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Specialty Spotlight

$1 Million per-Patient-per-Year for Cancer Immunotherapy?

"If new immunotherapy combinations were administered to the half a million Americans dying of cancer each year, the nation's price tag for treating them—for just 1 year—could top $174 billion, according to projections by **Leonard Saltz, MD**, Chief of Gastrointestinal Oncology and Chair of the Pharmacy and Therapeutics Committee at Memorial Sloan Kettering Cancer Center." "We must acknowledge that there must be some upper limit to how much we can, as a society, afford to pay to treat each patient with cancer," Dr. Saltz said.

Dr. Saltz was speaking at the latest ASCO meeting. He focused on the CheckMate 067 trial of nivolumab (Opdivo) plus ipilimumab (Yervoy) in advanced melanoma. The study demonstrated "a median progression-free survival of 11.4 months for a disease that 5 years ago was thought virtually untreatable," Dr. Saltz said. His problem is with cost, not the benefit. The cost of treating an "average -sized" (80 kg) American patient with the study combination of nivolumab plus ipilimumab for advanced melanoma would exceed $295,500. Treatment with nivolumab alone would be $103,220, and ipilimumab alone—to achieve a median remission of less than 3 months—would cost $158,252. A patient with a 20% copay would be responsible for about $60,000.

Taking this nationally—with 1.6 million cancer cases expected this year and 589,430 deaths—giving $295,000 worth of drugs to each patient with metastatic disease would cost $173,881,850,000, Dr. Saltz projected. "That's $174 billion in 1 year for drugs treating patients with metastatic disease—no adjuvant therapy—for 1 year only," he emphasized.

Commentary:
It is interesting that the once verboten topic of cost in treating life threatening diseases is now front and center. The federal government has been debating adding price considerations in the FDA approval process. This is currently being done in Europe and Australia. There has also been much debate about CMS, especially in Medicare Part D, negotiating prices with the drug industry. Interestingly, what has not been discussed is rationing. Probably, because there are no criteria at present, adopted by ASCO or any other oncology group, for selecting which patients will receive the selected immunotherapy, and who will not. While rationing is common in the European protocols, Oregon is the only state to establish rationing for anything.

Cost has obviously reached a tipping point. Cost-benefit analyses are common, but affordability may often override the best of intentions. The debate must stimulate more research on severity banding of disease in different age and gender groupings. The focus should be on the impact of various regimens of drugs, therapeutic lifestyle changes, patient choice, affordability and other non-

drug therapeutic options. Without this information we will be focusing only on cost, and place the emphasis on denial of therapy for all, or for only the lucky few, when other options exist.

Source: 1. Wolchok JD, Chiarion-Sileni V, Gonzalez R, et al: Efficacy and safety results from a phase III trial of nivolumab alone or combined with ipilimumab versus ipilimumab alone in treatment-naive patients with advanced melanoma. 2015 ASCO Annual Meeting. Abstract LBA1. Presented May 31, 2015.

Find out more

Cancer Survival Is Now 2/3 by 5 Years

IMS data now indicates that two-third of patients are alive five years after cancer diagnosis as compared to 50% in 1990. Of course, the survival from different types of cancer varies. IMS reports an overall increase in survival of 12%. Prostate cancer survival increased the most at 18% while Lung NSC and CRC Colon survival increased 4%.

Commentary:
Obviously, this is good news. Now comes the debate on what caused the increase. The multifactorial reason for cancer fuels the debate. Certainly, several factors are involved – personal habits, medications, diet, therapeutic lifestyle changes, etc. On the other hand, smoking, obesity, genetics and other factors work against the improvements. The Pharmaceutical industry has targeted cancer with a pipeline of new medications that are very expensive. Health Plans and various special interest groups have targeted lifestyle changes. Regardless of the reasons for increased survival, there will be benefit designs that shift responsibility for lifestyle changes to subscribers. Then the debate focuses on affordability. However, the real debate should focus on how to change behavior for the better.

Is Hoarding Data a Target for Hacking?

Experts are now saying that cyberattacks are more impactful because Health Plans retain customer data after the individuals are no longer covered by their insurance. The topic has come up because of the publicized cyberattacks most notably against CareFirst Blue Cross, Premera Blue Cross and Anthem.

It is notable that the Health Plans did keep data in multiple databases so that medical and financial information is not stored in the same place as subscriber information. Yet, the cyberattacks do obtain confidential subscriber information. Hence, the method of distributing information (technically rationalized databases) is necessary, but not a sufficient control to defend against cyber-attacks.

States determine how long medical records must be retained. HIPAA, a federal law, requires data to be held by covered entities “for six years from the date of its creation or the date when it last was in effect, whichever is later.”

Commentary:
Health Plans hold on to data for its value. This value may be for research, trending, comparison of outcomes, litigation, benefit defense, DNA records, etc. The ultimate defense is to store the data on a system that is not accessible from the outside. However, this is not enough. Any manual handling of data needs to be secured as much as possible. That is the reason for policies and procedures and security audits. Ultimately, nothing is 100% secure!

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a subsidiary of Pro Pharma Pharmaceutical Consultants, Inc. (Pro Pharma) offers integrated healthcare analytical management tools, utilizing concurrent management methodologies to address payer goals and objectives of managing quality, utilization, risk and cost.

Concurrent management requires data to be transparent to all stakeholders and for analytics to be readily available in order to ask the "what if" questions and compare the impact of various options. Decision- making starts with identifying problem areas. Necessary information includes:

- What is our current situation? What is driving it?
- What do we change? What do we change to?
- How do we implement change?
- How do we measure that the change(s) have created improvement?

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