

Speaking of Employers: Purchasers Detail the Challenges of Getting a Handle on Oncology Care Costs

Mary Caffrey

A tradition of not questioning what the doctor says, because it's cancer, and a person could die.

A shifting financial landscape that lets some patients with cancer choose between an academic center and a community practice, whereas others have no choice at all.

Million-dollar treatments. And patients who have no idea what their health plan covers.

THESE ARE ASPECTS of the world that today's employers face as the workforce ages,¹ the price of cancer treatment rises,² and the obesity epidemic means millennials face double the risk of cancers that baby boomers did a generation ago.³

Good health benefits are essential to attracting top talent, but for employers, this comes at a price. An initiative by the Northeast Business Group on Health estimated that US employers spent \$125 million on cancer care in 2015, or 12% of their entire health-care spend.⁴ Cancer therapy costs have increased substantially since then, with the expanded use of immunotherapy, including the introduction of chimeric antigen receptor (CAR) T-cell therapy.

As today's employers try to balance the need to provide healthcare for their workers while keeping an eye on cost, they are banding together to learn more about cancer care and how to gain value for the millions they are spending. Meanwhile, provider groups like the Community Oncology Alliance (COA) are reaching out to employer and purchasing coalitions to discuss how community oncologists can help hold down costs.

Last fall, the 2 came together during COA's Payer Exchange Summit, held October 28 and 29, 2019, in Tysons Corner, Virginia. *Evidence-Based Oncology*TM listened as leaders from employer and purchasing groups shared experiences from their members in a roundtable discussion.

The participants were the following:

ASHLEY TAIT-DINGER, MBA, director of analytics, alternative payment models and finance for the Florida Health Care Coalition, based in Orlando

CHRIS SYVERSON, chief executive officer of Nevada Business Group on Health/Nevada Health Partners, based in Reno

MARIANNE FAZEN, PHD, president and chief executive officer, Texas Business Group on Health/Dallas-Fort Worth Business Group on Health

MAGDA RUSINOWSKI, vice president of health care cost and delivery, Business Group on Health, Washington, DC

RANDY VOGENBERG, PHD, principal, Institute for Integrated Healthcare, and board chair, Employer-Provider Interface Council of the Hospital Quality Foundation, Greenville, South Carolina

BRET JACKSON, president, Economic Alliance for Michigan, a bipartisan business and labor coalition

KYLE MONROE, MBA, vice president of network development and provider relations, The Alliance, based in Madison, Wisconsin

RUTH ANTONIADES, MS, executive director, Labor Health Alliance, New York, New York

Participants were asked a simple question: What does value in cancer care mean to your organization? And the discussion flowed from there. Tait-Dinger said her group's employers have been learning about bundled payments and value of navigators and whether it makes sense to use large providers. Fazen said her members also are learning about the value of navigators, and both said these professionals not only coordinate care but also can help members understand the details of the benefit package.

"The idea is to focus on the patient experience," Fazen said. "That's a big trend."

One item that emerged: ensuring that employees have help understanding the details of their short-term disability policies. In some cases, they can use individual benefit days for treatment.

Vogenberg said he sees "value" through more than 1 lens because he previously worked in Massachusetts and now works in South Carolina, where cancer care options can be limited, depending on where patients live. In South Carolina, partnerships among stakeholders in cancer care are still relatively new, he said. "Leapfrog and Leapfrog-like" activities are happening, he added, referring to the watchdog organization best known for its safety ratings.⁵

Site of Care Is Critical

Several participants discussed how site of care drives cost and considered ways employer coalitions can push back, assuming choices are available. Monroe said that in rural Wisconsin and Minnesota, some community oncology clinics have been acquired by area hospital systems, so patients no longer have real options—and neither do the people paying the bills. "If you're in the system, they're getting their pound of flesh," he said.

There are success stories, too. Syverson discussed how her members banded together and negotiated lower-cost care and better transition arrangements through Huntsman Cancer Institute at University of Utah for patients who needed specialty care, so they didn't need to go for care at one of the medical centers in the University of California system.

