

WHAT PAYORS, ONCOLOGISTS, AND ONCOLOGY PRACTICE MANAGERS

Are Seeing in the Trenches

A Discussion with

Mark Zitter, MBA

Founder and CEO of The Zitter Group



The Zitter Group provides clients with leading-edge insights from its quantitative and qualitative market research focused on managed care policies and plans for managing specialty therapies. Over the years, the company has remained on the forefront of the evolving managed markets and pioneered the national dialogue between payors and manufacturers, producing the industry's first meeting on pharmaco-economics, the first newsletters on outcomes and health economics, and the nation's largest managed care conference on outcomes and accountability. The Zitter Group was also involved in the birth of disease management as an influence on the healthcare system in the 1990s, producing the first educational programs

and conference on disease management, as well as a variety of tools for managed care organizations and health systems. This tradition continues today in the company's *Managed Care Oncology Index* – a semiannual survey of payors, oncologists, and oncology practice managers. The company also tracks prior authorizations (PAs) from more than 350 public and private payors for 30 different oncology agents. At six years and counting, the ongoing study represents the longest-running quantitative sample of its kind. *ManagedCare Oncology* sat down with Mark Zitter, MBA, founder and chief executive officer of The Zitter Group, to discuss the most recent results from his company's *Managed Care Oncology Index* and gain his insights on the implications of these findings in the treatment of lymphoma today.

MCO: From where does The Zitter Group garner its perspective on the current managed care oncology landscape?

Mr. Zitter: First of all, we conduct the largest and longest-running study of oncology reimbursement in the nation. It's an ongoing, semiannual study called the *Managed Care Oncology Index*, where we survey 100 payor executives, 100 oncologists, and 100 oncology practice managers. What we're looking at in this study is how payors are managing oncology therapies and how practices are noticing and responding. In addition to the *Managed Care Oncology Index*, we also track the PAs for more than 350 government and commercial payors for 30 different major oncology therapies. We track and rate how restrictive each payor's policy

is based on objective criteria validated across the spectrum. With this, we can see not only payor-by-payor information, but also trends across the nation. These are the two main places we're getting the quantitative data.

MCO: What is the general consensus on the current management of oncology therapies among payors, oncologists, and practice managers?

Mr. Zitter: With rising costs and a pipeline stuffed with expensive therapies, payors don't have a choice but to address oncology. Cost pressures are causing payors to become increasingly aggressive in their management. This is made somewhat easier by the growing number of competing therapies for clinicians to choose from. Still, while payors are more willing and more able than ever to manage the class, oncology agents are still not managed as much as therapies from other classes.

MCO: Where do the various stakeholders see opportunities for cost savings in the management of oncology therapies?

Mr. Zitter: The most significant area where payors see an opportunity for cost savings is in the general category of unnecessary care. This includes both end-of-life care and inappropriate use, but overwhelm-

ingly in end-of-life care. Specifically, we ask payors, "What degree of money spent on cancer is wasted?" According to our results, payors believe that, on average, 22% of costs can be eliminated without impacting outcomes. That likely drives some of the behavior behind PAs and other utilization management directives. Furthermore, only 17% believe that inappropriate therapy does not drive excessive costs. The number one reason for this is inappropriate treatment at the end of life.

Of course, the general opinion on where costs can be cut varies depending on who you talk to. Practice managers believe that payors should reduce utilization management initiatives such as PA requirements to reduce practice costs by eliminating overhead burden and staffing needs. Oncologists believe that laboratory and testing requirements should be reduced. And many payors believe the current level of management is absolutely necessary for a sentinel effect that prevents costs from rising uncontrolled. The bottom line is that all parties involved believe that costs can be reduced in oncology.

MCO: What are the key issues that have had a major impact on the market dynamics of oncology over the past six to 12 months?

Mr. Zitter: First of all, there appears to be a sense of resigned acceptance among oncologists and practice managers. The new norm is category management, as payors attempt to reduce treatment heterogeneity. As a result, PAs, treatment guidelines, and clinical pathways are here to stay, and providers know it. That's the reality, and the oncologists seem to accept it, albeit grudgingly.

