The Rising Cost of Cancer Care in the Era of Individualized Therapy: A Q&A With Thomas J. Smith, MD

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Emerging targeted therapies are extending survival in many cancers, but the cost of these new treatments is often high. For example, sipuleucel-T (Provenge, Dendreon) for metastatic castration-resistant prostate cancer costs $93,000 for the full course of three infusions. Ipilimumab (Yervoy, Bristol-Myers Squibb), the first treatment for metastatic melanoma to improve overall survival in more than 10 years, costs $120,000 for four infusions over a span of just three months. Everolimus (Afinitor, Novartis), for renal cell carcinoma and pancreatic cancer, costs $10,000 a month.

Many of these medications are indicated at the final stage of cancer; on average, they extend lifespan by a few months at most. As a result, as new therapies become available in clinical practice, questions about costs versus benefits are increasingly emerging. Among the often difficult questions being asked: Are the survival gains worth the burden on the healthcare system and individual patients? How do we pay for new drugs, diagnostics, and technologies— and who should pay?

Like it or not, economics are driving treatment choices for patients in the real world. Even when a drug is covered by insurance, many patients are not able to afford even the copay. Thus, despite advances in innovation and care, cost is hindering use of new therapies.

To gain perspective on these issues, *Targeted Therapy News* spoke with Thomas J. Smith, MD, director of Palliative Medicine at The Sidney Kimmel Comprehensive Cancer Center and professor of Oncology at Johns Hopkins Medical School in Baltimore, Maryland. Smith discussed the rising cost of cancer therapies, the burden of cost, and the cost-benefit analysis of end-of-life care, and will also speak about these issues at the 2012 annual meeting of the American Society of Clinical Oncology (ASCO) in a session titled, “Costs of Cancer Care: Affordability, Access, and Policy.”

TTN: How can oncologists stay informed about the best decisions on care alongside their patients in the context of new high-cost targeted therapies?

Smith: It is complicated. I think the first question we have to ask ourselves as oncologists is, “Does it work?” Is there a clear-cut improvement in overall survival or disease-free survival, or quality of life that makes it better

than other treatments? If the answer to this first question is yes, then the next question is, "How much does it cost and to whom?" And these are really difficult questions because sometimes the cost can be extraordinary to society as a whole but very little to the patient. The patient may only have an annual $1000 copay for a $120,000 new melanoma treatment, for example. In other cases, they may need to pay up to 40% of the cost of treatment. Oncologists need to discuss costs directly with their patients. I have learned to ask my patients, "What is your insurance coverage?" and "How much is this going to cost you?" before having the patient receive a $120,000 bill they cannot pay.

For example, aromatase inhibitors for breast cancer cost $450 a month even though there are three of them on the market and all of them are essentially interchangeable. This gets to an issue of compliance. Some patients simply cannot afford the 20% copay.

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The cost of the end-of-life care is very high for cancer patients. How do oncologists reconcile these costs with providing the best treatment for their patients, while also recognizing whether the quality of life may be more important for a patient with advanced-stage cancer?
Many of us were trained to treat the disease and as long as there is something that can be done, to keep treating as long as it does not make the patient deathly ill. This has worked for our patients for the most part. Sometimes, I think the deathly ill part gets neglected a little bit because we tend to ask less about our patients' quality of life than we should.

What role does palliative care play?
Palliative care was always designed to improve patients' symptoms and coping, to lessen depression, and to lessen caregiver burden. It is only an interesting sidebar that it results in cost savings. The cost savings are substantial. It could be anywhere from 20% to 50% of the cost in the last month or six months of life that can be reduced. This type of care allows patients to get out of the hospital, where most people don't want to be.

How does this affect our current healthcare spending as a whole?
There are really imperative reasons to have this cost discussion. First, our cancer care system is simply not sustainable. Even though it is only 5% of the national budget, in the insured population it is 15% to 20%, a substantial amount. The cost per person per year in the US is $8100. It is $4500 in Canada for exactly the same amount of health benefit. The cost of insurance for a family of four has gone from $6000 in the year 2000 to over $15,000 in the year 2012. Insurance premiums went up 8% to 9% last year, and that is simply not sustainable either. There were close to a million, if not more, medical bankruptcies last year alone. So we need to do something. The question is, "What can we do that will cause as little harm as possible?"