"You Can't Control Demand"

Talk of escalating drug costs was never far from the surface. If anything, the participants said, the 6-figure blockbuster therapies of recent years have finally pushed oncology off its untouchable perch; employers are finally seeking management strategies years after taking similar steps in cardiology, orthopedics, and other high-cost areas.

According to Jackson, when employers did an end run on the payers and the hospitals and talked directly to oncologists, it was an eye-opener. "Employers have been so focused on trying to control the demand side of healthcare," he said. That makes sense in some areas, such as setting limits on physical therapy. "When you get to oncology, you can't control demand," he said. "If they have cancer, they need treatment—otherwise, they are going to die."

Talks with oncologists revealed a great desire to stick to evidence-based guidelines, limit scans, and use just the right amount of therapy. But there are other forces at work. "They can't get the administration of their health system or their hospital to buy into those things," Jackson said. Less radiation means "fewer trips through the machine, and the bean counters at the hospital don't like that," he said. »



TAIT-DINGER

Ashley Tait-Dinger, MBA, director of analytics, alternative payment models and finance, Florida Health Care Coalition



SYVERSON

Chris Syverson, chief executive officer, Nevada Business Group on Health/Nevada Health Partners



FAZEN

Marianne Fazen, PhD, president and chief executive officer, Texas Business Group on Health/Dallas-Fort Worth Business Group on Health



RUSINOWSKI

Magda Rusinowski, vice president, health care cost and delivery, Business Group on Health

PAYING FOR CANCER CARE



VOGENBERG

Randy Vogenberg, PhD, principal, Institute for Integrated Healthcare; board chair, Employer-Provider Interface Council



JACKSON

Bret Jackson, president, Economic Alliance for Michigan



MONROE

Kyle Monroe, MBA, vice president, network development and provider relations, The Alliance



ANTONIADES

Ruth Antoniadis, MS, Labor Health Alliance

Jackson's Economic Alliance convened a multistakeholder group that brought oncologists, payers, purchasers, and consumer groups to the table to ask how to improve the delivery system for everyone. "We need the employer community to stand up for the right thing with the CEO [chief executive officer] and the CFO [chief financial officer] of the health system to make it all happen," he said. "And, of course, we need to pay for it. We need the insurance companies to buy in this." That means prior authorization and step therapy must follow evidence-based guidelines, as well.

Blockbuster Therapies Shape Coverage

Both Rusinowski and Syverson discussed the distortions caused by the rise of extremely expensive gene therapies. CAR T-cell therapy starts at \$373,000 just for the treatment; with administration costs, it can rise to \$1 million.⁶ With financial models that require the assumption of more risk and more of these therapies in the pipeline, small employers in particular are worried, Rusinowski said: "This is not going away."

"Employers have been so focused on trying to control the demand side of healthcare. ...When you get to oncology, you can't control demand. If they have cancer, they need treatment—otherwise they are going to die."

—Bret Jackson,
Economic Alliance for Michigan

Others discussed how solutions for self-insured employers, such as carve-outs for high-cost therapies that call for these treatments to be packaged in a reinsurance pool, are no free lunch. Reinsurance costs are going up, too; for small employers, especially, the rise of high-cost curative therapies is beginning to drive coverage decisions and will make self-insurance off limits. One employer in Syverson's area that had been self-insured had to rejoin a commercial plan because it hired a man with a hard-to-treat chronic blood disorder. "They were going to go bankrupt based on 1 employee," she said.

"With all the new drugs that are coming out, we are coming up what I consider to be ethical decisions on plan design issues," Syverson said. "And they write their plan any way they want."

One small casino in Nevada stopped paying for specialty drugs because the owner could no longer afford to pay for high-cost drugs. "And that's not unusual," Syverson said.

Paying for six-figure therapies when the average tenure of an employee is 2 years is also an issue. Tait-Dinger said in the Orlando area, where she is based, employer groups are coming to grips with the idea that if everyone commits to taking on the high-cost therapies that emerge in the employee base, even if there is employer turnover, every employer will pay a fair share for these new therapies over time.