Financially, we continue to find that practices in general are not very aware of their reimbursement terms with payors. They just sign a contract and then go out and practice the way they want to practice. They can't tell you the length of the contracts and when they expire. And they certainly can't tell you the margin they're making or the fees they're awarded for administration. They negotiate the best deals they can – which usually aren't very good – and then they just go forth and practice medicine. This phenomenon is more common among smaller practices, but most aren't aware in general, even some of the larger practices. This may be a result of the fact that average sales price (ASP) reimbursement has settled down a bit and there's a greater use of specialty, so they're less affected by these factors than they used to be. They generally don't make the margin on the drugs anymore, so they're less aware of it than they were previously.

The most surprising finding for us over the last six to 12 months has been the tremendous rise in oral medications, which now account for two-thirds of oncologists' prescriptions. In the last installment of our study and for the first time since its existence, a plurality of oncologists showed a preference for orals. ASP is pressuring reimbursement, and they're losing money on infused drugs – or they have a hunch they're losing money – so they say, "Let's not risk going underwater on these drugs. If all things are equal, let's just prescribe



the oral." So that's a dramatic shift over the last couple of years. The orals are easier to control for the payor, but they're often more expensive for the patient. If a product is on the pharmacy benefit, there's almost always a copay. On the medical benefit, there may be coinsurance, but there's usually not. So typically products on the pharmacy benefit are more expensive for the patient and less expensive for the plan than products on the medical benefit. The incentives should be aligned here, but they're really not.

Patients are also getting more and more pressure with cost sharing. Overall, in the last six months, we saw about a \$10 increase in office visit and drug copays, which is a reasonably large amount over a short period of time. It's disconcerting, but we're also finding that nearly 40% of practices have had to discontinue treatment for at least one patient because he or she couldn't pay. Even though we know that generally patients will prioritize oncology therapies if money is tight, we're still seeing a lot of practices that discontinue care or refer patients elsewhere because they just can't pay.

MCO: How do payors prioritize the management of lymphoma therapies and why?

Mr. Zitter: Payors tend to prioritize the management of the most expensive drugs and the drugs they're able to manage. So it's basically a "will and skill" issue. When I say drugs that payors are "able to manage," I'm referring to the payors' technical and political ability to manage a class of agents. Cancer is a tough one politically because it's a serious disease with significant pushback. From a technical standpoint, the management is complicated by many of the therapies still being infused and the difficulties surrounding

management on the medical side, where the costs aren't broken out and it's difficult to track who's administering the drug. So across all classes there is relatively less management of cancer overall.

Our survey looks at 17 different types of cancers, and on a scale of 1 through 5 – with 1 being very light management and 5 being very heavy management – payors rate non-Hodgkin lymphoma (NHL) at 3.3 (moderate management, seven of the 17 cancers) and Hodgkin lymphoma at 2.98 (lighter management, nine of 17).

So they're both in the middle, and that falls right in line with the costs associated with treating the disease, which are also right there in the middle.

In terms of unmet therapeutic need, payors rate NHL at 3.49 out of 5 (12 out of 17) and Hodgkin lymphoma at 3.27 out of 5 (13 out of 17). Oncologists have lower numbers here, with a mean of 3.32 (15 out of 17) for NHL and 2.71 (17 out of 17) for Hodgkin lymphoma. What was interesting here was that Hodgkin lymphoma was the only disease out of 17 where a plurality of oncologists did not believe there was an unmet therapeutic need.

MCO: How are payors using PA in lymphoma?

Mr. Zitter: PA is used in lymphoma by 40% to 50% of payors. Looking at NHL and the four major therapies there – Bexxar, Treanda, Arzerra, and Rituxan – 39% to 49% of payors have a PA in place. So more than half of payors did not have any PA in place whatsoever. I think the feeling here is that if someone's getting Bexxar, they probably need it, so why fuss with it? It would



end up costing more than it's worth to manage it. All the IV lymphoma therapies fall somewhere in that <50% range of payors having PA requirements, but 66% of plans have PAs for Zolanza for T-cell lymphoma. That's because it's an oral agent and easier to administer PAs.

MCO: Are you seeing any other management tools being used by payors?

