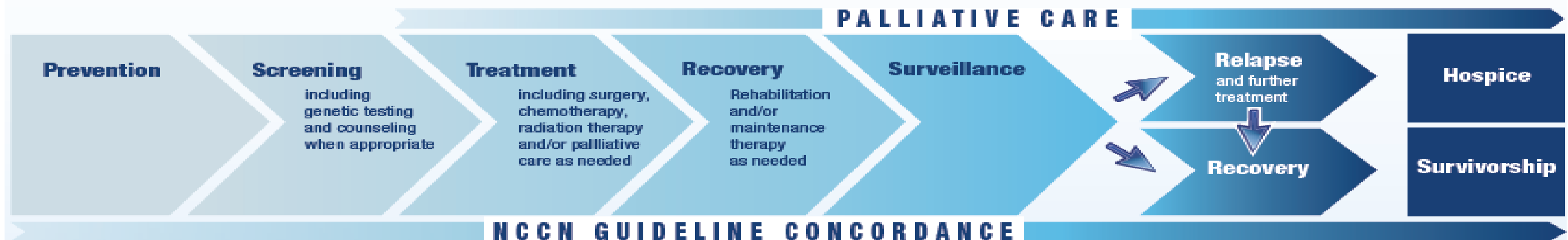
Evidence-based, personalized care for beneficiaries

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



NCCN National Comprehensive Cancer Network®

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

www.businessgrouphealth.org/cancer/resources

Model Benefit and Practice Recommendations

Health Plan Benefits

Health and Productivity Programs

Health and Wellness Programs

An Employer's Guide to Cancer Treatment and Prevention

Executive Summary

Tool 1: Quick Reference Guide and Assessment

Tool 2: Plan Design and Assessment Tool

An Employer's Guide to Cancer Treatment & Prevention

Tool 2: **Plan Design & Assessment Tool**

1.0: General Medical & Behavioral Health

Medical Benefit 1.1

Recommended Benefit or Practice	Benefit plan should include access, within the available provider network, to a wide range of cancer care providers, including medical oncologists, hematologists, radiation oncologists, oncology surgeons, palliative care specialists, pathologists and other specialties. Also included are providers in the community setting and in large, academic cancer centers, such as National Cancer Institute (NCI)-designated Comprehensive Cancer Centers and Cancer Centers, which provide access to multidisciplinary care for rare and complex cancers.
Objective(s)	• To ensure that beneficiaries have access to the expertise needed to accurately diagnose and appropriately treat their cancer.
Benefit Plan Recommendation	• *Applicable Plan:* General Medical • *Benefit or Practice Definition:* Adequacy of number of specialists and a sufficient number of providers in the network. • *Recommended Cost Sharing:* Should not differ between network providers in the community and those in academic medical center settings.

National Business Group on Health

National Comprehensive Cancer Network®

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NCCN National Comprehensive Cancer Network®

Key Pharmacy Benefit Recommendations

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.

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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**