Monroe said that when it comes to cancer care, historically, the conversation has been about quality. When his group, which represents 120,000 lives, tried to talk about value, there was pushback. "Traditionally, our employers stay away from this," he said. "We wanted the providers to have those conversations."

But in the past year or so, there's been a shift, he said: "The million-dollar therapies in the pipeline have raised the level of awareness and a reasonable concern."

Finding Their Place at the Table

For years, employers have focused on running their business, and the cost of cancer care has not been on their radar. It's something that Rusinowski can relate to from her days on that side, but she said that attitude is changing. Today, she said, employers are learning just how "opaque" the drug pricing system is: They know what they don't know and are not willing to accept the lack of information.

"My employers are really struggling," Syverson said, with all the new terms, such as *biosimilars* and *orphan drugs*. It's a lot to learn, she said. Employees still tend to do whatever the doctor tells them to do, and it's still hard for the employer or someone on the employer's behalf to step in and ask if there's a better solution.

It's important for employers to ask who works for whom in the cancer care process, according to the participants. Does the navigator work for the physician? Is the navigator independent? Or does the navigator work for the health plan? Because if it's the latter, one participant said, that's like "the fox watching the henhouse."

Rusinowski said the lack of transparency around drug pricing, including the rebate system, is designed to keep employers from understanding the big picture. A self-insured employer that gets a big check might not ask questions, but, Rusinowski said, the questions need to be asked: "Are there rebates? Are the rebates properly assessed?" Cleaner pricing models, she said, might be more beneficial in the long run.

In the end, Antoniadis said, it comes down to matching care with what the patient wants. She described at length how her own views on value-based care shifted after seeing her son live, work, and travel with Hodgkin lymphoma for the past 2 years.

"It seems like we have to think about a different kind of approach," she said. "Even if the diagnosis is the same, one size doesn't fit all. There needs to be a way to connect with people, to get them the treatment they're entitled to, while recognizing that everyone isn't going to accept everything they're offered." ♦

REFERENCES

1. McEntarfer E. Older people are living longer, earning more. US Census Bureau. [census.gov/library/stories/2018/04/aging-workforce.html](https://www.census.gov/library/stories/2018/04/aging-workforce.html). Published April 24, 2018. Accessed January 25, 2020.
2. Cancer Action Network. The costs of cancer: addressing patient costs. American Cancer Society website. [fightcancer.org/sites/default/files/2018/04/2018-Costs-of-Cancer-Final-Web.pdf](https://www.fightcancer.org/sites/default/files/2018/04/2018-Costs-of-Cancer-Final-Web.pdf). Published April 2017. Accessed January 25, 2020.
3. H. Sung, Siegel RL, Rosenberg PS, Jemal A. Emerging cancer trends among young adults in the USA: analysis of a population-based cancer registry. *The Lancet*. 2019;4(3):e137-e147. doi: 10.1016/S2468-2667(18)30267-6.
4. Nobel J, Sasser E, Weiss J, Pickering L. Cancer and the workplace: an employer perspective. The Northeast Business Group on Health. [nebgh.org/wp-content/uploads/2015/10/Cancer-Workplace_FINAL.pdf](https://www.nebgh.org/wp-content/uploads/2015/10/Cancer-Workplace_FINAL.pdf). Published October 2015. Accessed January 25, 2020.
5. The Leapfrog Group. The Leapfrog Group website. [leapfroggroup.org/](https://www.leapfroggroup.org/). Accessed January 25, 2020.
6. Rosenberg J. CMS proposes increased reimbursement for CAR T-cell therapy, price hikes for rural hospitals. *The American Journal of Managed Care* website. [ajmc.com/newsroom/cms-proposes-increased-reimbursement-for-car-t-cell-therapy-price-hikes-for-rural-hospitals](https://www.ajmc.com/newsroom/cms-proposes-increased-reimbursement-for-car-t-cell-therapy-price-hikes-for-rural-hospitals). Published April 24, 2019. Accessed January 25, 2020.

Pharmacy Times

Payment Models for Pricey Pharmaceuticals

Read more at: [pharmacytimes.com/link/293](https://www.pharmacytimes.com/link/293)