Mr. Zitter: What it comes down to is that the tools for management in a payor toolkit fall into four basic categories. There's the demand side, which is basically cost sharing: How do you make patients want it less? There's the supply side, which is essentially use rules: How do you make physicians jump through hoops so they'll prescribe it less or more appropriately? There's reimbursement, and here payors have used ASP payment to curtail use and cost of oncology therapy. And finally there's the site-of-care dynamic: the use of specialty pharmacy or other sites of administration that are less costly than the provider's office. The challenge on the cost-sharing front is that it tends to be a pretty blunt instrument. You hate to do too much of that

because it keeps people from getting care. It's important to keep in mind that payors don't create a benefit design with a drug or even a disease in mind. Instead, they create a benefit design and then try to fit a drug into it.

On the use rules, by far and away the most common are PAs. In addition to the basic requirement that an agent must be prescribed by an oncologist, there are step-edits, requirements on patient characteristics, specific line of therapy, and quantity limits. Payors report having these line-of-therapy and quantity limits a lot more than oncology practice managers do, which leads us to believe that either these specific requirements are not very restrictive or oncologists are good at staying within the lines.

In general, we are seeing a statistical trend of more PA-eligible products coming to market, more restrictive PAs, and more PAs in general. That being said, the counter-trend we're also seeing is with the more sophisticated organizations using clinical pathways driven by provider groups rather than PAs. And while these programs are developed under the guidance of provider groups, payors do feel much more strongly – statistically significantly more strongly – than oncologists that adoption of clinical pathways will improve care quality and reduce costs. This may presage a trend: While 19% of payors tell us that they've adopted pathways, another 55% to 60% tell us that they're going to do so in the next one to two years.

MCO: How prevalent are category management techniques in lymphoma?

Mr. Zitter: In lymphoma, they're not very prevalent. Nationally, 38% of payors have some sort of established preferred therapy in at least one category. Of that 38%, 21% have a preferred therapy for lymphoma, either Hodgkin or non-Hodgkin. This means that only 8% of all the payors in the country have a preferred therapy for

lymphoma. While this is a very small percentage, it is up significantly from our last study six months ago. For the most part, it seems as if payors want to give clinicians the opportunity to treat lymphoma the way they see fit. Also, the way the financial dynamics work, when payors have preferred therapies, it's usually because of manufacturer contracts. If there's no opportunity to leverage a contract to save money, there is usually no preferred agent.

MCO: How often do you see a copay vs. coinsurance for lymphoma therapies? What kinds of rates are being applied?

Mr. Zitter: Not surprisingly, you're seeing very few copays for infused therapies in this area. Looking at Bexxar specifically, out of the 101 payors we surveyed, only four of them have a drug copay only, and nine of them have a drug copay and an office visit copay. Coinsurance is also not that common for the drug, only at about 11% of payors, but 23% have coinsurance with an office visit copay. About 30% of payors report an office visit copay only with no drug copayment. The average copay that we're seeing for Bexxar is \$24. The average coinsurance is 20%. All the other major IV lymphoma therapies have similar cost-sharing figures. For Zolanza in the treatment of T-cell lymphoma, 72% of payors have a copay, with only 22% having coinsurance, since it's an oral therapy. The copay for this agent is higher than for the IV therapies at an average of about \$45.

MCO: Considering the current cost pressures in oncology, how do you envision the managed care environment for payors and providers in the future?

Mr. Zitter: Oncologists and practice managers are mixed on this question: While they've reported improved financial viability over the

past 18 months, they consistently predict that things will get worse. This may mean that practices have found ways to cope but believe that they have few tricks left up their sleeves. Nearly half of oncologists report referring patients out due to financial viability. And often they're going to hospital outpatient departments, so it ends up being more expensive for the payor. More than half of practice managers say there's been a loss of revenue since ASP came into play. The majority say it's between 10% and 30% of revenue, which is a pretty big sum of money for a business. And while it's a dynamic field, certainly cancer as a disease is not going away. We're also seeing some favorable trends in some cases along with these unfavorable trends. We're seeing cancer being managed as a chronic disease, which is good news from a mortality standpoint although not necessarily from a cost standpoint. We're seeing all kinds of therapies being launched, more often than not at a premium, and for now the government is paying for them. It's not clear how this will all play out, but we'll certainly see more dollars going into cancer therapies and more products launched to treat the different diseases. This strongly implies that we'll see more aggressive payor management well into the future.