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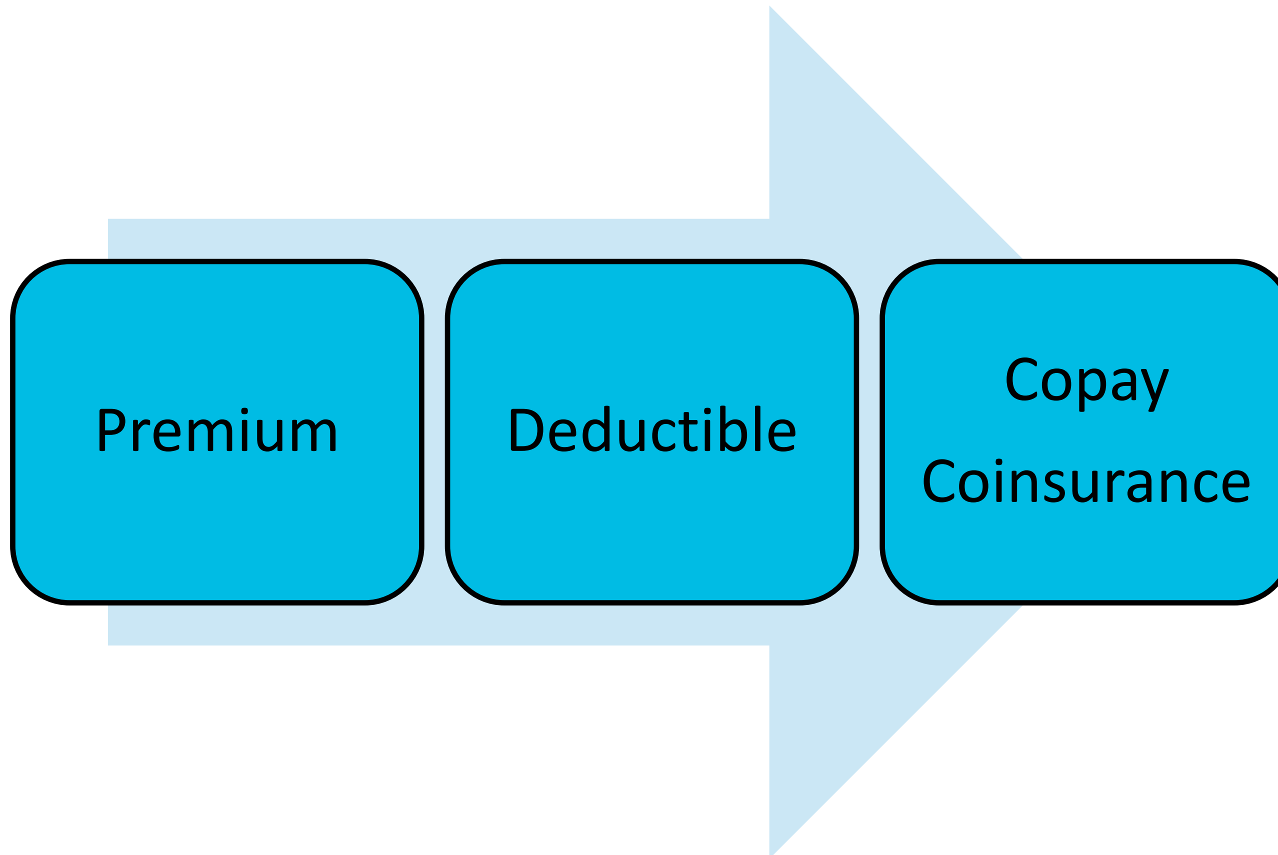
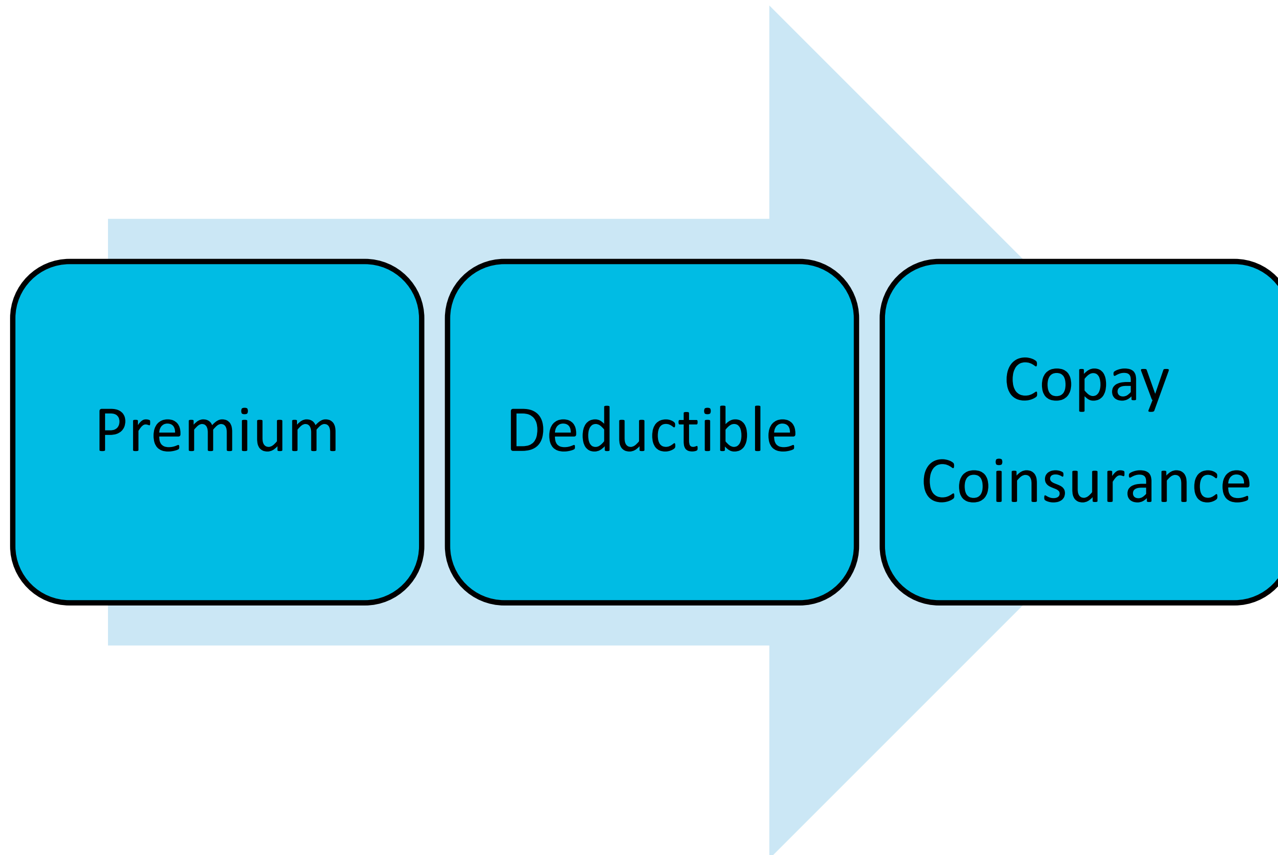
Pre ACA