What are some of the ways that oncologists can curb costs while providing good care for patients at the end of life?
There are a couple of strategies for oncologists that make good sense. One is to get people into a care system that keeps them out of the hospital near the end of life. The best way to do this is hospice. ASCO and many of us who are practicing oncologists are now recommending that when patients have about three to six months left to

live, they should visit a hospice for information. This does a few things. It makes it real for the patient and the family that this is where things are headed and it is time to plan. It introduces the hospice team as the best way to take care of people at the end of life—which all professional societies agree on, every single one. It introduces the hospice care team as part of the regular oncology care plan. Integrating the hospice early is now part of best practices for most oncologists. It makes the transition easier, so that when a patient has tried a third-line chemotherapy in lung cancer or colorectal cancer without success, the oncologist can say, "Now is the time for you to switch to the hospice care," with the nurses and social workers that the patient has already met.

ASCO released palliative care guidance in March of this year. How do you see this being implemented?
Palliative care should be a part of the care of anyone with a serious illness. The uptake should not be slow. All of us who are practicing oncologists work with hospice providers. I like to use the analogy of we know the radiation therapist and our surgeons very well. We know their phone numbers and their fax numbers probably by heart. For the hospice providers, it tends to be a love-hate relationship. It shouldn't be that way. It should be part of the normal process of care. I think oncologists like me should be calling the hospice providers and saying, "We actually work a lot together. Let's figure out what we can both do to improve the care our patients get." Hospice providers like to see patients when they have at least a month to live rather than a day left to live. It is a terrible process of care when we simply avoid having this conversation until the patient is bed-bound, in renal failure, and has an infection and two days left to live. In this situation, hospice is just scurrying around and doesn't even have a chance to speak to the patient, and is left to pick up the pieces for bereavement and grief counseling. Patients in hospice care and with palliative care tend to live longer rather than shorter.

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Oncologists should speak to the hospice providers to understand how they can do better. We should ask them how our statistics compare to the national average in terms of referral time. As oncologists, we need to be having realistic conversations about how many treatment types a patient can go through before we run out of options. Saying that there is a limit to treatments and there will be a time when treatment will only do more harm than good is necessary. This conversation needs to happen early and be reinforced throughout treatment.

Who are the other players that need to be involved in these cost decisions on a policy level?
This is a big point. I don't think that cost control should fall to the individual oncologist. I think one of the worst things would be that no one at the insurance or government or societal level wants to make these decisions, so it is all a burden on the individual oncologist. I don't think individual oncologists should be the only ones having difficult conversations with patients because no one else wants to do it. But, as oncologists, we need to be prepared to ask our patients about cost.

What is the current level of change and awareness on a government and policy level?
Change is already happening. Insurance companies are making decisions about what they cover and don't cover. Medicare makes decisions by basically not making decisions on whether Medicare will pay for an FDAapproved indication. But we do need to be having more adult conversations about what we can and cannot pay for. This

extends beyond cancer to ventricular assist devices, $100,000 pulmonary hypertension treatment, and the expensive rheumatologic drugs. We cannot continue to spend the way we have been spending.

The US highly values new scientific innovation. The FDA last year approved 35 new, innovative drugs. Most of these approvals were the first global approvals. How do we reconcile the need and benefit of new innovations in spite of cost?

I think it is fascinating that the average cost of a new therapy has gone up by hundreds of percentage points while the improvement in overall survival or disease-free survival has stayed at about 1%. I would like to see data showing that [the cost increases are] due to the increased cost of clinical trials, but it seems hard to imagine. I think companies are doing what we would like them to be doing from a business perspective. They are valuing their drugs at what they think the market will bear. It is great for the company, but it is impossible to sustain.

There may be instances where targeted therapies or testing will actually save money. A good example is the Oncotype DX 21 [21 gene assay] in breast cancer, which we use routinely. The data are quite convincing that this allows us to spare chemotherapy in many situations and simply treat patients with a hormonal agent. To me, there is not an obvious correlation between a high price and the fact that a therapy is targeted. Many of these drugs are in the metastatic setting at the end of life. We as a society need to step up and say, "How much of this can we actually afford?"

As an individual oncologist, I can't fix the cost of targeted therapies. What I can fix as a regular oncologist is the high cost of end-of-life care, much of which is not desired by the patient. I can fix this part by having an open and honest conversation with patients and their families about the reality of the situation. Keeping patients out of the hospital in the last one or two months of life would save billions of dollars for insurance companies and Medicare, and it is what many patients want. This cost savings will allow us to better afford many of these innovative and exciting therapies, all of which I want to keep using.

Are we going in the right direction and having this discussion?

I think that it is fascinating to see what is being proposed on the federal level. A lot of the plans being proposed will actually turn over the benefit determination to insurance companies. It will not be Medicare making the decision, but it will contract with an insurance company that will determine what is covered. Somehow, that is thought to be better at this point. Medicare is already divided into regions. Coverage is determined by someone, whether a bureaucrat or at a large company. I think things will get worse before they get better.