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**

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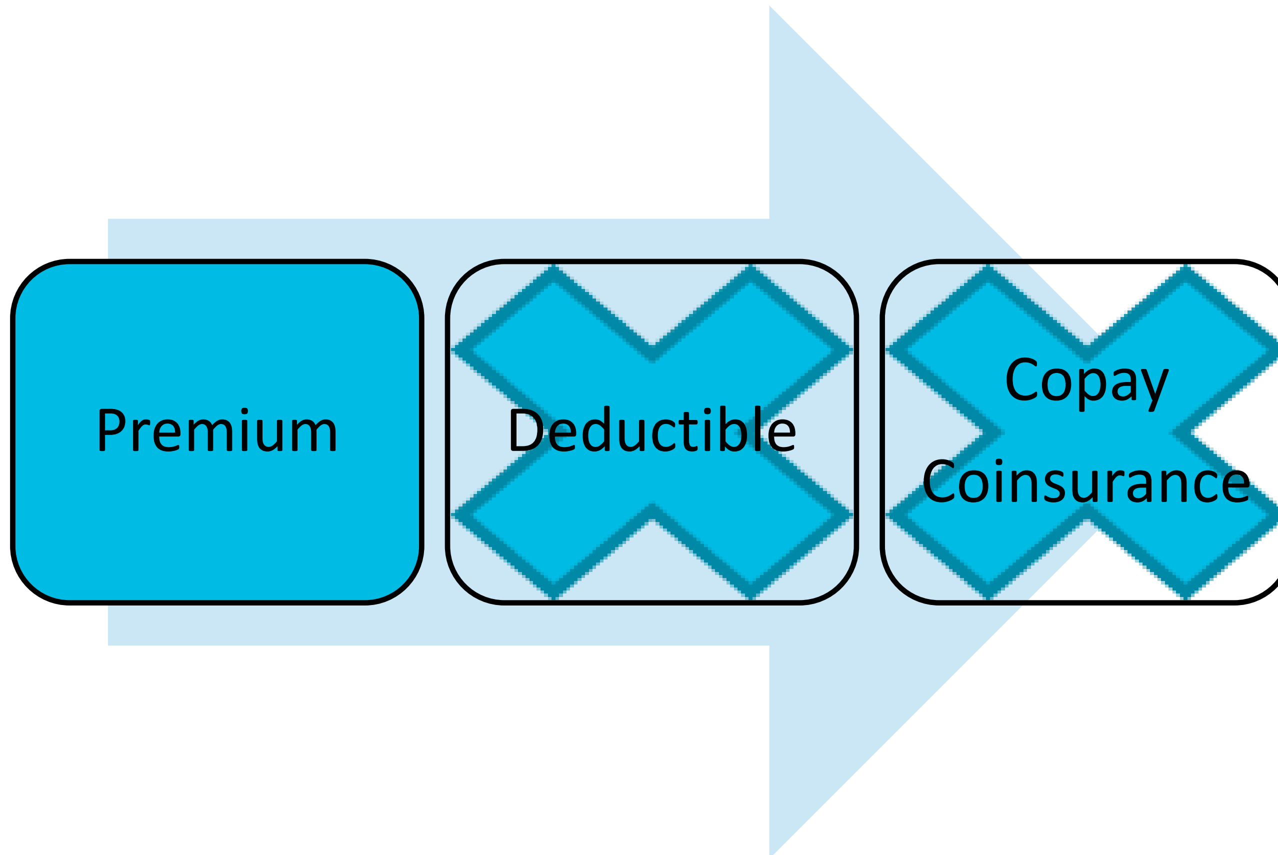
Post ACA, expensive oral cancer dug



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**

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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

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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

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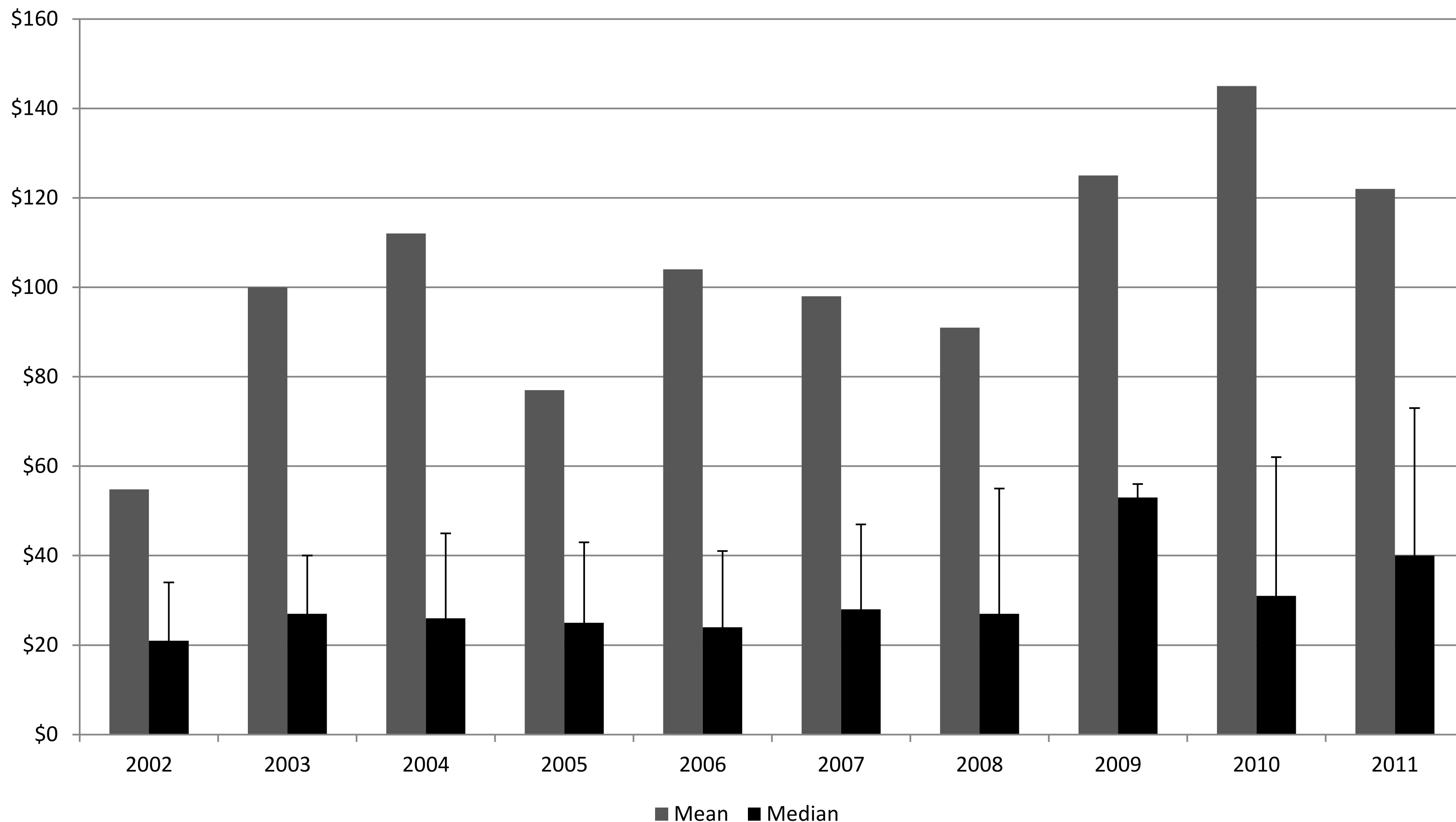
Mean and Median Patient Copayments



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

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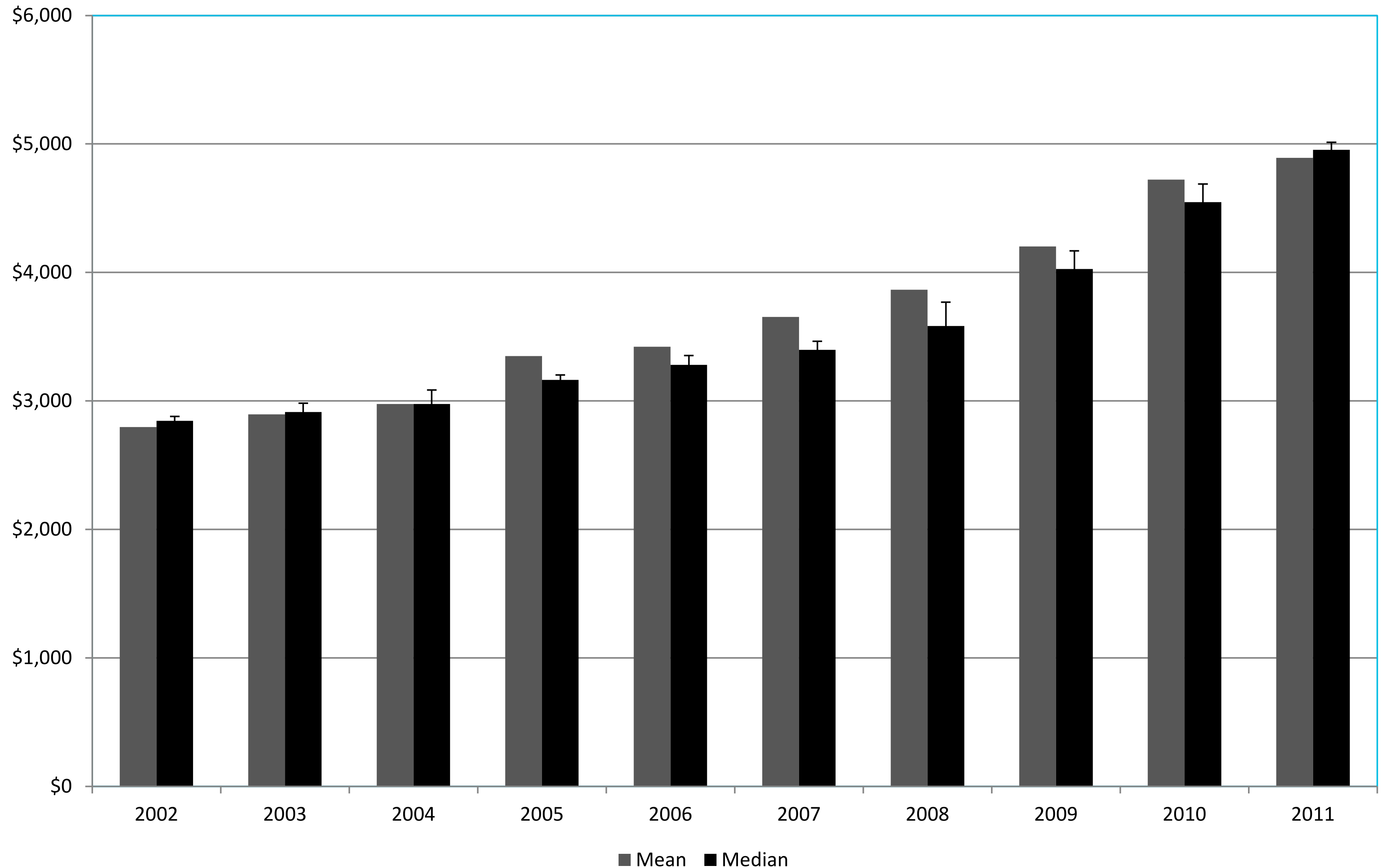
Mean and Median Total Expenditures



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

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Association between Copayments and Discontinuation & Adherence

	Lower copayments*	Higher copayments*	Risk Ratio Higher to Lower (95% CI)
Discontinue within 180 days	10%	17%	1.70 (1.30-2.22)
<80% adherent in first 180 days	21%	30%	1.42 (1.19-1.69)

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

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

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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

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Upcoming challenges

1. **Unit consumption: personalized medicine**
2. **Unit cost: sequence of therapy**
3. **Cost of innovation**

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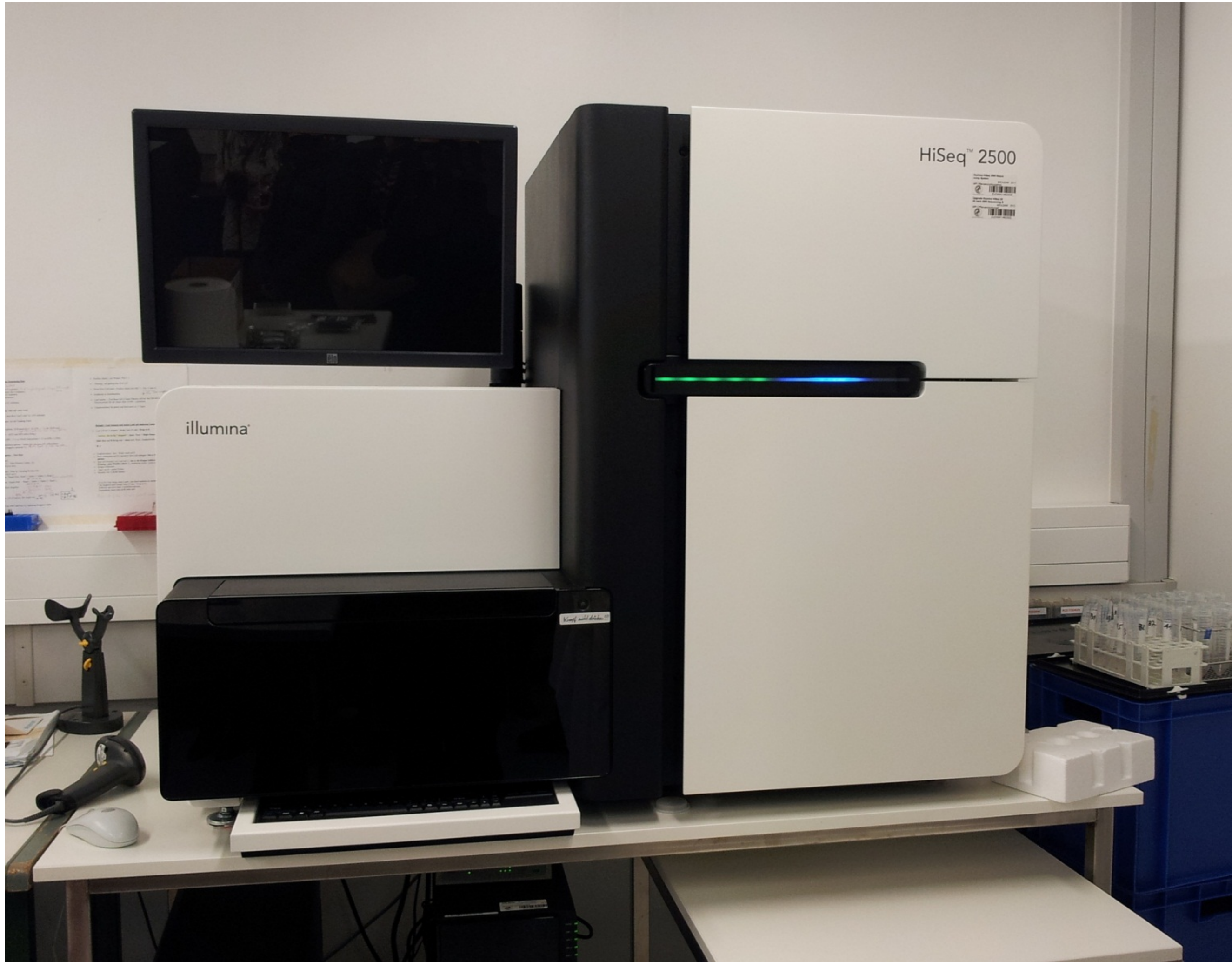
HiSeq™ 2500
illumina

Monthly cost of oral agents used to treat renal cell carcinoma

Sunitinib	**$11,900**
Sorafenib	**$10,500**
Pazopanib	**$7,800**
Everolimus	**$9,400**
Axitinib	**$11,000**

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JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

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 Krahn, Ming-Sound Tsao, Jean-Claude Cutz, and Natasha B. Leighl

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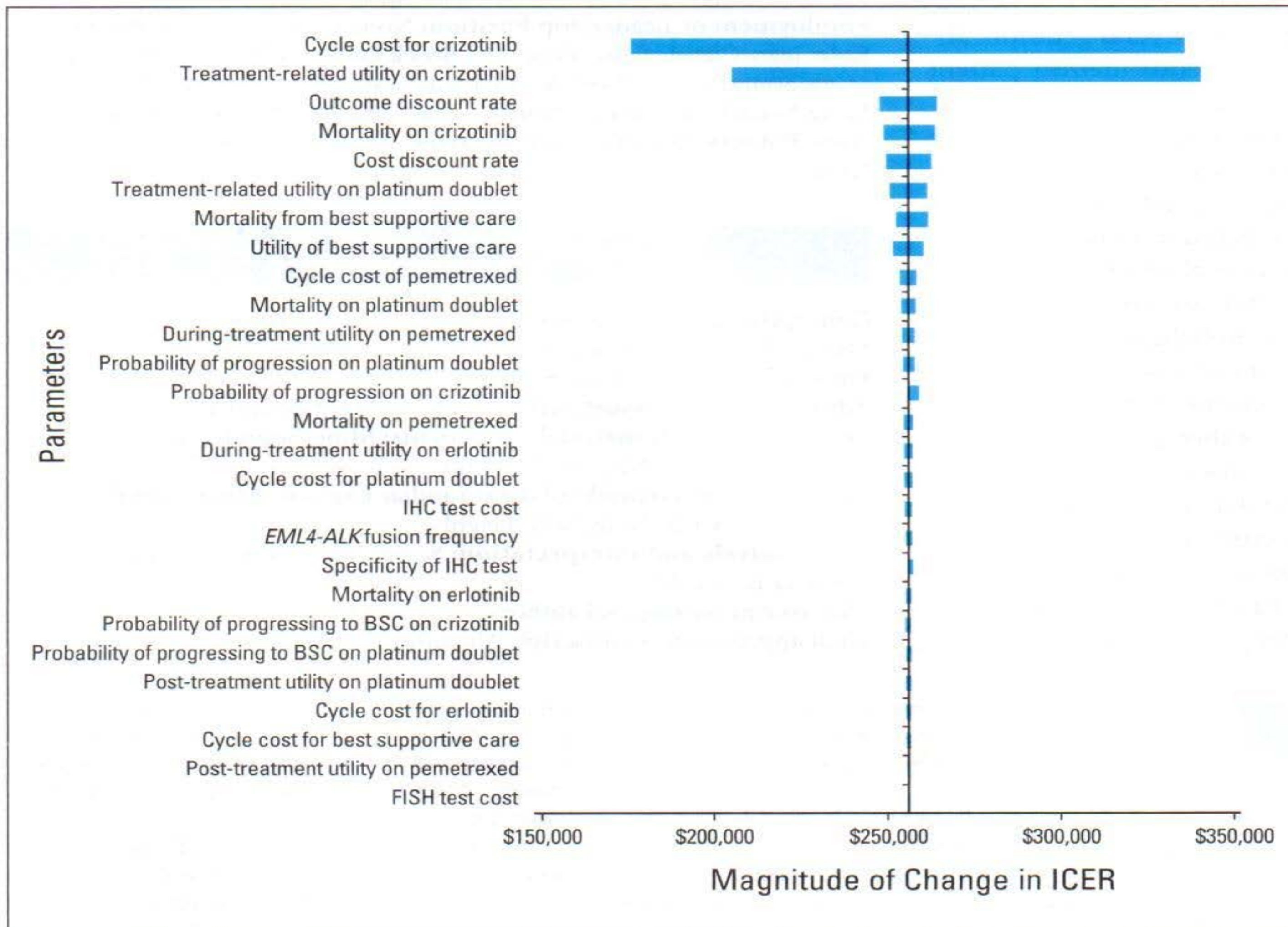

Djalalov et al.
JCO 32: 1012-19

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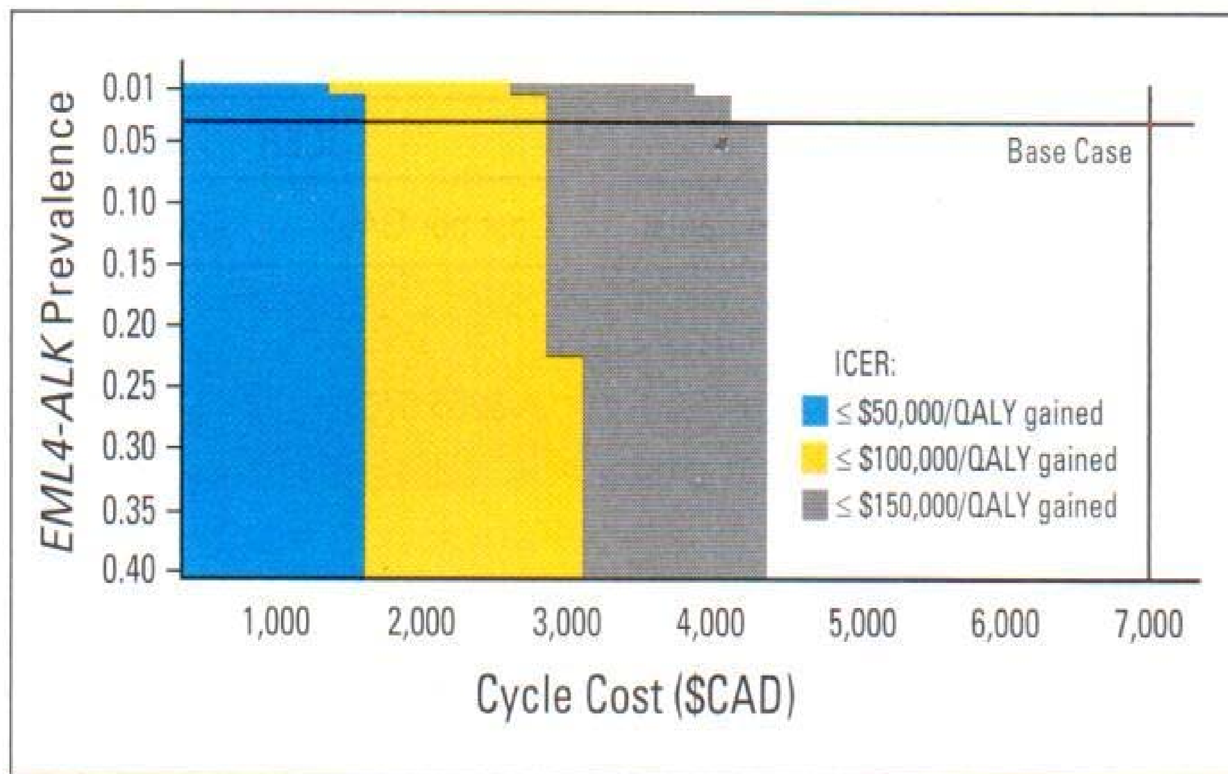

Fig 4. Two-way sensitivity analysis of crizotinib cost versus *ALK* prevalence. ICER, incremental cost-effectiveness ratio; QALY, quality-adjusted life-year.

Djalalov et al.
JCO 32: 1012-19

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JOURNAL OF CLINICAL ONCOLOGY SPECIAL ARTICLE

Cancer Drugs in the United States: *Justum Pretium*—The Just Price

Hagop M. Kantarjian, Tito Fojo, Michael Mathisen, and Leonard A. Zwelling

Kantarjian et al.
JCO 31:3600-4

CML: Background

1. **CML is rare (5000 cases per year, prevalence 80,000).**
2. **Imatinib is AMAZING**
3. **2nd and 3rd generation TKI's out-perform imatinib in many surrogate endpoints but NOT survival**
4. **There are clinical subsets of patients that do better with 2nd and 3rd 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 2nd and 3rd generation TKI's = $115,000-$138,000/year**

Kantarjian et al.
JCO 31:3600-4

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Imatinib will be available in a generic formulation in 2015

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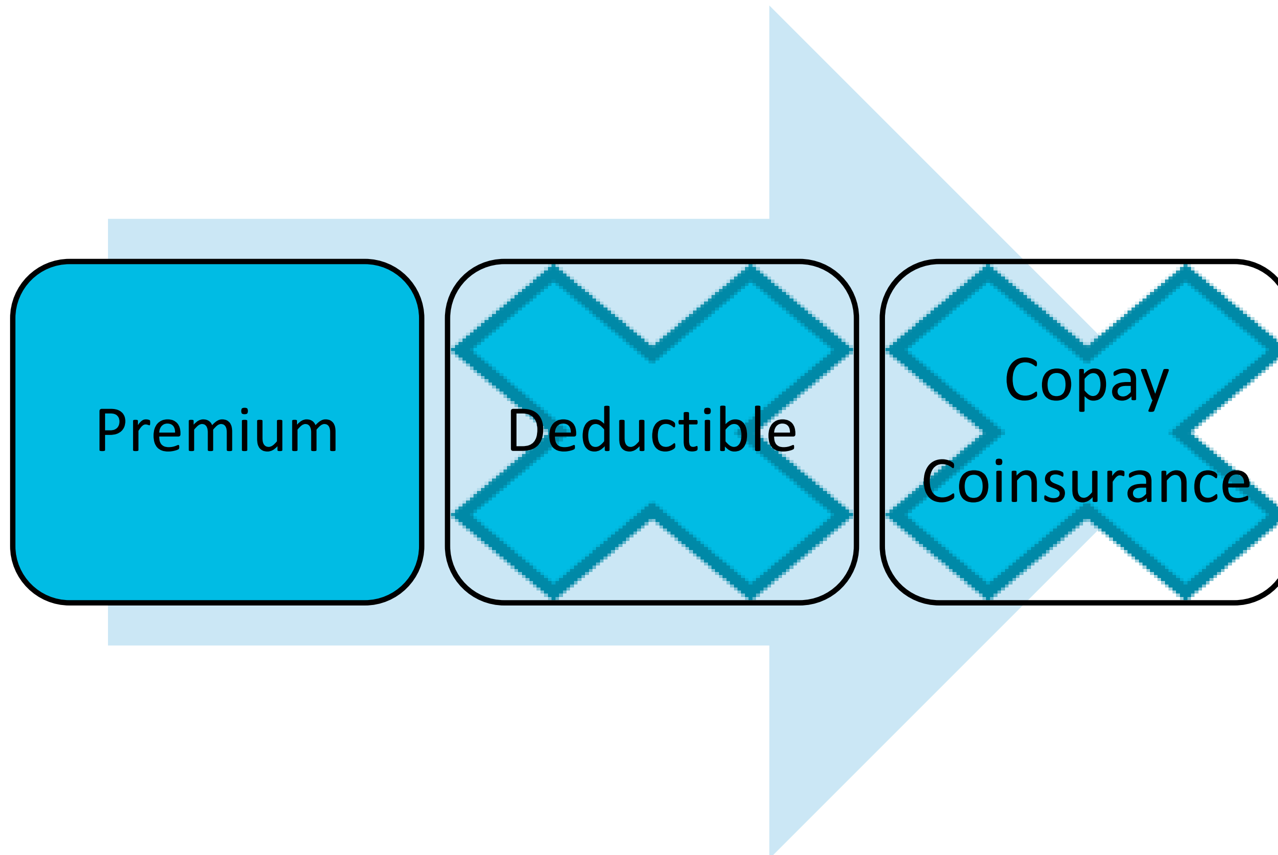
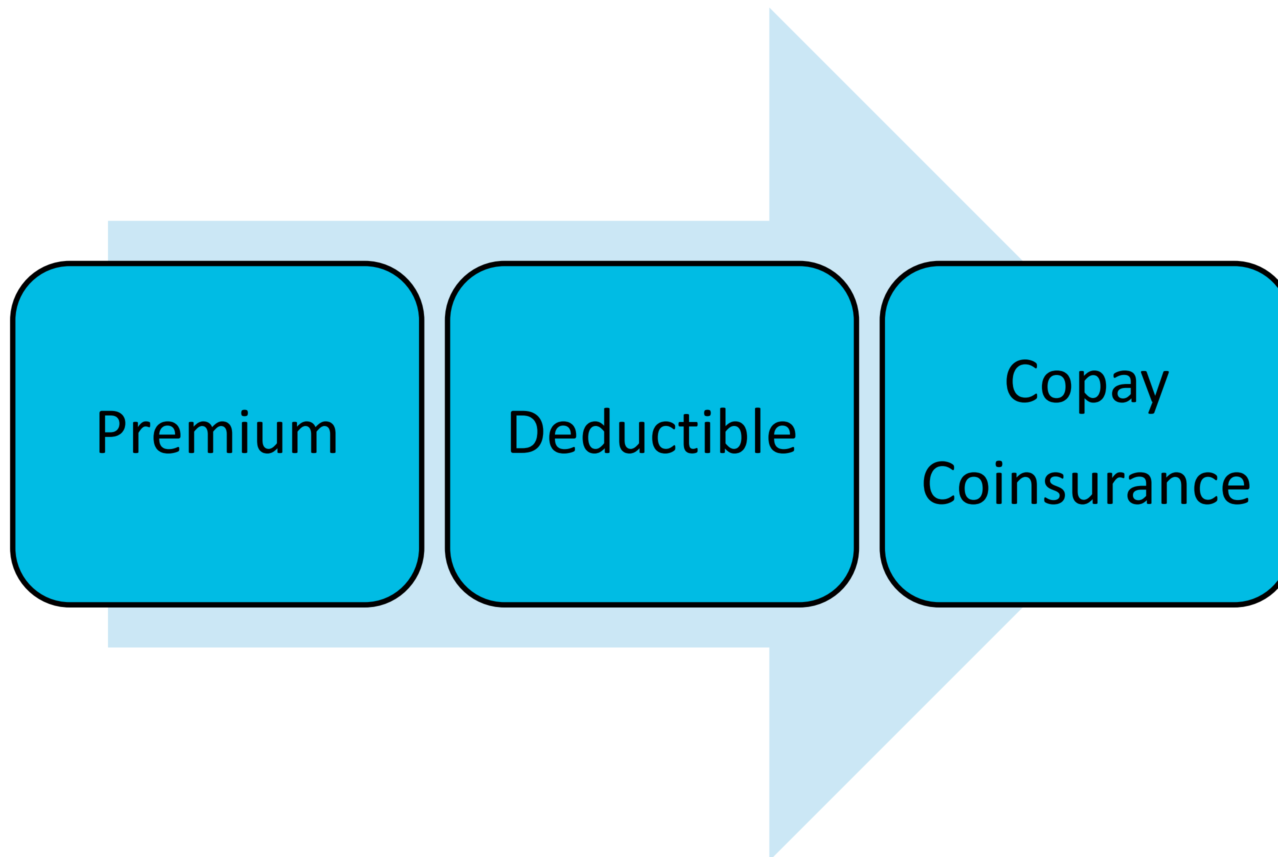
Post ACA, CML therapy



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

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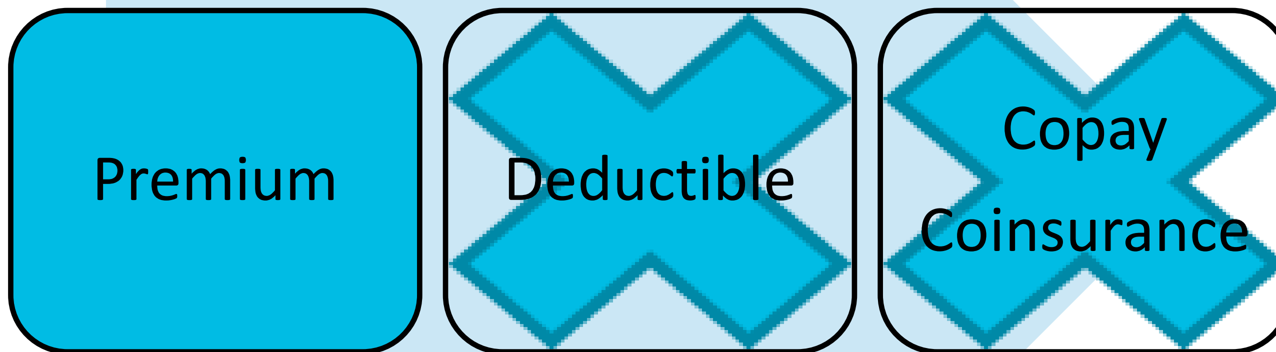
CML paradigm
2nd and 3rd generation TKI



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**

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Value-Based Pricing Agreements